MEDICAL STAFF BYLAWS

TEXAS HEALTH HOSPITAL FRISCO

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MEDICAL STAFF

2021

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PREAMBLE

Whereas, the Physicians and other licensed independent Practitioners who are appointed to the Medical Staff at Texas Health Hospital Frisco are organized to provide leadership for the Medical Staff and accountable to the Board of Trustees as required by legal and accreditation requirements;

Therefore, these Medical Staff Bylaws set out:

- the organization and structure, rights, and obligations of the Medical Staff of Texas Health Hospital Frisco and its Members, and the relationship of the Medical Staff and its Members to the Board of Trustees;

- the Medical Staff's responsibility for the oversight, review and appraisal of the quality of the professional services provided by Members of the Medical Staff and others with Clinical Privileges;

- the mechanism by which Medical Staff membership and Clinical Privileges are granted, limited, and terminated; and

- the Medical Staff's accountability to the Board of Trustees.

DEFINITIONS

Adverse Recommendation or Action: Any action or recommendation listed in Article 9 which entitles a Practitioner to certain procedural rights of review under these Bylaws.

Allied Health Professional or AHP: An individual, other than a Practitioner, who meets the criteria established by and is in a discipline approved by the Board of Trustees for Allied Health Professional status, as set forth in Hospital policy. AHPs are not eligible for Medical Staff membership. Allied Health Professionals function in a support role under the delegation, direction and/or supervision of a Practitioner.

Article: An article in these Bylaws.

Board of Trustees: The governing body of Texas Health Hospital Frisco, which has the ultimate responsibility and authority for the operation of the Hospital as required by legal and accreditation requirements.

Bylaws or **Medical Staff Bylaws**: These Medical Staff Bylaws of the Medical Staff of Texas Health Hospital Frisco.

Chief Medical Officer: The individual appointed by the Hospital President to provide strategic, long term direction for the Hospital's quality, patient safety, and risk management programs, and build support and involvement with the Medical Staff, or, unless otherwise stated in the Bylaws, his designee.

Clinical Privileges: Permission granted to Practitioners and certain Allied Health Professionals to provide patient care, treatment, and services, including access to Hospital equipment, facilities and personnel.

Complete Application: An application that is deemed complete as defined in Article 2, Section 2.5.3.

Corrective Action: An action taken in accordance with the procedures in Article 9, unless otherwise specified therein.

Dentist: A Practitioner with a DDS or DMD degree who holds a current license to practice dentistry in Texas.

Department: An organizational component of the Medical Staff grouped by specialty or subspecialties, as further described in Article 5.

Department Chair: The Member of the Medical Staff serving as chair of the Department, as further described in Article 5.

Division: An organizational component of the Medical Staff and subgroup of a Department as further described in Article 5.

Ex-officio: Service as a member of a body by virtue of an office or position held and, unless otherwise provided, means without voting rights.

FPPE: Focused professional practice evaluation of a Practitioner, as referenced in Article 9 and/or in Medical Staff Policy.

Good Standing: Not currently subject to any limitation or restriction, or automatic action (excluding any automatic suspension for failure to complete medical records), and not currently subject to Corrective Action, or under Investigation. For purposes of a former Member of the Medical Staff, the Member is considered in Good Standing if these applied on the date of termination or expiration of appointment from the Medical Staff. See Section 2.9.2 for additional requirements if Member resigned.

Hospital: Texas Health Hospital Frisco.

Hospital President: The individual appointed by Texas Health Hospital Frisco Board of Trustees who is responsible for the daily operations of the Hospital. Unless otherwise provided in these Bylaws, any reference to the Hospital President shall include his designee.

Investigation: An investigation as defined in Article 12.

Manual or **Manuals:** Any documents adopted and/or amended as set forth in Article 14 other than the Rules and Regulations or Medical Staff policies.

Medical Executive Committee: The governing committee of the Medical Staff as detailed in Article 6.

Medical Peer Review: The activity or activities described in Article 12.

Medical Staff President: The Member of the Medical Staff serving as chair of the Medical Executive Committee and responsible for the organization and conduct of the Medical Staff, as further described in Article 7.

Medical Staff or **Staff**: All Practitioners who currently hold an appointment to the Medical Staff granted in accordance with these Bylaws.

Medical Staff Services: The Hospital department which provides administrative services to support the Medical Staff.

Medical Staff Year: January 1 through December 31 of each year.

Member: A Practitioner who has been appointed to the Medical Staff in accordance with these Bylaws.

NPDB: The National Practitioner Data Bank established by the federal Health Care Quality Improvement Act.[1]

OPPE: Ongoing professional practice evaluation of a Practitioner, as referenced in Article 9 and/or Medical Staff Policy.

Oral Maxillofacial Surgeon: A Dentist who has successfully completed an accredited postgraduate program in oral and maxillofacial surgery (DDS or DMD or DDS/MD or DMD/MD) and who holds a current Texas license to practice dentistry.

Patient Contacts: Patient care activities in the Hospital or one of its affiliated outpatient centers, carried out by the Member (or Allied Health Professional as detailed below) pursuant to a Member's Clinical Privileges, defined as:

- The admission of a patient either as an inpatient or outpatient ("admitting provider");
- Holding primary responsibility for an inpatient or outpatient ("attending provider");
- Consulting on a patient with the entry of a written report in the medical record, in any venue of the Hospital whether inpatient or outpatient ("consultant");
- Performing patient rounds with entry of a progress note in the medical record, including when providing coverage for a partner or under a call-sharing arrangement (the patient contact is credited only to the actual Member that rounded on the patient);
- Performing any procedure on a patient that requires a History and Physical examination (H&P), whether that H&P was done by the Member or not (e.g., endoscopy, surgery, delivery, etc.);
- Interpretation of any diagnostic test with entry of a report of that interpretation in the medical record, either as a separate entry or as part of a more comprehensive note; and
- Any of the above activities when carried out by an Allied Health Professional under the direct or indirect supervision of the Member, which will be attributed to the Member.

Multiple Patient Contacts by a Member (or Allied Health Professional under the direct or indirect supervision of a Member) as listed above during a single inpatient admission or outpatient stay will constitute a single patient contact by that Member for purposes of this definition.

Performance Improvement Plan: The Hospital's written plan for performance improvement activities including, but not limited to, those conducted through Medical Peer Review.

[1] 42 U.S.C. Sec. 11101-11151.

Physician: A Practitioner who holds a current license to practice medicine in Texas with a MD or DO degree.

Podiatrist: A Practitioner with a DPM degree who holds a current license to practice podiatry in Texas.

Practitioner: A Physician, Dentist, Oral Maxillofacial Surgeon, or Podiatrist on the Medical Staff or applying for Medical Staff membership and/or Clinical Privileges. This term does not include AHPs.

Proctoring: is the process through which skills and/or knowledge that a Practitioner asserts he/she already possess are confirmed.

Rules and Regulations: The Rules and Regulations of the Medical Staff adopted as set out in Article 14.

Special Notice: Written notice: (1) sent by certified or registered mail, return receipt requested, which shall be deemed to have been delivered on the date indicated on the receipt of delivery (or the date delivery was refused); (2) hand delivered which shall be deemed to have been delivered on the date indicated on the receipt of delivery (or on the date delivery is refused and so noted on the receipt of delivery); or (3) sent by email which shall be deemed to have been delivered on the date the Practitioner sends a reply confirming receipt. If delivery of notice is made by a combination of the means specified in this definition, delivery shall be deemed to have occurred on the earliest date made. Special Notice to a Practitioner shall be effective if delivered to the Practitioner's office or administrative staff or if delivered to the Practitioner or an individual at the Practitioner's home address, using the addresses currently on file with Medical Staff Services.

Unrestricted License: A professional license that is not currently subject to any type of order or conditions, including but not limited to an agreed order, disciplinary order, or remedial plan. A Practitioner enrolled in the Texas Physician Health Program with no other order or limitations on the Practitioner's license is considered to have an unrestricted license.

Any action provided for in these Bylaws by the Hospital President or another member of Hospital administration, a Medical Staff or Department officer, or a committee chair may be taken by that individual's designee.

Any reference to "**day**" or "**days**" means calendar days including weekends or holidays, unless otherwise provided.

Whenever the word "**he**", or any other form of masculine pronoun, appears in these Bylaws, it shall be deemed to include the word "she" or other appropriate form of feminine pronoun.

1. MEDICAL STAFF STRUCTURE, FUNCTION AND PURPOSES

1.1. STRUCTURE AND FUNCTIONS

1.1.1. The Medical Staff is structured through the use of Medical Staff categories and Departments as set out in Articles 3 and 5. [2] Performance of the functions of self-governance and other Medical Staff responsibilities are accomplished primarily by the voting Members of the Active Staff serving as the "Organized Medical Staff" as defined by

The Joint Commission, the Medical Executive Committee and the Departments, as well as the committees of the Medical Staff and Departments, as detailed in these Bylaws, the Rules and Regulations, the Manuals, and the Medical Staff policies.[3]

1.1.2. The primary functions of the Medical Staff are to:

1.1.2.1. Provide oversight for the quality and uniformity of standards of care, treatment, and services provided by Practitioners and others with Clinical Privileges;[4] and

1.1.2.2. Approve, amend, and enforce the Bylaws, the Rules and Regulations, Manuals, and Medical Staff policies,[5] which shall be compatible with the bylaws of the Board of Trustees, Hospital policies and law and regulation.[6]

1.1.3. The Medical Staff reports and is accountable to the Board of Trustees for fulfilling these functions as provided in these Bylaws.[7]

1.2. PURPOSES AND OBLIGATIONS

1.2.1. The purposes and obligations of the Medical Staff shall include, but are not limited to, the following:

1.2.1.1. Establish criteria and standards for appointment and reappointment to the Medical Staff, the delineation of Clinical Privileges, and the criteria for those Clinical Privileges, subject to the approval of the Board of Trustees;

1.2.1.2. Review and make recommendations to the Board of Trustees regarding applications from Practitioners for appointment and reappointment to the Medical Staff, and requests for Clinical Privileges;

1.2.1.3. Monitor and evaluate, through FPPE and OPPE, the performance of each Member and others with Clinical Privileges in accordance with the Performance Improvement Program, the quality of care rendered all patients admitted to or treated in any of the facilities of the Hospital, and the uniformity of care;

1.2.1.4. Monitor and evaluate, through FPPE and OPPE in accordance with the Performance Improvement Program, the professional conduct of Members and others with Clinical Privileges in the Hospital;

1.2.1.5. Implement appropriate actions and/or make recommendations for actions to improve the quality and uniformity of patient care, the professional conduct of Members and others with Clinical Privileges, and intervene and/or take Corrective Action when indicated as set forth in these Bylaws;

[3] Department of State Health Services, Hospital Licensing Standards, 25 Tex. Admin. Code Sec. 133.41(k)(3)(C).
[4] MS.03.01.01.
[5] MS.01.01.01 EP 1.
[6] MS.01.01.01 EP 4; see also Medicare Conditions of Participation, 42 C.F.R. Sec. 482.11(a).
[7] 42 C.F.R. Sec. 482.12(a)(5), 482.22(b); 25 Tex. Admin. Code Sec. 133.41(k)(2).

1.2.1.6. Recommend and implement policies and procedures regarding the delivery of care and provide educational opportunities to the Medical Staff and others in the Hospital to enhance professional knowledge and skill;

1.2.1.7. Assist Hospital administration and the Board of Trustees with strategic planning and budgeting; and

1.2.1.8. Review and evaluate the qualifications of Allied Health Professionals, permissible Clinical Privileges and scope of practice, and appropriate level of delegation, direction, and/or supervision, and make recommendations to the Board of Trustees as set forth in Hospital policy.

2. MEDICAL STAFF MEMBERSHIP

2.1 GENERAL

2.1.1. Eligible Disciplines. The Medical Staff must be composed of Physicians and may also include Dentists, Oral Maxillofacial Surgeons, and Podiatrists. [8] Except as specifically provided in these Bylaws, membership on the Medical Staff and Clinical Privileges may only be granted by the Board of Trustees, and shall confer only such rights and prerogatives as are set out in these Bylaws. Only Practitioners who have been appointed to the Medical Staff and/or who have been granted Clinical Privileges in accordance with these Bylaws may admit and treat patients in the Hospital.

2.1.2. Burden on Practitioner. Membership on the Medical Staff is available only to those Practitioners who continuously meet the criteria and qualifications and fulfill the obligations of Medical Staff Members as set out below and as required by the Board of Trustees. [9] The Practitioner has the burden of providing sufficient and credible documentation to establish his qualifications for Medical Staff membership and any requested Clinical Privileges at the time of application, reappointment, on any request for Clinical Privileges, and in between terms of appointment as requested by a Medical Staff Committee.

2.1.3. No Automatic Eligibility. No Practitioner shall be entitled to membership on the Medical Staff or to the exercise of particular Clinical Privileges in the Hospital merely by virtue of the fact that the Practitioner: (a) is licensed to practice any profession in Texas or any other state; (b) is a member of any professional organization; (c) resides in the geographic service area of the Hospital; (d) is certified by any specialty or clinical board; (e) is affiliated with, under contract to, or a member of any managed care plan, insurance plan, or managed care organization; or (f) had in the past, or currently has, medical staff appointment or privileges in another health care facility or other practice setting.

2.1.4 Resources. In making decisions regarding appointment to the Medical Staff, the number of Practitioners necessary for a specialty or required for Hospital services and specialties of current Members, the availability of Hospital services, the needs of the community

[8] 25 Tex. Admin. Code Sec. 133.41(f)(4)(E), 133.41(k)(1); 42 C.F.R. Sec. 482.22(a).
[9] 42 C.F.R. Sec. 482.22(a)(2).

served by the Hospital, and the Hospital's strategic plan may be considered by the Board of Trustees.

2.1.5. Prohibited Grounds. No aspect of Medical Staff membership or Clinical Privileges shall be denied on the basis of sex, race, religion, age, national origin, or any other basis prohibited by law.[10]

2.2 GENERAL CRITERIA AND QUALIFICATIONS[11]

2.2.1. Professional Licensure.[12] Each Practitioner must hold a current valid license issued by the Texas professional licensing agency to practice medicine, dentistry or podiatry, as applicable. The Practitioner must disclose any current or past professional license in any other state, and any current or past investigation or action by any licensing agency.

2.2.2 Controlled Substances Registration. Each Practitioner must hold a current registration to prescribe controlled substances issued by the federal Drug Enforcement Administration (DEA) unless the registration requirement has been waived by the Medical Executive Committee, with the approval of the Board of Trustees, because the Practitioner does not prescribe. A waiver of this requirement is effective as long as the Practitioner remains a Member of the Medical Staff, unless the Practitioner requests different Clinical Privileges which would require controlled substances registration.

2.2.3 Lack of Exclusion. Each Practitioner must not be, and never have been, excluded from participation in the Medicare, Medicaid, TRICARE, or any other federal or state governmental health care program or convicted of fraud or abuse under the Medicare, Medicaid or other federal or state governmental health care program.

2.2.4 Professional Liability Insurance. Each Practitioner must maintain professional liability insurance in the form and amounts required by the Board of Trustees applicable to the Practitioner's practice in the Hospital, including the use of any Allied Health Professionals or other health care providers not employed by the Hospital. Evidence of coverage must be submitted: (i) at the time of application to the Medical Staff; (ii) no later than the last day of coverage for the policy currently in effect or within one business day of receipt of documentation of coverage from the insurance carrier, whichever occurs first; and (iii) within five days of a request from Medical Staff Services.

2.2.5 Current Competencies, Experience and Clinical Judgment. [13] Each Practitioner must demonstrate the areas of general competencies, experience and clinical judgment to include: patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

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[10] MS.06.01.07 EP 3; 25 Tex. Admin. Code Sec. 133 41(f)(4)(F)(i)(III).
[11] MS.01.01.01 EP 13; 42 C.F.R. Sec. 482.12(a)(6)-(a)(7), 482.22(c)(4); 25 Tex. Admin. Code Sec. 133.41(f)(4)(E)(i), 133.41(k)(3)(D).
[12] 42 C.F.R. Sec. 482.11(c); MS.06.01.03 EP 6.
[13] 42 C.F.R. Sec. 482.12(a)(6); MS.06.01.03, MS.06.01.05.

2.2.6 Health Status and Ability.[14] Each Practitioner must possess the necessary health status and ability to perform the basic obligations of Medical Staff membership and exercise all or any of the Clinical Privileges requested or granted in accordance with accepted professional standards and without posing a direct threat to patients.

2.2.6.1 Documentation of health status and ability shall be provided at the time of application for appointment and reappointment to the Medical Staff and request for Clinical Privileges, and at any time thereafter on request if there are concerns regarding impairment, as defined in written Medical Staff policy. Impairment is defined as any condition that interferes with, or presents a reasonable probability of interfering with, the Practitioner's ability to perform the basic obligations of Medical Staff membership, and exercise all or any of the Clinical Privileges requested or granted in accordance with accepted professional standards and without posing a direct threat to patients. A request to provide documentation of necessary health status and ability may include, without limitation, submitting to examination, evaluation and/or testing in accordance with written Policy and cooperating with the Health and Rehabilitation Committee.

2.2.6.2 Requests for documentation may be made as set forth in written Medical Staff policy.

2.2.7 Character[15], Ethics and Ability to Work with Others. Each Practitioner must provide evidence of appropriate character and adherence to professional ethics, including but not limited to, a good reputation, integrity, acceptable interpersonal skills, the ability to work effectively and professionally with others in the delivery of patient care, and the ability to meet the obligations of membership in Section 2.3 below.

2.2.8 Proximity. Each Practitioner with Clinical Privileges must reside and practice within sufficient proximity to the Hospital to permit timely response to emergencies and any emergency services call coverage obligations.

2.2.9 Electronic Health Record (EHR). Each Practitioner with Clinical Privileges must complete the Hospital's training on EHR and be competent to use the Hospital's EHR system.

2.2.10 Board Certification and Residency Training.[16]

2.2.10.1 Physician.

2.2.10.1.1 Each Physician Practitioner must be currently certified by the specialty board appropriate to the Clinical Privileges being requested, either by the American Board of Medical Specialties (ABMS) or Bureau of Osteopathic Specialists (BOS), [17] and must maintain that certification during membership on the Medical Staff.

[14] MS.06.01.05 EP 2, 6.
[15] 42 C.F.R. Sec. 482.12(a)(6).
[16] 42 C.F.R. Sec. 482.12(a)(6); see also MS.06.01.05 EP 2.
[17] 25 Tex. Admin. Code Sec. 133.41(f)(4)(E)(i)(VII).

2.2.10.1.2 If a Physician applying for initial appointment to the Medical Staff is not board certified but is within five years of successful completion of residency or fellowship training that makes the Physician eligible to be tested for board certification, the Physician shall be deemed to meet this requirement but must obtain board certification within the first two testing cycles offered by the specialty board following appointment to the Medical Staff.

2.2.10.2 Oral Maxillofacial Surgeon.

2.2.10.2.1 Each Oral Maxillofacial Surgeon Practitioner must be currently certified by the American Board of Oral and Maxillofacial Surgery and maintain that certification during membership on the Medical Staff.

2.2.10.2.2 If an Oral Maxillofacial Surgeon applying for initial appointment to the Medical Staff is not board certified but is within five years of successful completion of fellowship training and eligible to be tested for board certification, the Oral Maxillofacial Surgeon shall be deemed to meet this requirement but must obtain board certification within the first two testing cycles offered by the specialty board following appointment to the Medical Staff.

2.2.10.3 Podiatrist.

2.2.10.3.1 Each Podiatrist Practitioner must be board certified by the American Board of Podiatric Surgery and maintain that certification during membership on the Medical Staff, and have successfully completed a minimum of a two-year post-doctoral podiatric surgical residency approved by the Council on Podiatric Medical Education in an acute care hospital.

2.2.10.3.2 If a Podiatrist applying for initial appointment to the Medical Staff is not board certified but is within five years of successful completion of residency or fellowship training and eligible to be tested for board certification, the Podiatrist shall be deemed to meet this requirement but must obtain board certification within the first two testing cycles offered by the specialty board following appointment to the Medical Staff.

2.2.10.4 Failure to Achieve or Maintain Board Certification. Failure of a Physician, Oral Maxillofacial Surgeon, or Podiatrist to achieve board certification within the first two testing cycles of initial appointment as provided above, or failure to maintain certification, shall constitute an automatic resignation from the Medical Staff and shall not entitle the Physician, Oral Maxillofacial Surgeon, or Podiatrist to any procedural rights of review under these Bylaws or otherwise.

2.2.10.5 Dentist. Each Dentist Practitioner must have successfully completed a post-graduate training program accredited by the American Dental Association Commission on Dental Accreditation, and document appropriate training in or exposure to an acute care hospital surgical environment.

2.2.10.6 Clinical Privileges. Other or additional board certification or qualifications may be required for certain Clinical Privileges.

2.2.10.7 Exceptions to Board Certification. Exceptions to the board certification requirements in Sections 2.2.10.1 – 2.2.10.6 may be recommended by the Medical Executive Committee and approved by the Board of Trustees in the case of practitioners who (i) are current members of a medical staff at a Texas Health Resources wholly-controlled hospital or a University of Texas Southwestern Medical Center affiliated hospital, and (ii) are able to demonstrate training, experience, and current competency equivalent to that required for board certification and the member is otherwise in good standing as a member of such medical staff, to include without limitation a satisfactory quality record as evidenced in Performance Improvement records and fulfillment of all other requirements appropriate to the member's membership level; demonstrate current competence, adherence to the ethics of their profession, good reputation, physical and mental health status (subject to any necessary reasonable accommodation to the extent required by law), the ability to work with others (staff members, members of other health care disciplines, Hospital management and employees, visitors, patients, and the community in general).

2.2.11 Lack of Criminal History. Practitioner may not have been convicted of, pled guilty or pled *nolo contendere* to any felony reasonably related to the Practitioner's qualifications, competence, functions, or duties as a medical professional or involving an act of violence, child abuse, or a sexual offense, or have been court-martialed for such actions. Other criminal offenses may be considered in evaluating a Practitioner's qualifications.

2.2.12 Lack of Corrective Action.

2.2.12.1 A Practitioner who is currently subject to corrective action investigation by another hospital or health care entity or subject to investigation by the Texas professional licensing agency is not eligible for consideration for initial appointment until the investigation has been completed.

2.2.12.2 A Practitioner who has been subject to a final decision by a hospital or other health care entity involving the Practitioner's competence or professional conduct affecting medical staff appointment, clinical privileges, or other participation in the hospital or health care entity within the 10 years prior to submitting the application for Medical Staff initial appointment or Clinical Privileges, is not eligible to apply for Medical Staff appointment.

2.2.13 Coverage. The Practitioner must provide written confirmation of arrangements for appropriate alternative medical coverage by a Member for patients for whom the Practitioner is or will become responsible should the Practitioner be unavailable. The Member who has agreed to cover for the Practitioner must have at least the same Clinical Privileges as the Practitioner and meet the proximity requirements in Section 2.2.8 when providing coverage.

2.2.14 Communication Skills. The Practitioner must have the ability to read, write, understand, and speak the English language in an intelligible manner, including in medical record entries in the electronic health record.

2.2.15 Lack of Eligibility. Lack of eligibility for consideration for Medical Staff appointment or processing of an application due to failure to document compliance with objective criteria set out above is not an Adverse Recommendation or Action and does not entitle the Practitioner to any procedural rights of review under these Bylaws or otherwise.

2.3 DUTIES AND OBLIGATIONS

The following shall be the duties and obligations of each Member of the Medical Staff:

2.3.1 Provide patients with quality care in accordance with accepted professional standards and the standards of the Medical Staff, including evidence-based protocols, comply with the ethical standards and professional guidelines of the Member's profession, and conduct the Member's professional practice with honesty and integrity;

2.3.2 Provide for the continuous care of the Member's patients by personally attending those patients or by arranging for appropriate coverage by another Member who holds at least the same Clinical Privileges during any time that the Member is not available, as determined by the Medical Executive Committee subject to the approval of the Board of Trustees;

2.3.3 Abide by these Bylaws, the Rules and Regulations, all Manuals and Medical Staff policies, the Medical Staff Code of Conduct and corporate compliance program and other Hospital policies, and legal and accreditation requirements, including without limitation HRO Education on error prevention;

2.3.4 Maintain continued compliance with all criteria and qualifications of Medical Staff membership and notify Medical Staff Services within the time frame noted after receiving notice of any of the following:

<u>ONE BUSINESS DAY AFTER RECEIPT OF NOTICE</u>

2.3.4.1 Suspension, termination, restriction, or denial, in whole or in part, of the Member's professional licensure to practice medicine, dentistry or podiatry in any state or controlled substances registration, either federal or any state;

2.3.4.2 Loss, cancellation, reduction, or other modification of professional liability insurance;

2.3.4.3 Exclusion from participation in Medicare, Medicaid or any other governmental programs;

<u>FIVE BUSINESS DAYS AFTER RECEIPT OF NOTICE</u>

2.3.4.4 Initiation of an investigation or implementation of an agreed order, remedial plan, or any other action by any professional licensing agency or a professional certification board;

2.3.4.5 Imposition of: (i) any disciplinary or corrective action (including probation), (ii) initiation of an investigation for purposes of possible corrective action, (iii) suspension, reduction or loss of clinical privileges, (iv) proctoring, monitoring or review for any reason other than FPPE applicable to new Practitioners or the exercise of newly granted clinical privileges, or (vi) denial of appointment, reappointment or renewal of medical staff membership or clinical privileges at any other hospital or health care entity, but not including automatic action for delinquent medical records;

2.3.4.6 Resignation of clinical privileges or medical staff membership at any other hospital or health care facility;

2.3.4.7 Leave of absence, whether voluntary or involuntary, from another hospital or health care entity;

2.3.4.8 Filing of any report concerning the Member with the National Practitioner Data Bank;

2.3.4.9 Pending investigations, formal or informal actions, or sanctions, whether criminal or civil, by the Texas Medical Foundation, Medicare, Medicaid, or any other state or federal governmental program;

2.3.4.10 Filing of, or notice of claim, for any civil or administrative action alleging professional incompetence, professional negligence, or improper professional conduct or professional misconduct;

2.3.4.11 Judgment, settlement or dismissal of any claim for any civil or administrative actions alleging professional incompetence, professional negligence, or improper professional conduct or professional misconduct;

2.3.4.12 Voluntary or involuntary challenge, denial, limitation, suspension, revocation or relinquishment of membership in any medical/professional society or association or initiation of any action that would affect membership in such a society or association;

2.3.4.13 Any change in health status or ability, including a failure to comply with recommended treatment, that might affect the Member's ability to fulfill the basic obligations of Medical Staff membership and/or exercise Clinical Privileges in accordance with accepted professional standards and without posing a direct threat to patients; and

2.3.4.14 Any conviction, guilty plea or deferred adjudication, or *nolo contendere* plea or filing of formal charges for a felony or misdemeanor (including DUI or PI) other than minor traffic violations, or any court-martial;

2.3.5 Seek consultation when indicated and provide consulting services in the care of patients requiring those services on request within the Member's specialty, capability and capacity, without regard to the patient's ability to pay;

2.3.6 Discharge in a professional and cooperative manner the responsibilities and assignments associated with membership, including Hospital and Medical Staff committee assignments

2.3.7 Participate in Medical Peer Review (including serving as a witness, panel member on a hearing committee, expert reviewer or consultant, or as otherwise requested by a Medical Staff leader or committee), and maintain in strict confidence the records and proceedings of Medical Peer Review and all involved committees;

2.3.8 Prepare and complete in a timely manner, accurate, legible and clinically pertinent medical records for all patients to whom the Member provides care in the Hospital, including utilization of electronic hospital records system(s) and completion of any associated training, and maintain the confidentiality of those records, to include accessing only those records for which the Member has a legitimate reason and maintaining proper controls on access by the Member's employees and AHPs;

2.3.9 Participate in emergency services call coverage as required by the Member's Department and Staff category, subject to the ultimate authority of the Board of Trustees following consultation with the Medical Executive Committee and provide appropriate post-discharge follow up care for the condition treated or for which consulted as a result of that emergency services call coverage, without regard to ability to pay, as set forth elsewhere in these Bylaws, Rules and Regulations, Hospital and Medical Staff and Department policies;

2.3.10 Cooperate with other Members, Hospital staff and administration, patients and their representatives, and others in the delivery of patient care in the Hospital in a respectful, courteous and professional manner so as to promote the delivery of quality patient care and orderly operation of the Hospital;

2.3.11 Discharge such other reasonable responsibilities and obligations as may be established by the Medical Executive Committee or the Board of Trustees; and

2.4.11 Maintain accurate and current contact information with Medical Staff Services, including email address, all office addresses and home address, as well as all phone numbers including offices, home and mobile telephone.

2.4 TERM OF APPOINTMENT

2.4.12 Duration. The term of appointment shall be for a period of up to two years from the appointment date and may be for a period of less than two years.[18] A term of less than two years is not an Adverse Recommendation or Action and shall not entitle the Practitioner to any procedural rights of review under these Bylaws or otherwise.

[18] 42 C.F.R. Sec. 482.22(a)(1); 25 Tex. Admin. Code Sec. 133.41(k)(1)(B); MS.06.01.07 EP 9.

2.4.13 Conditions. An appointment may be subject to the Practitioner's compliance with specific conditions which relate to compliance with the qualifications for Medical Staff

2.5 PROCESS FOR APPOINTMENT[19]

2.5.1 Application. As part of Medical Peer Review, a separate credentials file shall be maintained for each Practitioner applying for Medical Staff appointment. Each application for appointment and reappointment to the Medical Staff or Clinical Privileges shall be electronically submitted on a form approved by the Medical Executive Committee and the Hospital President, and signed by the Practitioner. The Practitioner applying for initial appointment shall be provided with a copy of or access to these Bylaws, the Rules and Regulations, and any Manuals. The Practitioner must complete the entire application form, and accurately disclose all requested information on the form. The application form will also require an attestation from the Practitioner as to the items in Section 2.5.2 below.

2.5.2 Representations. On submission of an application for appointment or reappointment to the Medical Staff and/or Clinical Privileges, each Practitioner represents the following which shall remain effective during the term of Medical Staff appointment and any exercise of Clinical Privileges:

2.5.2.1 Signifies the Practitioner will abide by the Medical Staff Bylaws, Rules and Regulations, and Medical Staff policies, as well as Hospital policies;[20]

2.5.2.2 Certifies that all information submitted in connection with the application is true, correct and complete, and agrees to provide any new or updated information pertinent to the Practitioner's qualifications or the information on the application to Medical Staff Services within seven days of receipt of notice of the information;

2.5.2.3 Agrees that any misstatements, omissions or misrepresentations in connection with the application, whether intentional or not, shall be grounds to withdraw the application from further processing, deny appointment or reappointment and/or Clinical Privileges, or take Corrective Action;

2.5.2.4 Authorizes the Hospital and Medical Staff and representatives to consult with other health care entities, medical staffs, and any other individuals and entities regarding the Practitioner's professional qualifications and any other information related to his application for appointment and/or Clinical Privileges, and agrees to appear for an interview if requested;

2.5.2.5 Authorizes the release of information by the Hospital, any Medical Staff committees, and by third parties, including medical records regarding any of the Practitioner's

[19] MS.01.01.01 EP 26-27, MS.06.01.03 EP 4.
[20] 25 Tex. Admin. Code Sec. 133.41(k)(2)(E).

patients and the Practitioner and Medical Peer Review data, relating to the Practitioner's professional qualifications and any other information related to the application for appointment and/or Clinical Privileges, provided such information is provided in good faith;

2.5.2.6 Releases from liability and agrees to hold harmless all third parties, as defined in Section 12.3.2, who provide information to the Hospital and the Medical Staff, and further releases from liability and agrees to hold harmless the Hospital, its affiliates and their successors, assigns, and transferees, and their representatives, the Medical Staff, Board of Trustees, directors, officers, members of the Medical Staff committees and Departments, and any other individuals for any acts, communications, reports, records, statements, documents, recommendations, or disclosures made in good faith concerning any matter that might directly or indirectly affect the Practitioner's exercise of Clinical Privileges or relating to the Practitioner's qualifications for appointment or reappointment to the Medical Staff;

2.5.2.7 Acknowledges and agrees to the immunity provisions as set forth in Article 12 and to execute all requested authorizations and releases to give effect to the provisions in these Bylaws; and

2.5.2.8 Acknowledges that the agreements, authorizations, and releases in these Bylaws and on the applications for appointment, reappointment and/or Clinical Privileges are express conditions to the Practitioner's appointment, continuation of appointment and reappointment, and to the Practitioner's exercise of Clinical Privileges in the Hospital.

2.5.3 Complete Application Required. An application must be a Complete Application to be submitted for consideration and the Practitioner is responsible for ensuring that the application is a Complete Application.

2.5.3.1 A Complete Application means:

2.5.3.1.1 The application form has been completely filled out and signed by the applicant;

2.5.3.1.2 All questions on the application form have been answered to the satisfaction of the applicable Department Chair and involved Medical Staff committees and all supplemental information as requested has been provided (e.g., malpractice claims, copies of licenses, DEA/DPS certificates, etc.);

2.5.3.1.3 All reference requests**,** required documentation, and requests for additional information/clarification forwarded to the applicant and/or other parties**,** and any other documents/verifications solicited by the Hospital, the Department Chair, and the applicable Medical Staff committees have been received;

2.5.3.1.4 If an interview or meeting has been requested, the applicant has participated and provided the requested information to the satisfaction of individual or committee;

2.5.3.1.5 Any questions or issues raised during the processing of an application have been resolved to the Department Chair's and all involved Medical Staff Committees' satisfaction; and

2.5.3.1.6 The applicant has provided any responses when reasonably requested by the Hospital from outside sources when the Hospital's internal OPPE reports do not provide sufficient information at reappointment to verify competence and acceptable performance.

An application can be a Complete Application, but then become incomplete due to a subsequent request for information.

2.5.3.2 If an application is not a Complete Application, Medical Staff Services will provide the Practitioner with Special Notice of:

2.5.3.2.1 what information is needed and from whom;

2.5.3.2.2 the time period within which the information must be received;

2.5.3.2.3 the fact that the application will be withdrawn from further processing if the information is not received within that time period; and

2.5.3.2.4 that withdrawal of an application from further processing is not a denial of the application or an Adverse Recommendation or Action, and does not entitle the Practitioner to any procedural rights under these Bylaws or otherwise.

2.5.3.3 Once an application has been withdrawn from processing due to not being a Complete Application as provided in this section, the Practitioner may not submit a new application for a period of at least one year from the date the application was withdrawn.

2.5.4 Review by Department Chair.[21]

2.5.4.1 Once an application is a Complete Application, Medical Staff Services will forward the application and any supporting documentation to the Department Chair appropriate to the Practitioner's specialty. The Department Chair shall have 14 days from receipt to review the application and may conduct a personal interview with the Practitioner. Should the Department Chair not complete this action within 14 days, the Credentials Committee may initiate its review.

2.5.4.2 The Department Chair shall issue a written recommendation to the Credentials Committee as to whether Medical Staff membership should be granted and, if so, what Staff category and Clinical Privileges are appropriate and any conditions or

[21] Joint Commission allows for expedited credentialing with "clean applications" whereby a subcommittee of at least two voting members of the Board of Trustees to make final decision on appointment, reappointment and privileges. MS.06.01.13. Application must still go to full MEC.

limitations on that category or Clinical Privileges. If appointment or Clinical Privileges are not recommended or any conditions or limitations are recommended, a statement of the reasons for such shall be included.

2.5.6 Review by Credentials Committee

2.5.6.1 The Credentials Committee shall review the application and the recommendation of the Department Chair, if provided, by the next regularly scheduled meeting, not to exceed 30 days. The Credentials Committee may conduct a personal interview with the Practitioner.

2.5.6.2 The Credentials Committee shall issue a written recommendation to the Medical Executive Committee as to whether Medical Staff membership should be granted and, if so, what Staff category and Clinical Privileges are appropriate and any conditions or limitations on that category or Clinical Privileges. If appointment or Clinical Privileges are not recommended or any conditions or limitations are recommended, a statement of the reasons for such shall be included.

2.5.6.3 The Credentials Committee, or any other committee responsible for processing the application, may defer action on an application for the purpose of obtaining additional information. The committee must follow up within 30 days of deferral with a recommendation.

2.5.7 Review by Medical Executive Committee.

2.5.7.1 The Medical Executive Committee shall review the application and the recommendation of the Credentials Committee within 30 days of receipt. The Medical Executive Committee may conduct a personal interview with the Practitioner.

2.5.7.2 The Medical Executive Committee shall issue a written recommendation to the Board of Trustees as to whether Medical Staff membership should be granted and, if so, what Staff category and Clinical Privileges are appropriate and any conditions or limitations on that category or Clinical Privileges. If appointment or Clinical Privileges are not recommended or any conditions or limitations are recommended, a statement of the reasons for such shall be included.

2.5.7.3 If the recommendation of the Medical Executive Committee is an Adverse Recommendation or Action, the Hospital President shall provide the Practitioner with Special Notice of the recommendation as provided in Article 10 and all further procedures shall be as set forth in that Article.

2.5.7.4 If the recommendation of the Medical Executive Committee is not an Adverse Recommendation of Action, it shall be forwarded with any supporting documentation to the Board of Trustees for review.

2.5.8 Review by Board of Trustees.

2.5.8.1 At its next regular meeting, but in no event more than 60 days from its receipt of the Complete Application, the Board of Trustees shall review the application and recommendations of the Department Chair, Credentials Committee, and Medical Executive Committee and issue a recommendation.

2.5.8.2 The Board of Trustees shall issue a written recommendation as to whether Medical Staff membership should be granted and, if so, what Staff category and Clinical Privileges are appropriate, and any conditions or limitations on that category or Clinical Privileges. If appointment or Clinical Privileges are not recommended or any conditions or limitations are recommended, a statement of the reasons for such shall be included.

2.5.8.3 If the recommendation of the Board of Trustees is an Adverse Recommendation or Action, the Hospital President shall provide the Practitioner with Special Notice of the recommendation as provided in Article 10 and all further procedures shall be as set forth in that Article.[22]

2.5.8.4 If the recommendation of the Board of Trustees is not an Adverse Recommendation or Action, it shall be the final decision of the Board of Trustees. The Hospital President shall notify the Practitioner in writing within 20 days of the decision.[23]

2.5.9 Failure to Act. If a Department Chair or any Medical Staff committee responsible for processing an application fails to act on the application within the required time period, the application shall be forwarded to the next committee or to the Board of Trustees, whichever is next, for consideration in accordance with the above procedures.

2.5.10 Privileges. See Article 4 for additional detail on processing of applications for Clinical Privileges.

2.6 PROCESS FOR REAPPOINTMENT[24]

2.6.6 Time Frame. At least 120 days prior to expiration of the current term of a Member's appointment, the Medical Staff Services Office shall provide the Member with an application for reappointment of Medical Staff membership and/or renewal of Clinical Privileges. Each Member seeking reappointment or renewal must submit a Complete Application at least 60 days prior to the expiration of the current term.

2.6.6.1 If a Member fails to submit a timely Complete Application without good cause, as determined by the Medical Executive Committee subject to the approval of the Board of Trustees, Medical Staff membership and all Clinical Privileges shall expire at the end of the current term of appointment. Failure to submit a reappointment application may be subject to mandatory reporting.

[22] MS.06.01.09 EP 4, 5.
[23] 25 Tex. Admin. Code Sec. 133.41(f)(4)(F)(i)(VIII).
[24] MS.01.01.01. EP 27; 25 Tex. Admin. Code Sec. 133.41(k)(1)(A).

2.6.6.2 The schedule for reappointment shall be established by Medical Staff Services, subject to the approval of the Medical Executive Committee.

2.6.7 Application. The reappointment application shall be a prescribed form approved by the Medical Executive Committee and the Hospital President, and shall require information necessary to maintain a current file on the Member's professional activities as well as verify continuing compliance with the qualifications of membership. The Practitioner must complete the entire reappointment application form, and accurately disclose all requested information on the form. The reappointment application form will also require an attestation from the Practitioner as to the items in Section 2.5.2.

2.6.8 Additional Information. The process for reappointment shall be the same as for appointment, except that the information considered shall also include at a minimum:

2.6.8.1 The results of any FPPE and OPPE, other information generated by Medical Peer Review, and when available relevant Practitioner-specific data as compared to aggregate data, morbidity and mortality data, clinical outcomes, efficiencies, and patient satisfaction;

2.6.8.2 Compliance with the duties and obligations of Medical Staff membership;

2.6.8.3 Usage of the Hospital, attendance at Medical Staff meetings and fulfillment of Medical Staff assignments, and fulfillment of other activities related to the Member's professional services and contributions;

2.6.8.4 Results of the National Practitioner Data Bank query; and

2.6.8.5 Any other information required by legal or accreditation standards, Policy, or the Medical Executive Committee and the Board of Trustees.

2.7 WITHDRAWAL OF COMPLETE APPLICATION OR CERTAIN REQUESTS

2.7.1 Permissible Timeframe. A Practitioner may withdraw an application for initial appointment or reappointment or a written request to change the Staff category, or may amend or withdraw a written request for Clinical Privileges, before the scheduled commencement of the meeting of the Board of Trustees at which the matter is to be considered for a final decision.

2.7.2 Limitation on Reapplication. A Practitioner who withdraws an application or written request to change the Staff category, or withdraws or amends a written request for Clinical Privileges, may not resubmit such application or request for a period of one year from the date of the withdrawal, unless the Practitioner has obtained additional training, in which case the Credentials Committee may, in its discretion, waive the one year waiting period. There are no procedural rights of review under these Bylaws for a failure to waive the waiting period.

2.7.3 Reporting. Nothing contained herein shall alter any mandatory reporting requirement.

2.8 LEAVE OF ABSENCE

2.8.1 Mandatory. Any Member who will not be engaged in the Member's customary or usual professional practice for longer than 45 consecutive days must take a Leave of Absence (LOA) in accordance with this Section. A Leave of Absence is not a surrender or relinquishment of Clinical Privileges.

2.8.2 Types of LOA.

2.8.2.1 Medical Leave of Absence. A Member may request and be granted a LOA for the purpose of evaluation and/or obtaining treatment for a health condition. If the Member is unable to make his own request due to health reasons or unavailability, a member of the Member's practice and/or spouse/first degree relative may make such a request on behalf of the Member.

2.8.2.2 Military Leave of Absence. A Member may request and be granted a LOA to fulfill military service obligations. In addition to a written request for the LOA, the Practitioner shall submit a copy of deployment/activation orders.

2.8.2.3 Educational Leave of Absence. A Member may request and be granted a LOA to pursue additional education and training. Any additional Clinical Privileges that may be desired upon the successful conclusion of additional education and training must be requested in accordance with Article 4.

2.8.2.4 Personal Leave of Absence. A Member may request and be granted a LOA for personal reasons (e.g., to pursue a volunteer endeavor such as contributing work to "Doctors Without Borders/USA") or family reasons (e.g., maternity leave).

2.8.2.5 Administrative Leave of Absence. If the Medical Executive Committee finds that a Member was unable to notify Medical Staff Services of a request for LOA on the Member's own due to emergent and unexpected circumstances, the Medical Executive Committee may place the Member on an Administrative LOA. Placement on an Administrative LOA is not Corrective Action. The Member will be notified of the Administrative LOA in writing by the Hospital President within five business days from the date of findings of the Medical Executive Committee and such notification shall include the inclusive dates of the LOA.

2.8.3 Process for Requesting LOA. A Leave of Absence must be requested in writing in advance specifying the type of leave requested and the requested duration. The written request must be submitted to the Medical Staff President by delivery to Medical Staff Services. Following recommendation by the Medical Executive Committee, the Board of Trustees may grant a Practitioner a Leave of Absence under Section 2.8.2. See Section 2.8.2.5 if the Medical Executive Committee finds the Practitioner was unable to request a LOA.

2.8.4 Duration of LOA and Extension. A Leave of Absence shall not exceed one year or the Practitioner's remaining appointment period, whichever is shorter, unless an extension is granted. A Military LOA shall be for the period of deployment. An extension may be requested by the Practitioner under the same process as for the initial period of Leave of

Absence. See Section 2.8.6 if reappointment due during LOA or period of requested extension.

2.8.5 Status of Practitioner While on LOA.

2.8.5.1 Unless sufficient extenuating circumstances (e.g., immediate military deployment/activation) preclude it, the Practitioner shall be responsible for completing all medical records for patients the Practitioner cared for before the LOA.

2.8.5.2 The Practitioner on LOA is responsible for arranging call coverage for the Practitioner's assigned Emergency Room Call, unless sufficient extenuating circumstances preclude it (in which case the Department Chair shall resolve the issue). The Practitioner also is responsible for arranging coverage for any current inpatients, as well as coverage (or providing notification of alternatives) for care for the Practitioner's private practice in accordance with accepted standards of professional practice. The Practitioner will notify Medical Staff Services of the Practitioner's designated call and coverage substitutes.

2.8.5.3 During the LOA, the Practitioner shall not admit patients, exercise Clinical Privileges, or vote or hold Medical Staff, Department or Division office. Further, the Practitioner may not take emergency room call or serve as a proctor. The Medical Staff President will determine whether a Practitioner's LOA constitutes a vacancy on a committee and, if so, assign an alternate or fill the vacancy as provided in these Bylaws.

2.8.6 LOA and Reappointment.

2.8.6.1 A Leave of Absence or extension of the LOA may not be granted to extend beyond the date of expiration of the Practitioner's current term of appointment unless the Practitioner submits and is reappointed under the reappointment process outlined in Article 2. If the expected LOA will extend past the date of the next reappointment, the Practitioner can request to be reappointed prior to the start of the LOA.

2.8.6.2 If the Practitioner is not able to submit a reappointment application prior to the end of the current reappointment, the Practitioner may be conditionally reappointed with the condition that the Practitioner must verify his qualifications, including without limitation the Practitioner's ability to perform the Clinical Privileges subject to the reappointment, upon the Practitioner's return.

2.8.7 Requesting Reinstatement.

2.8.7.1 To request reinstatement, the Practitioner must file a written request prior to the requested date of reinstatement or the end of the LOA. The reinstatement request shall include any required information concerning the Practitioner's activities, professional or otherwise, during the LOA, and enable verification of continued compliance with the qualifications set out below.

2.8.7.2 The Practitioner must also:

2.8.7.2.1 Provide sufficient information that the Practitioner currently meets all of the qualifications for Medical Staff membership and the appropriate Staff category as set forth in Articles 2 and 3;

2.8.7.2.2 Demonstrate that the Practitioner meets the qualifications as set forth in Article 4 for all Clinical Privileges for which the Practitioner is requesting reinstatement; and

2.8.7.2.3 Agree to provide all requested documentation and other information to allow the appropriate Medical Staff committees and Board of Trustees to verify that the matter that necessitated the LOA has been resolved and that no other events have occurred during the LOA that could affect the Practitioner's ability to practice before the Practitioner is eligible for reinstatement.

2.8.8 Reinstatement Procedures.

2.8.8.1 Expedited Approval Process. The Medical Staff President, Credentials Committee Chair and either the Hospital President or Chief Medical Officer together shall have the discretion to approve a reinstatement request on an expedited basis. However, any expedited approval process decision is subject to the Medical Executive Committee and Board of Trustees' determination at their next meetings.

2.8.8.1 Credentials Committee. The Credentials Committee, after consultation with the Practitioner's Department Chair, shall review the reinstatement request and any supporting documentation at its next meeting, and may conduct a personal interview with the Practitioner. After the Credentials Committee reviews the reinstatement request and accompanying documentation, one of the following steps shall be taken:

2.8.8.1.1 The Credentials Committee shall issue a written recommendation as to reinstatement and whether any conditions or limitations are recommended, with a statement of the reasons for any denial of reinstatement or conditions or limitations. Its recommendation shall be forwarded to the Medical Executive Committee.

2.8.8.1.2 In the case of any Medical LOA or other reinstatement request the Credentials Committee deems appropriate, the Credentials Committee shall refer to the request with its recommendation to the Physician Health and Rehabilitation Committee to be reviewed in accordance with written Policy. The Physician Health and Rehabilitation Committee's recommendation regarding reinstatement and any recommendation of the Credentials Committee shall be forwarded to the Medical Executive Committee.

2.8.8.2 Medical Executive Committee. At its next meeting, the Medical Executive Committee shall review the reinstatement request and the recommendation of the Credentials Committee, as well as the recommendation of the Physician Health and Rehabilitation Committee if applicable. The Medical Executive Committee may conduct a personal interview with the Practitioner. The Medical Executive Committee shall issue a

written recommendation to the Board of Trustees as to whether reinstatement should be granted and any conditions or limitations that should apply. If reinstatement is not recommended or any conditions or limitations are recommended, a statement of the reasons for such shall be included.

2.8.8.2.1 If the recommendation of the Medical Executive Committee is an Adverse Recommendation or Action, the Hospital President shall provide the Practitioner with Special Notice of the recommendation as provided in Article 10 and all further procedures shall be as set forth in that Article.

2.8.8.2.2 If the recommendation of the Medical Executive Committee is not an Adverse Recommendation of Action, it shall be forwarded with any supporting documentation to the Board of Trustees for review.

2.8.8.3 Board of Trustees. The Board of Trustees shall review the recommendations from the involved committees and individuals listed above and issue its recommendation at its next meeting. If reinstatement is not approved, or there are conditions or limitations on reinstatement, a statement of the reasons for such shall be included in the recommendation.

2.8.8.3.1 If the recommendation of the Board of Trustees is an Adverse Recommendation or Action, the Hospital President shall provide the Practitioner with Special Notice of the recommendation as provided in Article 10 and all further procedures shall be as set forth in that Article.

2.8.8.3.2 If the recommendation of the Board of Trustees is not an Adverse Recommendation or Action, it shall be the final decision of the Board of Trustees. The Hospital President shall notify the Practitioner in writing within 20 days of the decision.

2.8.8.4 Failure to Request Reinstatement. If a Practitioner fails to request reinstatement as required above, or to provide all required documentation and information to process the request, the Practitioner's Medical Staff membership and Clinical Privileges shall automatically expire on the last day of the LOA and the Practitioner must file an application for initial appointment.

2.8.8.5 Procedural Rights of Review. There are no procedural rights of review under these Bylaws or otherwise for failure to grant a request for a LOA, failure to grant an extension of a LOA, or expiration of Medical Staff membership and Clinical Privileges due to failure to timely request reinstatement or provide all required documentation and information to enable processing of the request.

2.9 RESIGNATION

2.9.1 Request and Obligations. A Member may submit a resignation of Medical Staff membership and Clinical Privileges at any time to the Medical Executive Committee, through Medical Staff Services. The resignation will not be effective until the Member has: (i) completed all outstanding medical records, (ii) completed emergency services

call coverage as required by the Department, and (iii) received the Board of Trustees' approval of the resignation.

2.9.2 Lack of Good Standing Status. Should the Member fail to complete all outstanding medical records or to fulfill any remaining emergency services call coverage obligations, the Practitioner shall not qualify as in Good Standing at the time of resignation, unless the failure to do so is because of health impairment or other circumstances deemed emergent by the Board of Trustees.

2.10 LIMITATIONS ON REAPPLICATION

2.10.1 Three Year Prohibition.

2.10.1.1 Adverse Recommendation or Action. If a Practitioner has been subject to an Adverse Recommendation or Action as a final decision of the Board of Trustees regarding an application for appointment or reappointment, a request for Clinical Privileges, or Corrective Action, resulting in denial or termination of Medical Staff membership and/or all or some Clinical Privileges, the Practitioner may not reapply for a period of three years following the date of the final decision.

2.10.1.2 Duty to Submit Information. Following the period of three years, the Practitioner must submit information demonstrating that the basis for the Adverse Recommendation or Action no longer exists, in addition to any other information requested, before an application will be accepted for processing.

2.10.2 Effect of Withdrawal of Application.

2.10.2.1 A Practitioner who withdraws an application for appointment or reappointment, or amends or withdraws a written request for Clinical Privileges, after the application or request has been presented to the Medical Executive Committee but prior to a final decision by the Board of Trustees, may not resubmit such application or request for a period of one year from the date of the withdrawal.

2.10.2.2 If the withdrawal occurred prior to a final decision by the Board of Trustees but after being afforded a hearing as set forth in Article 10, the Practitioner may not resubmit such application or request for a period of three years from the date of the withdrawal.

2.10.3 Failure to Process Application. If an application was closed or not processed due to failure of the applicant to provide requested or required information, the Practitioner is not eligible to submit another application for a period of one year following the date of withdrawal from processing.

2.11 WAIVER OF REQUIREMENTS

The Board of Trustees, following consultation with the Medical Executive Committee, may waive a qualification for Medical Staff membership, Clinical Privileges, and/or a Staff category, but only on a finding that the waiver is in the best interests of the Hospital and the community it serves.

Failure to waive a requirement for a particular Practitioner does not entitle the Practitioner to any procedural rights of review under these Bylaws or otherwise.

2.12 MISREPRESENTATION, MISSTATEMENT OR OMISSION

A significant or material misrepresentation, misstatement or omission from an application for appointment, reappointment and/or Clinical Privileges, whether intentional or not, shall result in automatic withdrawal of the application from further processing. In the event that the application has already been processed and Medical Staff membership and/or Clinical Privileges have been granted, discovery of the significant or material misrepresentation, misstatement or omission shall result in automatic termination of Medical Staff membership and all Clinical Privileges. The determination of what constitutes a "significant or material" misrepresentation, misstatement or omission shall be made by the Medical Executive Committee, subject to the approval of the Board of Trustees, and shall involve information related to competence or professional conduct, and/or the assessment of the qualifications of Medical Staff membership and/or Clinical Privileges.

2.13 ORGANIZED HEALTH CARE ARRANGEMENT

The Hospital participates in an Organized Health Care Arrangement (OHCA) under the Health Information Portability and Accountability Act of 1996 (HIPAA) and in accordance with the Texas Health Resources Organized Health Care Arrangement Policy (OHCA Policy). The activities of the Medical Staff are intended to be included under this OHCA Policy, and as such, the Medical Staff acknowledges its participation with the Hospital in an Organized Health Care Arrangement. In accepting Medical Staff membership, each Member agrees to abide by the terms of the Hospital's *Joint Notice of Privacy Practices* (Notice) and the underlying Hospital privacy policies, with respect to Protected Health Information (PHI) created or received as part of participation in the OHCA. As stated in the OHCA Policy, each participant is individually responsible for compliance and the compliance of any privately employed personnel with the Notice and its underlying policies. The Notice will not cover PHI created or received by individual Members solely in their office setting. The Notice required by HIPAA and the OHCA Policy will be administered by Hospital personnel for all Hospital-based episodes of care, including inpatient and outpatient treatment.

3. CATEGORIES OF MEDICAL STAFF MEMBERSHIP[25]

3.1. CATEGORIES

The categories of Medical Staff membership are: Active, Courtesy, Consulting, and Affiliate. Each Member of the Medical Staff must be assigned to a specific Staff category as well as a Department (see Article 5).

3.2 ACTIVE STAFF

3.2.1 Qualifications. The Active Staff shall consist of Practitioners who:

[25] MS.01.01.01 EP 15, 17; 42 C.F.R. Sec. 482.22(c)(2); 25 Tex. Admin. Code Sec. 133.41(k)(3)(B).

3.2.1.1 Continuously meet the qualifications for Medical Staff membership in Article 2 and for assignment to the appropriate Department;

3.2.1.2 Actively and regularly provide patient care services to patients in the Hospital, with at least 24 Patient Contacts for each 12-month term of appointment (or at least a total of 48 Patient Contacts for a 24-month term of appointment) for those with Clinical Privileges; and

3.2.1.3 Actively support the Medical Staff and Hospital by participating in efforts to fulfill Medical Staff and Hospital functions as described below.

3.2.2 Rights and Prerogatives. The Members of the Active Staff shall be entitled to:

3.2.2.1 Vote on Medical Staff, Department and Division matters and any committees to which assigned as a voting member;

3.2.2.2 Hold Medical Staff, Department or Division office if qualified;

3.2.2.3 Serve as a member and/or chair of the Medical Executive Committee, chair of a Department or Division, chair or member of any standing or other committees of the Medical Staff, including subcommittee, task forces, or workgroups thereof, or of a committee of the Hospital;

3.2.2.4 Attend meetings of the Medical Staff, including any educational programs.

3.2.3 Duties and Responsibilities. Each Member of the Active Staff shall be responsible to:

3.2.3.1 Hold appropriate Clinical Privileges;

3.2.3.2 Provide emergency services call coverage as required by the Member's Department and Staff category, subject to the ultimate authority of the Board of Trustees following consultation with the Medical Executive Committee;

3.2.3.3 Attend at least 50% of all committee meetings to which the Member is assigned and it is recommended that the Member also attend at least 50% of the Medical Staff meetings during each year; and

3.2.3.4 Provide consulting services in the care of patients requiring those services on request within the Member's specialty, capability and capacity, without regard to the patient's ability to pay.

3.2.4 Failure to Meet Patient Contacts.

If, at the time of reappointment, a Member of the Active Staff has not met the required Patient Contacts during the prior term of appointment but has satisfied all other qualifications of membership, any reappointment shall be conditional for at least 12 months. The Member must comply with the Patient Contacts requirement for the first 12 months to be eligible for consideration for continued appointment to the Active Staff.

Failure to be eligible for consideration due to lack of required Patient Contacts is not an Adverse Recommendation or Action and does not entitle the Member to any procedural rights of review under these Bylaws or otherwise.

3.3 COURTESY STAFF

3.3.1 Qualifications. The Courtesy Staff shall consist of Practitioners who:

3.3.1.1 Continuously meet the qualifications for Medical Staff membership in Article 2 and for assignment to the appropriate Department;

3.3.1.2 Are members of the active staff of an acute care hospital accredited by The Joint Commission or Det Norske Veritas which will provide Medical Peer Review data to the Hospital if requested for purposes of evaluating competence and professional conduct; and

3.3.1.3 Provide consultation for a specialty not available from Members on the Active Staff or Hospital-Based Staff; and

3.3.1.4 Limit their Patient Contacts to 24 for each 12-month term of appointment or a total of 48 Patient Contacts for a 24-month term of appointment.

3.3.2 Rights and Prerogatives. Members of the Courtesy Staff:

3.3.2.1 May attend Medical Staff, Department and Division meetings, without vote, including educational programs; and

3.3.2.2 May attend committee meetings by invitation.

3.3.3 Duties and Responsibilities. Each Member of the Courtesy Staff shall:

3.3.3.1 Provide emergency services call coverage but only when providing coverage for a Member who is listed on the roster;

3.3.3.2 Provide consulting services in the care of patients requiring those services on request within the Member's specialty, capability and capacity, without regard to the patient's ability to pay;

3.3.3.3 Provide complete written OPPE data from another acute care hospital accredited by The Joint Commission or Det Norske Veritas to the Medical Executive Committee or its designee at least every nine months if the Member does not have sufficient Patient Contacts at the Hospital for the performance of OPPE. Failure to provide the required OPPE data shall be grounds for automatic action as provided in Article 11.

3.3.4 Exceeding Patient Contacts.

If at the time of reappointment, a Member of the Courtesy Staff exceeded the permissible number of Patient Contacts during the prior term of appointment, the Member shall not be eligible for reappointment to the Courtesy Staff for a period of at least 12 months and shall be automatically transferred to the Active Staff.

3.3.5 Lack of Patient Contacts.

If, at the time of reappointment, a member of the Courtesy Staff has not had any Patient Contacts during the appointment term, the Member may request appointment or shall be automatically reassigned to the Affiliate Staff if the Member meets the qualifications and criteria for that category.

3.4 AFFILIATE STAFF

3.4.1 Qualifications. Affiliate Staff membership is by invitation only and entirely discretionary. The Affiliate Staff shall consist of Practitioners who:

3.4.1.1 Continuously meet the qualifications for Medical Staff membership in Article 2, except for the controlled substances registration requirement, and for assignment to the appropriate Department;

3.4.1.2 Demonstrate a need and desire for an affiliation with the Hospital; and

3.4.1.3 Limit their practice at a hospital to the office setting.

3.4.2 Rights and Prerogatives. Members of the Affiliate Staff are not eligible to admit patients or hold other Clinical Privileges, but:

3.4.2.1 May make courtesy rounds on patients with whom they have a current Practitioner-patient relationship, subject to compliance with patient confidentiality requirements;

3.4.2.2 Order therapeutic and diagnostic procedures to be performed at the Hospital on an outpatient basis;

3.4.2.3 May attend Medical Staff, Department and Division meetings, including educational programs, without vote; and

3.4.2.4 May attend or serve on committee meetings by invitation, with or without vote as indicated in the invitation or appointment.

3.4.3 Termination of Status. As Affiliate Staff status is discretionary, the Medical Executive Committee may terminate the status at any time on prior Special Notice to the Practitioner. Termination is subject to the approval of the Board of Trustees.

3.4.4 Duties and Responsibilities. Each Member of the Affiliate Staff shall provide pre-hospitalization assessments and post-hospitalization follow-up care for their patients and accept patients without a primary care Physician for follow up care on a rotational basis.

3.5 CONSULTING STAFF

3.5.1 Qualifications. The Consulting Staff shall consist of Practitioners who:

3.5.1.1 Continuously meet the qualifications for Medical Staff membership in Article 2 and assignment to the appropriate Department;

3.5.1.2 Are members of the active staff of an acute care hospital accredited by The Joint Commission or Det Norske Veritas which will provide Medical Peer Review data to the Hospital if requested for purposes of evaluating competence and professional conduct; and

3.5.1.3 Have a special expertise not generally available among the Active or Courtesy Staff.

3.5.2 Rights and Prerogatives. Members of the Consulting Staff are not eligible for admitting Clinical Privileges and provide services at the Hospital only at the request of another Member of the Medical Staff. They may:

3.5.2.1 Attend Medical Staff, Department and Division meetings, without vote, including educational programs; and

3.5.2.2 Attend committee meetings by invitation without vote.

3.5.3 Duties and Responsibilities. Each Member of the Consulting Staff must:

3.5.3.1 Provide consulting services in the care of patients requiring those services on request within the Member's specialty, capability and capacity, without regard to the patient's ability to pay; and

3.5.3.2 Provide complete written OPPE data from another acute care hospital accredited by The Joint Commission or Det Norske Veritas to the Medical Executive Committee or its designee at least every nine months if the Member does not have sufficient Patient Contacts at the Hospital for the performance of OPPE. Failure to provide the required OPPE data shall be grounds for automatic action as provided in Article 11.

3.6 CHANGES IN STAFF CATEGORY

Any request to change a Member's Staff category will be processed only if the Member documents compliance with the above qualifications. Processing will be handled using the procedures for appointment in Article 2. Unless otherwise provided above regarding Patient Contacts, at reappointment, a Member who does not meet the threshold eligibility requirements for continuing in the same Staff category shall be reassigned to the appropriate Staff category if the Member meets the threshold eligibility requirements for such category. Reassignment is not an Adverse Recommendation or Action and does not entitle the Member to procedural rights of review under these Bylaws or otherwise.

3.7 HONORARY RECOGNITION

Honorary Recognition status is available to Practitioners who were Members of the Active Staff for at least 10 years, retired in Good Standing and are no longer engaged in professional practice, and who maintain a good reputation in the community served by the Hospital. Honorary Recognition is extended by invitation only and entirely discretionary. Practitioners with Honorary Recognition may attend Medical Staff meetings without vote and any educational programs of the Medical Staff.

These Practitioners are not eligible for Medical Staff membership or Clinical Privileges. As Honorary Recognition is discretionary, the Medical Executive Committee may terminate the status at any time on prior Special Notice to the Practitioner. Termination is subject to the approval of the Board of Trustees.

3.8 WAIVER FROM CALL COVERAGE

3.8.1 Criteria. A Member of the Active Staff category who is at least 65 years of age and who has been a Member of the Medical Staff for at least 5 consecutive years may request a waiver from any further emergency services call coverage obligation. The granting of a waiver is in the sole discretion of the Board of Trustees, following consultation with the Medical Executive Committee, and may only be considered if the Hospital's emergency services coverage needs are being adequately met by other Members of the Medical Staff.[26]

3.8.2 Failure to Grant. Failure to grant a waiver does not entitle the Member to any procedural rights of review under these Bylaws or otherwise.

4. CLINICAL PRIVILEGES

4.1. EXERCISE OF CLINICAL PRIVILEGES

4.1.1. General. A Practitioner providing patient care services at the Hospital may exercise only those Clinical Privileges requested and specifically granted by the Board of Trustees. Clinical Privileges must be Hospital specific, within the scope of the Practitioner's license authorizing such practice in this state, and limited by any conditions or restrictions imposed by the Board of Trustees.

4.1.2. Subject to Requirements. The exercise of Clinical Privileges shall be subject to these Bylaws, the Rules and Regulations, any Manuals, and Medical Staff and Hospital policies. The exercise of Clinical Privileges also shall be in accordance with accepted professional standards and the standards of the Medical Staff, as well as all applicable legal and accreditation standards.

4.2. DELINEATION OF CLINICAL PRIVILEGES

4.2.1. Development. The Medical Staff, through the Credentials Committee and Medical Executive Committee, and following consultation with the appropriate Department Chair(s), shall be responsible to develop and recommend to the Board of Trustees for

[26] 42 C.F.R. Sec. 489.20(r)(2), 489.24(j).

approval a listing of Clinical Privileges that will be available and offered at the Hospital. The list of Clinical Privileges shall take into consideration the needs of the community and the Members of the Medical Staff, the adequacy of resources, equipment and personnel of the Hospital to support the Clinical Privileges, and the cost to the Hospital of offering the particular Clinical Privileges.[27]

4.2.2. Criteria and Other Requirements.[28] The Medical Executive Committee, in consultation with the Credentials Committee and the appropriate Department Chair(s), shall also develop and approve criteria, including but not limited to minimum threshold criteria and other requirements, for the granting of the approved list of Clinical Privileges, which shall also be subject to the approval of the Board of Trustees. This process shall also apply to Clinical Privileges offered in more than one Department. Criteria for clinical privileges shall be in addition to the general criteria and qualifications in Section 2.2 above unless otherwise provided on the delineation of privileges.[29]

4.2.3. New Clinical Privileges/Clinical Privilege Offered in Multiple Departments. Any request by a Practitioner for a Clinical Privilege not currently available at the Hospital or that is offered in a Department other than the one to which the Practitioner is or will be assigned shall initially be reviewed by the Credentials Committee in consultation with the affected Departments before processing.

4.2.3.1. The Credentials Committee shall review the need for and appropriateness of the new Clinical Privilege or having a Clinical Privilege available in multiple Departments, and recommend appropriate criteria and other requirements for the Clinical Privilege.

4.2.3.2. In establishing the criteria and other requirements, the Credentials Committee may utilize an ad hoc committee with representatives from the affected Departments and may also obtain information from outside sources.

4.2.3.3. For a Clinical Privilege requested in another Department or that may be offered in multiple Departments, the Credentials Committee shall ensure that criteria are established to promote consistency in the delivery of patient care by the Practitioners exercising the Clinical Privilege, regardless of the Department in which the Clinical Privilege is granted or the Department to which the Practitioner is assigned.

4.2.3.4. The recommendations of the Credentials Committe shall be forwarded to the Medical Executive Committee for its review, and then to the Board of Trustees for a final decision. On establishment of approved criteria, requests may be processed.

4.2.3.5. Training in the new procedure shall not be conducted until first approved by the Board of Trustees based on a recommendation from the Medical Executive

[27] MS.06.01.01.

[28] MS.06.01.07 EP 2; 42 CFR Sec. 482.22(c)(6); 25 Tex. Admin. Code Sec. 133.41(k)(3)(E).

[29] For example, practitioners seeking telemedicine privileges under Section 4.8 generally would not be seeking Medical Staff membership.

Committee. Unless the preceptor is being granted Temporary Privileges, the preceptor and the preceptee shall be credentialed as described in Article Two of these Bylaws to verify the qualifications necessary for these roles. Clinical privileges shall be specifically delineated for the role in which the individual shall serve and the new procedure or new technology to be taught. The preceptor and the preceptee shall be subject to the Medical Staff Bylaws, Rules & Regulations, and policies, specifically including any relevant requirements related to patient rights, informed consent, and if applicable, requirements related to the conduct of research. After completion of training, the preceptee may be eligible to request clinical privileges for the new procedure or new technology, provided that competency in the privilege has been validated. For purposes of this Section, the following definitions shall apply:

Preceptor: An expert physician, podiatrist, oral maxillofacial surgeon, or dentist who undertakes to impart his or her clinical knowledge and skills in a defined setting to a preceptee. The preceptor must be appropriately privileged, skilled, and experienced in the procedure(s) and or technique(s) in questions. To serve as a preceptor in a specific procedure or technique, the preceptor must be a recognized authority (e.g., through publications, presentations, extensive clinical experience) in the particular field of expertise.

Preceptee: A physician, podiatrist, oral maxillofacial surgeon or dentist with appropriate basic knowledge and experience seeking individual training in skills and/or procedures not learned in prior formal training. The preceptee must have appropriate background knowledge, basic skills, and clinical experience relevant to the proposed curriculum.

4.3. PROCESS FOR GRANTING AND RENEWAL[30]

4.3.1. Application.

4.3.1.1. A request for the specific Clinical Privileges desired by a Practitioner shall be indicated on the prescribed form and must accompany each application for appointment or reappointment, except for Affiliate Staff or Honorary Recognition. A request by a Member for a modification of Clinical Privileges may be made at any time.

4.3.1.2. All such requests must be supported by documentation of required qualifications. Failure to document satisfaction of minimum threshold criteria and other objective requirements established for the requested Clinical Privilege shall result in lack of processing of the request as to that Clinical Privilege.

4.3.1.3. A Practitioner, while assigned to a specific Department, shall be eligible to apply for Clinical Privileges in other Departments upon documentation of satisfaction of applicable criteria and other requirements.

4.3.2. Criteria.[31] The determination of whether to grant Clinical Privileges shall be based on:

[30] MS.01.01.01 EP 14; 42 C.F.R. Sec. 482.22(c)(6).
[31] 42 C.F.R. Sec. 482.22(c)(4), 482.22(c)(6); 25 Tex. Admin. Code Sec. 133.41(k)(3)(E).

4.3.2.1. The Practitioner's education, training, experience, current competence, clinical judgment, health status and ability to perform the requested Clinical Privileges, peer recommendations when required, and other relevant information;[32]

4.3.2.2. Information regarding previously successful or currently pending challenges to or restrictions on any licensure or registration or the voluntary relinquishment of such licensure or registration;[33]

4.3.2.3. Information regarding voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, denial, or loss of Clinical Privileges at another health care entity;[34]

4.3.2.4. Information regarding professional liability claims and suits either pending or closed, regardless of the outcome;[35] and

4.3.2.5. The Practitioner's documentation of compliance with any minimum threshold criteria and any other requirements established under Section 4.2 above for those Clinical Privileges.

4.3.2.6. Physicians in training in an ACGME-approved residency program may be granted limited Clinical Privileges at the request of an Active Staff member and approved by the Department and Medical Executive Committee. Limited Clinical Privileges include:

(i) Provide routine rounds and write orders as needed (except for admission orders) and coordinate and update the care with the attending staff;

(ii) Initial assessment, and documentation of patient's history;

(iii) Order diagnostic studies;

(iv) Prepare patients for surgical procedures by ordering preoperative tests.

Further development and delineation of roles and responsibilities for such physicians may be developed by the Departments, subject to the approval of the Medical Executive Committee.

4.3.3. Process.[36]

4.3.3.1. The process for consideration and granting of Clinical Privileges, both initially and on renewal, shall be the same as that used for appointment and reappointment in Article 2.

[32] MS.06.01.05 EP 2.
[33] MS.06.01.05 EP 9.
[34] MS.06.01.05 EP 9.
[35] MS.06.01.05 EP 9.
[36] MS.01.01.01 EP 26; MS.06.01.03 EP 4; 25 Tex. Admin. Code Sec. 133.41(k)(3)(E).

4.3.3.2. The renewal process shall include any information relevant to the Practitioner's competence and professional conduct, including without limitation, consideration of information generated pursuant to Medical Peer Review, specifically OPPE [37] pursuant to the Performance Improvement Plan, relevant Practitioner-specific data as compared to aggregate data and morbidity and mortality data when available, and, if needed, information from other health care entities.[38]

4.3.4. Term.

4.3.4.1. Clinical Privileges may be granted for a period of up to two years and may be for a period of less than two years.[39] A term of less than two years is not an Adverse Recommendation or Action and shall not entitle the Practitioner to any procedural rights of review under these Bylaws or otherwise.

4.3.4.2. Any initial grant of Clinical Privileges shall be subject to FPPE as set out in written Policy.[40] The term of the initial FPPE may be extended, not to exceed a total of two years if the initial FPPE has not been satisfactorily completed or the Practitioner did not have a sufficient number of cases at the Hospital for completion of the initial FPPE.

4.3.5. Conditions. A grant of Clinical Privileges may be subject to the Practitioner's compliance with specific conditions. The exercise of Clinical Privileges shall be subject to OPPE in accordance with written Policy.

4.3.6. Administrative Practitioners. Practitioners in administrative positions who have or are seeking Clinical Privileges may be required to obtain and maintain their Clinical Privileges through the same procedures used for all other Practitioners.

4.3.7 Requests for Changes in Clinical Privileges. If a Practitioner desires to change Clinical Privileges (whether an increase or decrease) other than at the time of reappointment or renewal, the Practitioner must apply in writing to the Practitioner's Department Chair on the appropriate form.

4.3.7.1 The application shall state in detail the specific changes in Clinical Privileges desired and the Practitioner's recent training and experience which justify the change in Clinical Privileges. If a decrease in Clinical Privileges is requested, the application will state the reason for the requested decrease. The Department Chair will send the application regarding the request for change in Clinical Privileges with Department Chair's recommendations to the Credentials Committee within 14 days of receipt. Thereafter, it will be processed in the same manner as an application for initial Clinical Privileges.

[37] MS.08.01.03.
[38] MS.06.01.05 EP 9.
[39] MS.06.01.07 EP 9; 25 Tex. Admin. Code Sec. 133.41(k)(1)(B); 42, C.F.R. Sec. 482.22(a)(1).
[40] MS.08.01.01 EP 1.

4.3.7.2 Recommendations for changes in Clinical Privileges shall be based upon relevant recent training, compliance with training criteria established by the Department or the Medical Staff, evaluation of current patient care provided, review of records of patients treated in the Hospital or other hospitals, and a review of all other records and information from applicable Departments which evaluate the Practitioner's practice and support the changes in Clinical Privileges. Any grant of new Clinical Privileges will have a requirement for focused professional practice evaluation (FPPE).

4.4. EXCLUSIVE PROFESSIONAL SERVICES ARRANGEMENTS

4.4.1. Requirement to Process. If the exercise of Clinical Privileges is subject to an exclusive contract or other arrangement of the Hospital, an application for Clinical Privileges shall be processed only if the requesting Practitioner is subject to the arrangement, unless otherwise permitted by the Hospital.

4.4.2. Effect on Current Members. If the Hospital enters into an exclusive contract or other arrangement, only those Members subject to that exclusive contract or arrangement may continue to exercise the Clinical Privileges addressed by the exclusive contract or arrangement, unless otherwise permitted by the Hospital. Those Members who are not subject to the exclusive contract or arrangement will be considered to have automatically relinquished those Clinical Privileges.

4.5. TEMPORARY CLINICAL PRIVILEGES[41]

4.5.1. Criteria. Temporary Clinical Privileges may be granted only to Practitioners with a pending application for initial appointment or to fulfill an important patient care, treatment and service need, as detailed below. [42] In granting temporary Clinical Privileges, special requirements may be imposed in order to monitor and assess the quality of care rendered by the Practitioner exercising such privileges. Temporary privileges may be granted by the Hospital President with the written concurrence of the Medical Staff President.[43]

4.5.1.1. Practitioners Applying to the Medical Staff.

4.5.1.1.1. After receipt of a Complete Application for Medical Staff appointment, including a request for specific temporary Clinical Privileges and in accordance with the conditions specified below, the Hospital President may grant a Practitioner temporary Clinical Privileges upon the Medical Staff President's recommendation for a period not to exceed 120 days while awaiting Medical Executive Committee and Board of Trustees approval.[44]

4.5.1.1.2. The credentialing process must include:

[41] MS.06.01.13.
[42] MS.06.01.13 EP 1, 3.

- primary source verification of the applicant's current state professional licensure(s),
- relevant training and current competence at time of granting privileges,
- ability to perform the privileges requested,
- a query and evaluation of the NPDB information,
- no current or previously successful challenge to licensure or controlled substances registration,
- no record of involuntary termination of medical staff membership at another health care entity, and
- no record of involuntary limitation, reduction, denial or loss of clinical privileges at another health care entity.[45]

4.5.1.2. Important Patient Need - Applicable to Practitioners Not Applying to the Medical Staff.

4.5.1.2.1. After receipt of a written request and other required documentation, the Hospital President, upon the Department Chair's recommendation, may grant temporary Clinical Privileges to a Practitioner who is not an applicant for Medical Staff appointment for the care of one or more specific patients, or a specified number of days not to exceed 120 days, as named in the request for purposes of an important patient care, treatment or service need.

4.5.1.2.2. The credentialing process must include primary source verification of the Practitioner's current state professional licensure and current competence, and a query and evaluation of the NPDB information.[46]

4.5.1.2.3. All such patients shall be attended by a Member of the Active Staff with the Practitioner with temporary Clinical Privileges providing appropriate consultation.

4.5.1.2.4. Such Clinical Privileges shall be restricted to the treatment of not more than 10 patients in any one year by any Practitioner, after which such Practitioner shall be required to apply for appointment to the Medical Staff before being allowed to attend additional patients.

4.5.2. Authority of Department Chair. Practitioners with temporary Clinical Privileges shall be subject to the authority of the chair of the Department to which assigned, and special requirements of consultation and reporting may be imposed by that chair.

[45] MS.06.01.13 EP 3.
[46] MS.06.01.13 EP 2.

4.5.3. Termination of Temporary Clinical Privileges. The Hospital President may, after consultation with the Medical Staff President or appropriate Department Chair, terminate any or all of a Practitioner's temporary Clinical Privileges. If failure to act may result in imminent danger to the health of an individual, the termination (or a suspension) may be effected by any person entitled to impose summary Corrective Actions under Article 9. Temporary Clinical Privileges shall automatically terminate on issuance of an Adverse Recommendation or Action or on issuance of a final decision by the Board of Trustees. In the event of termination, the Practitioner's patients then in the Hospital shall be assisted to select another Practitioner by the Department Chair.

4.5.4. No Procedural Rights of Review. The granting of temporary Clinical Privileges is a courtesy on the part of the Hospital. A Practitioner is not entitled to any procedural rights afforded by these Bylaws or otherwise as a result of granting temporary Clinical Privileges, a failure to grant temporary Clinical Privileges or because of any termination or suspension of temporary Clinical Privileges.

4.6. CARE IN AN EMERGENCY

4.6.1. Authorization. During an emergency, any qualified Practitioner with Clinical Privileges, to the degree permitted by the Practitioner's professional license, shall be permitted and assisted to do everything appropriate in an effort to save the life of a patient or prevent serious harm, using every facility of the Hospital necessary, including the calling of any consultation necessary or desirable, even though some of the actions may be taken outside the scope of the Practitioner's Clinical Privileges or Staff category. The Practitioner shall promptly provide the Medical Executive Committee with a written statement setting out the circumstances giving rise to the care in an emergency under this Section.

4.6.2 When the emergency situation no longer exists, the Practitioner must request the temporary Clinical Privileges necessary if the Practitioner wishes to continue to treat the patient. In the event temporary Clinical Privileges are denied or not requested, the Medical Staff President or Department Chair will assist the patient to secure alternate coverage from another Member of the Medical Staff.

4.6.3 Emergency Defined. For purposes of this Section, an emergency is defined as a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

4.7. PRIVILEGES TO PERFORM H&P[47]

4.7.1. General. Clinical Privileges for performing a medical history and physical examination shall be delineated. The medical history and physical examination shall be performed by a Physician, Oral and Maxillofacial Surgeon, or Allied Health Professional with appropriate Clinical Privileges in accordance with the Rules and Regulations.

[47] MS.01.01.01 EP 16; 42 C.F.R. Sec. 482.22(c)(5); 25 Tex. Admin. Code Sec. 133.41(k)(3)(F).

4.7.2. Time Requirements.

4.7.2.1. The medical history and physical examination must be completed and included in the medical record within 24 hours after the patient arrives for admission to the Hospital but prior to surgery or any procedure requiring anesthesia, except in emergencies which preclude such documentation. See Rules and Regulations on documentation requirements in emergencies.

4.7.2.2. A medical history and physical examination performed within 30 days prior to admission may be included in the medical record if it is accompanied by documentation of the results of an updated history and examination by a Physician, Oral and Maxillofacial Surgeon, or Allied Health Professional with appropriate Clinical Privileges, with a notation of any changes or the absence of any changes. The updated history and physical examination must be performed and included in the medical record within 24 hours after registration or inpatient admission and prior to surgery or any procedure requiring anesthesia.

4.7.3. Dentists and Podiatrists.

4.7.3.1. Members who are Dentists and Podiatrists are responsible for that part of their patients' histories and physical examinations that relate, respectively, to dentistry and podiatry.

4.7.3.2. Dentists and Podiatrists are responsible to secure a Physician Member to manage and coordinate their patients' medical condition during hospitalization and meet any requirements in the Rules and Regulations.[48]

4.8. TELEMEDICINE CLINICAL PRIVILEGES

4.8.1. General. Practitioners who wish to provide telemedicine services in prescribing, rendering a diagnosis or otherwise providing clinical treatment to a Hospital patient shall be required to apply for and, except as provided below, be granted Clinical Privileges for these services as provided in these Bylaws. Telemedicine shall have the meaning assigned by the Medicare Conditions of Participation.[49]

4.8.2. Reliance on Distant Site Credentialing. The Board of Trustees[50], following consultation with the Medical Executive Committee, may authorize a written agreement with a distant site hospital or a telemedicine entity, which agreement allows reliance on the credentialing and privileging decisions of that distant site; provided that, the process meets the applicable legal and accreditation requirements. [51] Practitioners holding telemedicine Clinical Privileges only shall not be eligible for appointment to the Medical Staff and shall be subject to FPPE/OPPE.

[48] 42 C.F.R. Sec. 482.12(c)(4).
[49] 42 C.F.R. Sec. 482.12(a)(8)..
[50] 42 C.F.R. Sec. 482.22(a)(3)-(a)(4) (decision whether to rely on distant-site hospital credentialing belongs to governing body).
[51] 42 C.F.R. Sec. 482.12(a)(8)-(a)(9); see also Sec. 482.22(a)(3)-(a)(4); MS.13.01.01.

4.8.3. Scope of Telemedicine Services. Those clinical services that are appropriately delivered through a telemedicine medium, according to commonly accepted quality standards, shall be recommended to the Board of Trustees by the Medical Executive Committee.[52] Consideration of appropriate utilization of telemedicine equipment by the telemedicine Practitioner shall be encompassed in Clinical Privileges decisions.[53]

4.9. TEMPORARY DISASTER PRIVILEGES

4.9.1 Authority. If the Hospital's Emergency Management Plan has been activated, any Member, or other Practitioner with Clinical Privileges, to the degree permitted by his license, shall be permitted to and be assisted by Hospital personnel in doing everything possible to save the life of a patient or to save the patient from serious harm. Additionally, temporary disaster privileges may be granted to volunteer licensed independent practitioners who are not Members of the Staff if the hospital is unable to meet immediate patient care needs by the Hospital President or Medical Staff Chief, or their designees, as provided in Hospital policy.[54]

4.9.2 Process. The process for granting temporary disaster privileges shall include the basic steps of photo identification and direct observation, mentoring, and clinical record review of volunteer staff in accordance with legal and accreditation requirements. [55] A volunteer licensed independent practitioner applying for disaster privileges shall be directed to the area as designated by the Hospital's Emergency Management Plan and must present a valid government issued photo identification issued by a state or federal agency (e.g. driver's license or passport). In addition, the volunteer provider must provide at least one of the following:

4.9.2.1 A current hospital picture identification card that clearly identifies the individual's professional designation.

4.9.2.2 A current license to practice.

4.9.2.3 Primary source verification of the license.

4.9.2.4 Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), and Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or other recognized state or federal organization or group(s).

[52] MS.13.01.03 EP 1.
[53] Introduction to MS.13.01.01.
[54] EM.02.02.13 EP 2. and EM.02.02.15,EP1
[55] EM.02.02.13 EP 5-6. and EM 02.02.15,EP7-9

4.9.2.5 Identification indicating that the individual has been granted authority to render patient care, treatment, or services in disaster circumstances (such as authority having been granted by a federal, state, or municipal entity).

4.9.2.6 Identification by a current member of the Medical Staff or Hospital representative who possesses personal knowledge regarding the individual's ability to act as a licensed independent practitioner during a disaster.

4.9.3 All documents will be placed in the volunteer's file. The name of any hospital or medical staff member who has vouched for the volunteer also shall go in the file.

4.9.4 The Hospital President or Medical Staff Chief is not required to grant privileges to any individual. All decisions for granting privileges will be made on a case-by- case basis at the discretion of the Hospital President or Medical Staff Chief.

4.9.5 Primary Source Verification. As soon as the immediate situation is under control, the Hospital shall obtain primary source verification of the volunteer provider's license. Primary source verification must be completed within 72 hours from the time the volunteer licensed independent practitioner presented to the organization. In extraordinary circumstances (e.g. no means of communication or a lack of resources), verification may exceed 72 hours, but must be completed as soon as possible. Primary source is the entity or agency that has the legal authority to issue the credential in question. If the entity or agency has designated another entity or agency to communicate information about the status of a staff member's credential, then the other entity or agency may be considered the primary source. If the volunteer licensed independent practitioner is not providing care, treatment, or service which required the granting of disaster privileges, then primary source verification is not required. The Medical Staff Office, or its designee, shall be responsible for securing primary source verification on all volunteer practitioners.

4.9.6 Identification and Oversight. Volunteer licensed independent practitioners will be identified by a name badge or tag provided by the Hospital.

4.10. ALLIED HEALTH PROFESSIONALS

4.10.1. General. Certain individuals may be granted Clinical Privileges to provide health care in the Hospital as Allied Health Professionals (AHPs).[56] The process for reviewing applicants

[56] Clinical privileges are required by The Joint Commission for APRNs and PAs who practice within the hospital. HR.01.02.05 EP 10-11 (EPs allow use of medical staff process or an "equivalent process" to credential and privilege, but CMS does not accept equivalent process – telephone call with The Joint Commission July 31, 2012). The CMS Conditions of Participation require clinical privileges for any practitioner providing a "medical level of care" but also if performing surgery. The Joint Commission Booster Pak 2011 and telephone call with The Joint Commission July 31, 2012; 42 C.F.R. Sec. 482.51(a)(4). The accompanying

Interpretive Guidelines provide that the hospital “must specify the surgical privileges for each practitioner that performs

and granting Clinical Privileges to an AHP shall be set out in Hospital policy. Any grant of Clinical Privileges shall be in accordance with the Medical Staff credentialing and privileging process, and shall be subject to any required Practitioner delegation, direction and/or supervision as set out in Hospital policy following consultation and recommendation by the Medical Executive Committee. Allied Health Professionals are not eligible for Medical Staff membership or any of the procedural rights of review afforded to Practitioners under these Bylaws or otherwise. Any review rights shall be limited to those set out in the Hospital policy.

4.10.2. Supervising Practitioner. Except for those employed by the Hospital, each AHP must be engaged by a Member either as an employee or independent contractor of the Member or the Member's practice group. One Member shall be designated as the primary supervising Practitioner, and required to submit attestations as to the competence of the AHP and the obligations of the supervising Practitioner as set forth in these Bylaws, Hospital policy and the Rules and Regulations on use of the AHP. All other Practitioners utilizing the services of the AHP are considered alternate supervising Practitioners and subject to the same obligations. All supervising Practitioners are responsible to provide the required delegation, direction and/or supervision as set forth in these Bylaws, the Rules and Regulations, Hospital policy, and the AHP's delineation of Clinical Privileges when using the services of the AHP. Each supervising Practitioner retains full responsibility for the performance and care provided by the AHP in the Hospital.

4.10.3. Others. Practice in the Hospital by AHPs who are not eligible for Clinical Privileges, but practice pursuant to other authorization, and any other health care providers who are not Hospital employees shall be as set forth in Hospital policy and at the Hospital's sole discretion.

4.10.4. Improper Use. Use by a Practitioner of an AHP, other health care provider authorized to provide health care in the Hospital, or Hospital employee in a manner not permitted by the individual's Clinical Privileges or other authorization or these Bylaws, Rules and Regulations, or Hospital policies may be grounds for Corrective Action against the Practitioner.

5. CLINICAL DEPARTMENTS[57]

5.1. DEPARTMENTS

The Medical Staff shall be organized into the following Departments:

5.1.1. Emergency Medicine
5.1.2. Medicine
5.1.3. Pathology
5.1.4. Radiology
5.1.5. Surgery

surgical tasks, This would include practitioners such as MD/DO, dentists, oral surgeons, podiatrists, RN first assistants, nurse practitioners, surgical physician assistants, surgical technicians, etc." CMS State Operations Manual.

[57] MS.01.01.01 EP 12; 42 C.F.R. Sec. 482.22(c)(3).

5.1.6. Anesthesia
5.1.7. Obstetrics and Gynecology
5.1.8. Pediatrics
5.1.9. Neurology

5.2. ASSIGNMENT TO DEPARTMENT

Each Member of the Medical Staff and other Practitioner and Allied Health Professional with Clinical Privileges will be assigned to the appropriate Department in which the Member (or Practitioner or AHP has Clinical Privileges) and be accountable to the chair of that Department, as well as the Medical Executive Committee as set forth below. A Member may be assigned to more than one Department if the Member holds Clinical Privileges in more than one Department, but shall only have voting rights in the Department which most closely reflects the Member's primary Clinical Privileges and Hospital practice. The Member may serve as a voting member of Department committees of any Department to which assigned. A Member assigned to more than one Department may hold office or chair Department committees only in the Department in which the Member has voting rights and shall have only one vote on Medical Staff matters.

5.3. FUNCTIONS OF DEPARTMENT

Each Department is a division of the Medical Staff, delegated by the Board of Trustees and the Medical Executive Committee with primary responsibility to:

5.3.1. Implement and assist with conducting Medical Peer Review of the delivery of patient care in the Department;

5.3.2. Monitor the competence and professional conduct of Members and others with Clinical Privileges assigned to the Department;

5.3.3. Establish criteria for Clinical Privileges in the Department as provided in Section 4.2.2, subject to the Bylaws, Rules and Regulations, and Hospital policies;

5.3.4. Take appropriate action to improve the quality and efficiency of the delivery of patient care in the Department; and

5.3.5 Except as the Hospital has provided for by contract, establish a schedule providing adequate emergency services call coverage in the specialties represented in the Department to respond to requests from the Emergency Department, to requests for hospital-to-hospital transfers, and to requests for inpatient consultation outside the usual and customary referral process which Members may have with each other, such schedule subject to the approval of the Medical Executive Committee and the Board of Trustees.

These functions shall be delegated to the Department Chair who shall have the right to call Department meetings as needed to accomplish these functions, if necessary.

5.4. DEPARTMENT OFFICERS

5.4.1. Department Chair. Each Department shall be organized under the direction of a Department Chair who is responsible to the Board of Trustees, through the Medical Executive Committee. The Department Chair shall ensure the performance of all functions required for purposes of legal and accreditation requirements. The Department Chair is responsible for all clinically related activities of the Department, [58] subject to the direction of the Medical Staff President and the Hospital President. The Department Chair shall have the authority to call meetings of the Department and shall preside at such meetings.

5.4.2. Duties of Department Chair. Unless otherwise provided for by the Hospital, the Department Chair also shall be responsible for the following:

5.4.2.1. Administratively related activities of the Department, unless otherwise provided by the Hospital;

5.4.2.2. Continuing surveillance of the professional performance of all individuals in the department who have delineated Clinical Privileges;

5.4.2.3. Recommending to the Medical Executive Committee or its designee the criteria for Clinical Privileges that are relevant to care provided in the Department;

5.4.2.4. Assessing and recommending to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the Department or the Hospital;

5.4.2.5. Integration of the Department into the primary functions of the Medical Staff and Hospital;

5.4.2.6. Coordination and integration of interdepartmental and intradepartmental services;

5.4.2.7. Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;

5.4.2.8. Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;

5.4.2.9. Determinations of the qualifications and competence of Practitioners and Allied Health Professionals who provide care, treatment, and services in the Department as set forth in these Bylaws;[59]

5.4.2.10. Continuous assessment and improvement of the quality of care, treatment, and services;

[58] MS.01.01.01 EP 36.

[59] The modification of this Element of Performance for MS.01.01.01 EP 36 is based on clarification received from Lisa Vandecaveye, General Counsel, The Joint Commission, via email on February 22, 2018 to outside counsel. Ms. Vandecaveye stated that this standard deals with medical staff and, while department chairs might work cooperatively with hospital administration, they would not be responsible for determinations involving hospital staff. This clarification would also apply to Sec. 5.4.2.8. above.

5.4.2.11. Maintenance of quality control programs, as appropriate;

5.4.2.12. Orientation and continuing education of all persons in the Department; and

5.4.2.13. Recommending space and other resources needed by the Department.[60]

5.4.3 Department Vice-Chair. Each Department shall have a Vice-Chair who shall perform the functions of the Department Chair in his absence. The Vice-Chair shall assist the Department Chair as requested in fulfilling the functions and responsibilities under Section 5.4.2.

5.5. ELECTION OF DEPARTMENT OFFICERS

5.5.1. Qualifications.

5.5.1.1. Department officers must be Members of the Active Staff in Good Standing and may not have been subject to Corrective Action at the Hospital at any time.

5.5.1.2. They must be board certified by the specialty board appropriate to their specialty and Clinical Privileges or affirmatively establish comparable competence through the credentialing process.[61]

5.5.1.3. Department officers may not hold a similar position or serve as a medical staff officer at another health care entity during their service in these positions.

5.5.2. Election and Term. Prior to the end of the Medical Staff Year, Department officers shall be elected for 2-year terms, beginning on January 1 and ending on December 31. They may serve consecutive terms.

5.5.2.1. Nominations may be made by any member of the Department at least 30 days prior to voting, in writing to Medical Staff Services.

5.5.2.2. The Medical Executive Committee shall determine whether voting shall be at a Department meeting called for this purpose or by mail/facsimile/electronic ballot. If mail/facsimile/electronic ballot is selected, the procedures in Article 8, Section 8.7, shall be used.

5.5.3. Resignation and Removal.

5.5.3.1. A Department officer may resign at any time on written notice to the Medical Staff President.

[60] MS.01.01.01 EP 36.
[61] MS.01.01.01 EP 36.

5.5.3.2. Failure of a Department officer to maintain the qualifications of the office shall result in automatic removal.

5.5.3.3. A Department officer may be removed for cause by any of the following methods: (i) written petition signed by at least 1/3rd of the voting Members of the Department, followed by a special meeting of the Department and the affirmative vote of 2/3rds of the voting Members present with a quorum of at least 3 voting Members; (ii) the affirmative vote of 2/3rds of the voting Members of the Medical Executive Committee with the approval of the Board of Trustees; or (iii) the affirmative vote of 2/3rds vote of the Board of Trustees following consultation with the Medical Executive Committee.

5.5.4. Vacancies. A vacancy in the office of Department Chair shall be filled by the Vice-Chair (or a Member of the Department appointed by the Medical Staff President if there is no Vice-Chair willing to serve in the position) and an election shall be held within 60 days to fill the office of Vice-Chair. In the event of a vacancy in the office of Vice-Chair, an election shall be held within 60 days using the procedures in Section 5.5.2 above. In the event of a vacancy in both offices, the Medical Executive Committee shall appoint an interim Department Chair to serve for a period not to exceed 60 days until elections are held for both offices.

5.6. DEPARTMENT MEETINGS – see Article 8

5.7. DEPARTMENT COMMITTEES

5.7.1. Authority to Appoint. The Department Chair has the authority to appoint committees of the Department, whether standing or ad hoc, to accomplish the functions of the Department. Any committee appointed shall be subject to the approval of the Medical Executive Committee.

5.7.2. Procedures. The Department committee shall have a chair who must be a voting Member of the Department.

5.8. DIVISIONS

5.8.1. Authority to Establish. A Department may be further divided into one or more clinical Divisions within the Department, with the approval of the Medical Executive Committee and the Hospital President. A Division must have at least 3 Members of the Active Staff. An existing Division may be eliminated or merged with another Division by a Department Chair following notice to the Division and subject to the approval of the Medical Executive Committee.

5.8.2. Leadership. The Department Chair shall appoint a Chief for each Division within his Department. The Division Chief shall assist the Department Chair in carrying out his responsibilities as to the Division and Division Members, and shall represent the views of the Division to the Department Chair. The Division Chief shall report directly to the Department Chair.

5.8.3. Duties. The Division may carry out duties and obligations of the Department that are specific to the Members of the Division and the specialties and subspecialties within the Division, and such other duties as are assigned by the Department Chair or the Medical Executive Committee. Divisions are directly responsible to the Department.

5.9 DEPARTMENT RULES AND REGULATIONS

Each Department may develop written Department rules and regulations in support of these Bylaws specifying how the Department shall comply with the functions assigned to the Department. All Department rules and regulations shall be subject to the approval of the Medical Executive Committee, and may not be in conflict with these Bylaws, the Rules and Regulations and Medical Staff policies.

6. MEDICAL STAFF COMMITTEES[62]

6.1 GENERAL

6.1.1 Status. All Medical Staff committees shall be established and operate as medical peer review committees/medical committees/professional review bodies, as further detailed in Article 12.

6.1.2 Standing Committees. Standing committees shall report to the Medical Executive Committee unless otherwise provided in these Bylaws. Other standing committees of the Medical Staff or of the Medical Executive Committee may be established in writing by the Medical Executive Committee, subject to the approval of the Board of Trustees, and shall not require amendment of these Bylaws.

6.1.3 Special and Ad Hoc Committees. Standing committees and their chairs have the authority to form special or ad hoc committees and task forces to assist in the performance of authorized functions. Any such formation shall be reflected in writing with a statement of the purpose of the committee or task force.

6.1.4 Members and Attendance. The members of Medical Staff committees shall be appointed by the Medical Staff President and the chairs shall be members of the Active Staff, unless otherwise provided in these Bylaws. Since the Board uses a system of triad leadership, the Hospital President, Chief Medical Officer and Chief Nursing Officer may attend any Medical Executive Committee or other Medical Staff committee meeting, whether standing, ad hoc, special, or a task force, including a meeting in executive session.[63]

6.2 MEDICAL EXECUTIVE COMMITTEE[64]

6.2.1 General. The Medical Executive Committee shall serve as the governing committee of the Medical Staff. By approval of these Bylaws, the Medical Staff delegates and authorizes the Medical Executive Committee to represent and act on its behalf on all matters and in

[62] 42 C.F.R. Sec. 482.22(c)(3); MS.01.01.01 EP 12.
[63] MS.02.01.01 EP 2 (the standard references the CEO or his or her designee).
[64] MS.01.01.01 EP 20-23, MS.02.01.01.

between meetings of the Medical Staff, subject to any limitations imposed by these Bylaws and in a manner consistent with these Bylaws.

6.2.2 Duties. The Medical Executive Committee shall be the primary group accountable to the Board of Trustees for ensuring fulfillment of Medical Staff functions of governance, leadership and performance improvement, as well as managing the activities of growth, profitability, quality, safety, and disease management around patients who seek care across the Hospital continuum. Specific duties of the Medical Executive Committee shall include, but not be limited to:

6.2.2.1 Making recommendations to the Board of Trustees as to:

6.2.2.1.1 the Medical Staff structure,

6.2.2.1.2 the process used to review credentials and delineate Clinical Privileges,

6.2.2.1.3 Practitioners who should be appointed to the Medical Staff and/or granted Clinical Privileges,

6.2.2.1.4 the delineation of Clinical Privileges for eligible Allied Health Professionals,

6.2.2.1.5 the process by which Practitioners may be subject to Corrective Action,

6.2.2.1.6 the mechanism for affording procedural rights of review in the event of an Adverse Recommendation or Action,

6.2.2.1.7 participation of the Medical Staff in Medical Peer Review activities, and

6.2.2.1.8 the results of its review and actions on reports from the Departments, standing Medical Staff committees, and other committees or assigned groups;

6.2.2.2 Receiving and acting on the reports from the Departments, all standing Medical Staff committees or others concerning Medical Peer Review activities and the discharge of delegated Medical Staff responsibilities;

6.2.2.3 Periodically reporting results and recommendations concerning Medical Staff functions, as well as the status of Hospital accreditation, to the Medical Staff;

6.2.2.4 Coordinating the activities of the Departments, Medical Staff committees, and other groups within the Medical Staff organization;

6.2.2.5 Initiating and pursuing Corrective Action or other intervention in accordance with these Bylaws when indicated;

6.2.2.6 Providing oversight for the organization of inpatient, outpatient, ambulatory, and community clinical services through the Hospital and the Medical Staff, and establishing policies and procedures for the efficient, safe, and high-quality operations of the Hospital and the Medical Staff;

6.2.2.7 Determining reasonable emergency services call coverage responsibilities and schedules and ensuring that the Departments provide for timely and adequate call coverage for the Hospital's emergency department for each of the specialty areas within the Departments as directed by the Board of Trustees; and

6.2.2.8 Addressing issues of Practitioner health or impairment in accordance with written Policy, which Policy shall provide a process separate from the Corrective Action process unless Corrective Action is warranted*; and*

6.2.3 Composition

The Medical Executive Committee shall be comprised of the following:

(a) All Department Chairmen;
(b) The Medical Staff President
(c) The Medical Staff President-Elect
(d) The Immediate Past Medical Staff President
(e) The Secretary-Treasurer of the Medical Staff
(f) The Chair of the Credentials Committee
(g) Up to three (3) members-at-large who are members of the Medical Staff nominated by the Medical Staff President-Elect and approved by the Medical Executive Committee at its December meeting
(h) Two (2) past Presidents of the Medical Staff, ex officio with you, appointed by the current President of the Medical Staff
(i) The Hospital President or his designees shall serve on the Medical Board, Ex-Officio, without vote.

6.2.3.1 Medical Staff Members. The Medical Executive Committee shall have as voting members the elected officers of the Medical Staff and at least 5 but not more than 10 Members of the Active Staff.

6.2.3.1.1 Members shall be selected on the basis of the following behavioral and technical competencies: accountability, aspiration and passion for leadership, conflict management, engaged in the Hospital's vision, integrity, judgment, legal/ethical/political awareness, skillful communication, and trust and respect.

6.2.3.1.2 All disciplines and specialties from the Active Staff categories are eligible for membership on the Medical Executive Committee.[65] A majority of the voting members of the Medical Executive Committee must be Physicians.[66]

6.2.3.1.3 Members shall be elected by the voting Members of the Medical Staff from a ballot of qualified candidates, either at a Medical Staff meeting or by mail ballot using the procedures in Article 8. The candidates shall be proposed by the Nominating Committee.

[65] MS.02.01.01 EP 3.
[66] MS.02.01.01 EP 4; 42 C.F.R. Sec. 482.22(b); 25 Tex. Admin. Code Sec. 133.41(k)(2)(B).

6.2.3.1.4 Medical Executive Committee members may not hold a similar position at another health care entity during service on the Medical Executive Committee.

6.2.3.2 Hospital Members. The Medical Executive Committee shall also include as non-voting members: Hospital President, Chief Medical Officer, and Chief Nursing Officer. The Hospital President may invite other Hospital staff, including Medical Staff Services, to attend meetings as support and resources for the Medical Executive Committee

6.2.3.3 Chair. The Medical Staff President shall chair the Medical Executive Committee.

6.2.3.4 Terms. Except for the Medical Staff officers, whose terms shall be their terms of office, membership terms shall be 2 years and staggered. Members may serve consecutive terms.

6.2.3.5 Removal of Members. The procedures for removal of a Medical Staff officer are set out in Section 7.7. Any other Medical Staff Member of the Medical Executive Committee may be removed for cause on 2/3^{rds} vote of the Medical Executive Committee or for cause on 2/3^{rds} vote of the Board of Trustees. Only the Board of Trustees may remove the Hospital President, Chief Medical Officer, or Chief Nursing Officer, and only the Hospital President may remove another member appointed under Section 6.2.3. 2..

6.2.4 Meetings and Reporting.

6.2.4.1 The Medical Executive Committee shall meet at least 10 times each year on a monthly basis and otherwise on the call of its Chair or the Hospital President.

6.2.4.2 For a quorum, at least half of the voting Members of the Medical Executive Committee must be present in person, or by teleconference, videoconference or other appropriate means by which all participants can hear each other.

6.2.4.3 Affirmative action shall require majority vote of the voting members present, as defined above, in the presence of a quorum.

6.2.4.4 The Medical Executive Committee shall report to the Board of Trustees after each meeting.

6.3 BEHAVIORAL EVENT REVIEW COMMITTEE

6.3.1 Duties. The Behavioral Event Review Committee shall be responsible for evaluating reports of disruptive behavior and determining the appropriate disposition of the issue in accordance with the Medical Staff's Code of Conduct Policy. The committee will report its activities and findings on a quarterly basis.

6.3.2 Composition. The Behavioral Event Review Committee shall be composed of the Immediate Past President of the Medical Staff or President-Elect serving as Chair, the Chief Medical Officer, and two other Members from the Medical Executive Committee.

The Director of Medical Staff Services shall provide support for the committee, including without limitation, conducting validation of issues brought to the committee.

6.3.3 Meetings. The Behavioral Event Review Committee will meet as needed on the call of the Chair.

6.4 BYLAWS COMMITTEE

6.4.1 Duties. The Bylaws Committee shall:

6.4.1.1 Maintain the Medical Staff Bylaws and Rules and Regulations, any Manuals, and Medical Staff policies on an ongoing basis to reflect the current Medical Staff organization and function, and compliance with regulatory and accrediting requirements;

6.4.1.2 Conduct a review of the Bylaws, Rules and Regulations, any Manuals, and Medical Staff policies as set forth in Article 14;

6.4.1.3 Maintain current knowledge of legal and regulatory requirements pertinent to the Bylaws and other governance documents, and refer questions to Hospital legal counsel; and

6.4.1.4 Draft revisions to the Bylaws and ancillary governance documents as are necessary for submission to the Medical Executive Committee in accordance with the procedures in Article 14.

6.4.2 Composition. The Bylaws Committee shall be composed of at least 5 members to include: Medical Staff President, Medical Staff President Elect, and Medical Staff Secretary/Treasurer. The Medical Staff Secretary shall serve as Chair and the Chief Medical Officer shall serve as a non- voting member.

6.4.3 Meetings. The Bylaws Committee shall meet at least annually and otherwise as needed to accomplish its duties.

6.5 CREDENTIALS COMMITTEE

6.5.1 Duties. The Credentials Committee shall:

6.5.1.1 Coordinate the credentialing and privileging process for Practitioners and AHPs in accordance with the Bylaws;

6.5.1.2 Review the recommendations of the Department Chairs regarding appointment, reappointment and/or Clinical Privileges;

6.5.1.3 Make recommendations to the Medical Executive Committee regarding appointment, reappointment and/or Clinical Privileges, including Staff category and Department assignment; and

6.5.1.4 Make recommendations to the Medical Executive Committee for criteria for Clinical Privileges.

6.5.2 Composition. Voting members will consist of the Chair, and 8 additional members of the active medical staff. Non-voting members will include the Medical Staff Secretary, Hospital President, Chief Medical Officer, and Manager of Medical Staff Services.

6.6 NOMINATING COMMITTEE

6.6.1 Duties. The Nominating Committee shall solicit qualified and interested candidates for elected office, and review and document their qualifications and experience. If acceptable, the Nominating Committee shall nominate those Members for election as provided in the Bylaws.

6.6.2 Composition. The Nominating Committee shall be composed of at least three Members of the Active Staff, with preference to Immediate Past Presidents, with one designated as Chair. The President of the Medical Staff and the Chief Medical Officer shall be non-voting members of the committee.

6.6.3 Meetings. The Nominating Committee shall meet as necessary to accomplish its duties.

6.7 PEER REVIEW COMMITTEE

6.7.1 Duties. The Peer Review Committee shall perform the duties in the Medical Staff policies on Peer Review, including FPPE and OPPE. Receive, review, and/or take action based on the results of peer review committee reports. These recommendations may include the formation of Ad-hoc committees, focused reviews, and outside expert reviews for a specific physician(s).

6.7.2 Composition. The Peer Review Committee shall be composed of at least 5 Members of the Active Staff, with one designated as Chair. The Chief Medical Officer, the Chief Nursing Officer, and the Director of Quality Improvement and Patient Safety shall serve as non-voting members.

6.7.3 Reporting. In addition to reporting to the Medical Executive Committee, the Peer Review Committee shall also notify the appropriate Department Chair of any action taken as to a Member of the Department.

6.8 PHYSICIAN HEALTH AND REHABILITATION COMMITTEE

6.8.1 Duties. The Physician Health and Rehabilitation Committee shall provide assistance and support to Practitioners and AHPs on health issues, and coordinate the evaluation and intervention if indicated of reports of impairment, in accordance with Policy. The Policy

shall provide for identifying and managing matters of Practitioner health which is separate from the Corrective Action process in Article 9.

6.8.2 Composition. The Physician Health and Rehabilitation Committee shall be composed of at least 5 Members of the Active Staff, with one designated as Chair. The Chief Medical Officer shall serve as a non-voting member.

6.8.3 Meetings. The Physician Health and Rehabilitation Committee shall meet as needed.

7 MEDICAL STAFF OFFICERS

7.1 GENERAL [67]

The responsibility for the organization and conduct of the business of the Medical Staff shall rest with a Physician Member who shall serve as the Medical Staff President and Medical Executive Committee Chair.[68] The other officers of the Medical Staff shall be President-Elect, who shall succeed the President, and Secretary-Treasurer.

7.2 QUALIFICATIONS

7.2.1 Each Medical Staff officer must be a Member of the Active Staff in Good Standing and may not have been subject to Corrective Action at this Hospital at any time. A candidate for the office of President or President-Elect must be a Physician.

7.3 DUTIES

7.3.1 Medical Staff President. The duties and responsibilities of the Medical Staff President shall include the following:

7.3.1.1 Serve as the chief officer of the Medical Staff, and represent and act as a spokesperson for the Medical Staff to the Hospital, the Board of Trustees and the community;

7.3.1.2 Serve as a voting member of and chair the Medical Executive Committee;

7.3.1.3 Serve as an Ex-officio, non-voting member of all standing committees of the Medical Staff, the Departments and any Department committees, the Divisions, and all special and ad hoc committees or task forces of the Medical Staff or a Department;

7.3.1.4 Call, preside at and be responsible for the agenda of all regular and special meetings of the Medical Staff;

7.3.1.5 Enforce the Medical Staff Bylaws, Rules and Regulations, any Manuals, and Medical Staff policies, as well as Hospital policies applicable to Practitioners;

[67] MS.01.01.01 EP 19.
[68] Tex. Admin. Code Sec. 133.41(k)(2)(D); see also 42 C.F.R. Sec. 482.22(b) which only requires that it be an individual Practitioner.

7.3.1.6 Implement and interpret the policies of the Board of Trustees to the Medical Staff and report to the Board of Trustees regarding patient care, Medical Peer Review and other activities affecting the Medical Staff;

7.3.1.7 Interact with the Hospital President, Chief Medical Officer, other members of Hospital administration, and the Board of Trustees on matters of mutual concern affecting the Hospital;

7.3.1.8 Appoint Members to all Medical Staff committees and task forces, unless otherwise specified in these Bylaws; and

7.3.1.9 Perform those duties specifically listed in these Bylaws and as may be delegated by the Medical Executive Committee or the Board of Trustees.

7.3.2 President-Elect. The duties and responsibilities of the President-Elect shall include the following:

7.3.2.1 In the absence of the Medical Staff President, assume all of the duties and have the authority of the office of Medical Staff President until he returns;

7.3.2.2 Succeed to the office of Medical Staff President should a vacancy in that office occur during the second year and on completion of the term as President-Elect;

7.3.2.3 Serve as a voting member of the Medical Executive Committee;

7.3.2.4 Perform any other duties set out in these Bylaws, the Rules and Regulations, any Manuals, or Medical Staff policies, or as may be assigned to the President-Elect by the Medical Staff President, the Medical Executive Committee or the Board of Trustees.

7.3.3 Secretary. The duties and responsibilities of the Secretary shall include the following:

7.3.3.1 Ensure that accurate and complete minutes are maintained for all meetings of the Medical Staff and its committees and task forces;

7.3.3.2 Call meetings at the request of the Medical Staff President;

7.3.3.3 Attend to correspondence of the Medical Staff; and

7.3.3.4 Perform any other duties set out in these Bylaws, the Rules and Regulations, any Manuals, or Medical Staff policies, or as may be assigned to the Secretary by the Medical Staff President, the Medical Executive Committee or the Board of Trustees.

7.4 ELECTION OF OFFICERS[69]

The Medical Staff officers shall be elected by the voting Members of the Medical Staff at the last regular Medical Staff meeting before the end of the Medical Staff Year. The Nominating Committee shall nominate at least one qualified candidate for each position at least 30 days prior to the meeting and nominations may also be made from the floor at the meeting. The candidate receiving the majority of the votes cast at the meeting at which a quorum is present shall be elected. See Article 8 for additional procedures for meetings of the Medical Staff.

7.5 TERM OF OFFICE

The term of office shall be 1-year and begin on January 1, ending on December 31 of each year.

7.6 RESIGNATION OR REMOVAL OF OFFICERS[70]

7.6.1 Resignation. A Medical Staff officer may resign from his position at any time on written notice to the Medical Executive Committee.

7.6.2 Removal by Medical Staff. A Medical Staff officer may be removed from office by a 2/3^{rds} vote of the voting Members of the Medical Staff present at a special called meeting for that purpose with a quorum of the personal presence of at least 2/3^{rds} of the voting Members. To schedule the special meeting, there must be a written petition signed by at least 1/3rd of the voting Members of the Medical Staff submitted to Medical Staff Services. The only individuals permitted to attend the special meeting are the Hospital President, who shall serve as the presiding officer, the voting Members of the Medical Staff, Hospital legal counsel, and a representative of Medical Staff Services who shall take minutes.

7.6.3 Removal by Medical Executive Committee or Board of Trustees. A Medical Staff officer may also be removed by a 2/3^{rds} vote of the Medical Executive Committee with the approval of the Board of Trustees, or by the Board of Trustees for cause.

7.6.4 Automatic Removal. Removal shall be automatic if the Medical Staff officer no longer meets one or more of the qualifications in Section 7.2.

7.7 VACANCIES IN OFFICE

In the event of a vacancy in the office of Medical Staff President during the first year of the President's term, the Immediate Past-President shall serve as the Interim President until a special election can be held. If there is a vacancy in the office of President during the second year of the President's term, the President-Elect shall assume the duties and authority of the President for the remainder of the term. If there is a vacancy in any other office, the Medical Executive Committee shall appoint an Active Staff Member to serve out the remainder of the term.

[69] MS.01.01.01 EP 18.
[70] MS.01.01.01 EP 18.

8 MEETINGS

8.1 MEDICAL STAFF

8.1.1 Regular. Regular Medical Staff meetings shall be held on call of the Medical Executive Committee, with at least one meeting held before the end of the Medical Staff Year to allow for the election of Medical Staff officers in accordance with Article 7 and reports from retiring officers and standing Medical Staff committees chairs. At least 20 days prior written notice of the date, time and place of any regular Medical Staff meeting shall be sent to the voting Members of the Medical Staff**.** The program for the meeting shall be determined by the Medical Staff President, subject to any requirements in these Bylaws.

8.1.2 Special. Special called meetings of the Medical Staff shall be convened at the date, time and place designated by the Medical Executive Committee. Special called meetings shall also be convened within 14 days of the request of the Medical Staff President or the Hospital President or the written request of 25 of the voting Members of the Medical Staff. At least 10 days prior written notice of a special called meeting shall be given to the voting Members of the Medical Staff Members. The Medical Staff President shall preside at the meeting and the only business conducted at a special meeting is that stated in the notice for the meeting.

8.2 DEPARTMENT AND DIVISION

8.2.1 Regular. Each Department shall meet at least semi-annually, or more frequently if necessary at the request and at a time and place set by the Department Chair, to conduct and report the business of the Department and discuss matters concerning the Department. Notice for regular Department meetings shall be provided to voting members of the Department at least 7 days in advance. The Department Chair shall preside at the meeting and set the agenda, with emphasis on patient safety, quality improvement, aggregate departmental performance based on OPPE reports, and focused patient care evaluation in areas pertinent to the Department.

8.2.2 Special. A special meeting of the Department may be called by the Department Chair or the Hospital President, and shall be called on the written request of at least 20% of the voting members of the Department for the reason stated in the request. Each voting member of the Department shall be given notice of the date, time and place of, and reason for the special meeting at least 7 days in advance of the meeting. The Department Chair shall preside at the meeting and the only business which may be conducted is that stated in the notice for the meeting.

8.2.3 Division. Divisions shall follow the same procedures for meetings as set forth above for Department meetings.

8.3 COMMITTEE

Standing committees of the Medical Staff shall meet on a monthly basis unless otherwise provided in Article 6. Ad hoc or special committees and task forces shall meet on call of the chair of the committee or task force.

8.4 ATTENDANCE REQUIREMENTS

8.4.1 Medical Staff. There shall be no attendance requirements for regular or special called Medical Staff meetings. However, Members are encouraged to attend at least 50% of the meetings.

8.4.2 Department. There shall be no attendance requirements for regular or special called Department meetings. However, Members are encouraged to attend at least 50% of the meetings.

8.4.3 Division. There shall be no attendance requirements for regular or special called Division meetings. However, Members are encouraged to attend at least 50% of the meetings.

8.4.4 Committee. Active Staff Members are required to attend 50% of the meetings of committees of which they are a voting member.

8.5 NOTICE OF MEETINGS

Notice of regular or special meetings shall be deemed delivered to the Practitioner on: (i) deposit with the U.S. mail, (ii) on facsimile, or (iii) on electronic transmission of the notice to the most current address on file with Medical Staff Services.

8.6 QUORUM AND VOTING

8.6.1 Quorum. Unless these Bylaws provide otherwise, voting members of any group or body of the Medical Staff present at a meeting shall constitute a quorum with the exception of the Medical Executive Committee and the Credentials Committee, of which a simple majority of voting members will constitute a quorum.

8.6.2 Affirmative Vote. The affirmative vote of a majority of the Members present and voting at a meeting at which a quorum is present shall be required to take action, except as provided elsewhere in these Bylaws. Each Member present and eligible to vote shall be entitled to cast only one vote.

8.6.3 No Proxy or Absentee Ballots. If a Member is unable to attend a meeting, the Member may not send another person to attend and vote in the Member's place, nor may the Member vote by proxy. Absentee ballots are not permitted for voting at meetings.

8.7 MAIL/FACSIMILE/ELECTRONIC BALLOTS

8.7.1 General. Unless otherwise provided by the Medical Executive Committee or these Bylaws, any business of the Staff, a Department, a Division, or a committee may be conducted by mail, facsimile, or electronic ballot in lieu of a meeting. The mail/facsimile/electronic ballot setting out the issue or matter requiring action shall be presented to the voting Members of the Medical Staff, Department, Division, or committee as provided below.

8.7.2 Delivery. The ballot shall be deemed delivered to the Member on: (i) deposit in the U.S. mail, (ii) on facsimile, or (iii) on electronic transmission to the most current address on file with Medical Staff Services. Different forms of transmission may be used for the same mail/facsimile/electronic ballot (i.e., some ballots sent by mail, some by electronic transmission).

8.7.3 Return. Mail/facsimile/electronic ballots shall allow at least 14 days from the date of delivery for return. Affirmative action shall require the majority vote of those ballots returned. Return may be by mail, facsimile, electronic transmission, or hand delivery by the required date.

9 MEDICAL PEER REVIEW AND CORRECTIVE ACTION

9.1 GENERAL

9.1.1 Process. Medical Peer Review is conducted on an ongoing basis, with primary responsibility for implementation of the Performance Improvement Plan pertinent to the Medical Staff and others with Clinical Privileges placed on the Peer Review Committee with oversight by the Medical Executive Committee.

9.1.2 Objectives. The Medical Staff's objectives with regard to ongoing implementation of the Performance Improvement Plan are to:

9.1.2.1 assess the quality and uniformity of the standard of patient care, treatment and services, and patient safety;

9.1.2.2 evaluate FPPE and OPPE information, competence and professional conduct of Members and others with Clinical Privileges;

9.1.2.3 determine if improvement or practice changes are indicated, and communicate the findings to the appropriate individuals and committees;

9.1.2.4 enable the Members and others with Clinical Privileges to implement changes through performance improvement agreements or other means when appropriate, or recommend other appropriate intervention, including without limitation Corrective Action; and

9.1.2.5 evaluate the effectiveness of improvement efforts and actions, and communicate the findings to the appropriate individuals and committees, including to the Board of Trustees through the Medical Executive Committee.

9.1.3 OPPE/FPPE. In addition to evaluating the results of OPPE, reported concerns regarding the competence or professional conduct of Members or others with Clinical Privileges are evaluated by the Peer Review Committee, with referral to the Medical Executive Committee if indicated.[71] Members may be placed under FPPE or may be requested to participate in performance improvement activities as described in Section 9.2.2 for the purpose of

obtaining additional information or to modify practice, in accordance with the Medical Staff *Peer Review Policy*. Neither FPPE nor performance improvement activities entitle the Practitioner to procedural rights of review under the Bylaws or otherwise. See Section 12.4.2 on when FPPE constitutes Investigation.

9.1.4 Use in Reappointment. Information generated pursuant to Medical Peer Review, specifically the ongoing implementation of the Performance Improvement Plan and the results of FPPE and OPPE, is also used in the reappointment process.[72]

9.2 PERFORMANCE IMPROVEMENT INTERVENTION

9.2.1 Authority. As a part of the Medical Peer Review process, the Peer Review Committee, Department Chief, Chief Medical Officer, and Hospital President may review a Practitioner's medical records at any time. If indicated, the Peer Review Committee, Department Chief, Chief Medical Officer, and Hospital President may utilize performance improvement interventions to implement practice changes with the Practitioner on a voluntary basis in accordance with the Medical Staff *Peer Review Policy*. These actions are not considered Corrective action under these Bylaws and, as the Practitioner's compliance is not mandatory, do not entitle the Practitioner to procedural rights of review under these Bylaws or otherwise.

9.2.2 Actions in Absence of Review. This section does not preclude a member of the Medical Executive Committee, a Department Chair, the Peer Review Committee, or the Chief Medical Officer, on behalf of the Medical Executive Committee, from conferring with or counseling any Practitioner in the absence of a review when indicated. Voluntary or collegial efforts are not required prior to initiating Corrective Action.

9.3 SPECIAL REQUIREMENTS

9.3.1 Meeting. Whenever a suspected deviation from acceptable standard clinical or professional practice and/or professional conduct is identified, the Medical Staff President, a Department Chair, the Hospital President, or the Chief Medical Officer may require the Practitioner to confer with the Medical Executive Committee, the Board of Trustees, or another standing Medical Staff committee or special committee, task force or ad hoc committee thereof appointed to consider the matter.

9.3.1.1 At least five days prior to the meeting date, Special Notice of the conference shall be given to the Practitioner, including: (i) the date, time and place of the meeting, (ii) a statement of the issue(s) involved, (iii) a statement that the Practitioner's attendance is mandatory and that the Practitioner is subject to automatic suspension followed by automatic termination of Clinical Privileges pursuant to Section 11.2.8 for failure to attend, and (iv) notice of the procedures below if the Practitioner is unable to attend.

9.3.1.2 If the Practitioner is unable to attend, the Practitioner must immediately arrange, with the chair of the committee scheduling the meeting, an acceptable alternative date which date shall be within 14 days of the originally scheduled meeting.

[72]MS.08.01.03.

9.3.1.3 Failure to attend the first meeting without complying with Section 9.3.1.2 or failure to attend the second meeting arranged pursuant to Section 9.3.1.2 shall result in the automatic suspension of Clinical Privileges. If an automatic suspension is imposed, the Practitioner shall be given Special Notice of the automatic suspension. The Practitioner shall also be afforded a final opportunity for a meeting within 30 days of imposition of the automatic suspension and provided with Special Notice of the date, time and place of the meeting at least five days in advance. The Special Notice of the meeting shall also advise the Practitioner that failure to attend this final meeting shall result in automatic termination of Medical Staff membership and all Clinical Privileges. See Section 11.2.8 for additional detail.

9.3.2 Provide Information. Whenever a suspected deviation from acceptable standard clinical or professional practice and/or professional conduct is identified, the Medical Staff President, a Department Chair, the Hospital President, or the Chief Medical Officer may require the Practitioner to provide requested information to the Medical Executive Committee or the Peer Review Committee, or the Board of Trustees, or a standing committee or subcommittee, task force or ad hoc committee thereof appointed to consider the matter.

9.3.2.1 The Practitioner shall be provided with Special Notice of the requested information and at least 15 days to provide the requested information. The notice shall also advise the Practitioner that failure to provide the requested information will result in automatic suspension of Clinical Privileges, followed by automatic termination as provided in Section 11.2.9.

9.3.2.2 If the information is not received within the time period required under Section 9.3.2.1, the Practitioner's Clinical Privileges shall be automatically suspended. The Practitioner will be given Special Notice of imposition of the automatic suspension and an additional 30 days to provide the information. The notice of the automatic suspension shall also advise the Practitioner that failure to provide the information within 30 days of the automatic suspension shall result in automatic termination of Medical Staff membership and all Clinical Privileges. See Section 11.2.9 for additional detail.

9.3.2.3 This Section shall also apply to a request for verification of necessary health status by undergoing an examination or testing as authorized by Section 2.2.6 and in accordance with written Policy, but the time lines may be modified according to the type of examination or testing being requested.

9.3.3 Educational Program. Whenever an in-house educational program is recommended as a result of Medical Peer Review activities, the Practitioner whose performance has prompted the program and the Medical Staff President, the Practitioner's Department Chair or the Chief Medical Officer shall agree upon an acceptable program date within 30 days of the recommendation.

9.3.3.1 The Practitioner shall be given Special Notice that attendance is mandatory at least 14 days prior to the program.

9.3.3.2 Failure of the Practitioner to attend shall be reported to the Medical Executive Committee for consideration for possible Corrective Action.

9.4 REQUESTING CORRECTIVE ACTION[73]

9.4.1 Grounds. Grounds for Corrective Action include, but are not limited to, the following:

9.4.1.1 Whenever the activities or professional conduct of any Practitioner are considered to be: (i) lower than the standards or aims of the Medical Staff or Hospital and/or accepted professional standards, (ii) in violation of these Bylaws, Rules and Regulations, any Manuals, or Medical Staff or Hospital policies, (iii) disruptive to the operations of the Hospital or which undermine the culture of safety, or (iv) a known or suspected impairment, including without limitation, substance abuse;

9.4.1.2 Receipt of notice that a Practitioner is under investigation by a governmental agency or that the Practitioner's license or other legal credential authorizing practice in this state has been subject to any type of corrective or disciplinary action, including a remedial plan (see Article 11 for automatic action in the event of suspension or revocation of license);

9.4.1.3 Receipt of notice that a Practitioner's license or other legal credential authorizing practice in any other state has been subject to any type of corrective or disciplinary action, including a remedial plan, or is under investigation; or

9.4.1.4 Failure of the Practitioner to effect voluntary practice changes requested by the Medical Executive Committee or the Peer Review Committee or comply with other actions imposed pursuant to Section 9.2.

9.4.2 Request for an Investigation and Initial Handling. Any Member of the Medical Staff, the Hospital President, or the Board of Trustees or its Chair who reasonably believes there is sufficient basis for possible Corrective Action against a Practitioner may request that an Investigation for purposes of possible Corrective Action be initiated. Such request shall be made in writing to the Medical Executive Committee and shall state the basis for the request.

9.4.2.1 If the Medical Staff President in consultation with the Hospital President *determines* that the matter may be resolved without the necessity of initiating an Investigation for purposes of possible Corrective Action, they may attempt to do so subject to the approval of the Medical Executive Committee.

9.4.2.2 The Medical Executive Committee shall review the request at its next regular meeting or a special called meeting. If the Medical Executive Committee decides to initiate an Investigation for purposes of possible Corrective Action, such shall be documented in the minutes of the Medical Executive Committee meeting. The Medical Executive Committee also may refer the request to another committee, as not being

[73] MS.01.01.01 EP 30, 33; MS.09.01.01.

appropriate for Corrective Action at this time, and request that the committee report back to the Medical Executive Committee.

9.4.2.3 The Investigation may be conducted by the Medical Executive Committee itself, a standing committee, or an ad hoc committee appointed by the Medical Staff President within 15 days of initiation of the Investigation (hereinafter referred to as the "Investigating Committee").

9.4.2.4 If the request for possible Corrective Action was made by the Practitioner's Department Chair or a committee or its chair following review by that Department or committee of the same issues that are the basis of the request, an Investigation pursuant to Section 9.5 shall not be required if the Department or committee's review afforded the Practitioner an opportunity to be advised of the general nature of the concerns and to meet with the committee to address the concerns as a part of the review.

9.4.2.5 If the request for Corrective Action is made by the Board of Trustees and the Medical Executive Committee declines to initiate an Investigation, the Board of Trustees may initiate and conduct the Investigation itself or through an ad hoc committee. In doing so, the Board of Trustees shall comply with the procedures in Section 9.5 to the extent possible.

9.5 PROCEDURES FOR INVESTIGATION

9.5.1 Notice to Practitioner. The Hospital President shall provide the Practitioner with Special Notice of initiation of an Investigation by the Medical Executive Committee pursuant to Section 9.4 within five days of the action. The notice will include a general statement of the scope of the Investigation. If additional medical records or events are identified in the course of the Investigation, the Investigation may be expanded with appropriate notice sent by the Hospital President to the Practitioner affected.

9.5.2 Time. The Investigation shall be completed within 60 days of the Medical Executive Committee's decision to initiate the Investigation, unless the Medical Staff President in consultation with the Hospital President grants an extension for good cause.

9.5.3 Authority. The Investigating Committee shall have the authority to review medical records and other documents concerning the events under review, interview the Practitioner and witnesses, consult with other standing committees, request information from outside the Hospital, and, with the approval of the Hospital President, obtain outside expert review.

9.5.4 Meeting with Practitioner. As a part of the Investigation, the chair of the Investigating Committee may invite the Practitioner to meet with the committee or a special committee regarding the matter.

9.5.4.1 If the opportunity for a meeting is afforded, the Investigating Committee shall provide Special Notice to the Practitioner at least seven days prior to the meeting. The notice shall advise the Practitioner of the time, place and date of the meeting and the basis

for the request for Corrective Action, with a general listing of the medical records or events that are the subject of the Investigation.

9.5.4.2 The Practitioner must confirm in writing with Medical Staff Services, no later than three days from the date of receipt of the Investigating Committee's letter, the Practitioner's intent to meet with the Investigating Committee.

9.5.4.3 If the Practitioner does not respond in writing within the required time period, the Practitioner shall be deemed to have waived any opportunity for the meeting unless there is good cause for the failure to respond. In the event of waiver, the Investigating Committee shall conclude its Investigation and promptly forward its written report to the Medical Executive Committee.

9.5.4.4 If the Practitioner confirms the Practitioner's intent to meet with the committee, but fails without good cause, as determined by the Medical Executive Committee, to attend the meeting, the Practitioner waives any opportunity to meet with the Investigating Committee and the Investigation shall proceed.

9.5.4.5 The meeting between the Practitioner and the Investigating Committee shall be for purposes of fact-finding and shall afford the committee the opportunity to ask the Practitioner questions and gather additional facts regarding the matters under Investigation. The Practitioner shall also have the opportunity to provide information to the committee, orally and in writing. The Practitioner shall not be entitled to any procedural rights of review at the meeting under these Bylaws or otherwise.

9.5.5 Report by Investigating Committee. Following any meeting (or waiver) and any further Investigation that the Investigating Committee deems appropriate, within the 60 days referenced in Section 9.5.2 above, the committee shall prepare a written report of its findings. The report shall include its recommendation as to whether Corrective Action should be taken and, if so, what type. The chair of the committee shall forward the report and any supporting documentation to the Medical Executive Committee.

9.6 RECOMMENDATION FOR CORRECTIVE ACTION

9.6.1 Review by Medical Executive Committee. As soon as practical, the Medical Executive Committee shall review the report of the Investigation and any supporting documentation. The Medical Executive Committee may elect to interview the Practitioner who is the subject of the Investigation, require additional information including, but not limited to, evaluation or testing of health status, and/or return the matter to the Investigating Committee for further Investigation. Any deferral to obtain additional information or conduct additional Investigation shall be for a stated time period.

9.6.2 Issuance of Recommendation. Within 45 days of receipt of all information it deems necessary, including completion of any interview, the Medical Executive Committee shall evaluate the information and formulate its written recommendation as to whether Corrective Action is indicated, setting forth the reasons or bases for such recommendation. The recommendation may include, without limitation:

9.6.2.1 denying the request for Corrective Action;

9.6.2.2 issuing a letter of reprimand or admonition;

9.6.2.3 placing the Practitioner on probation[74] for a stated period of time;

9.6.2.4 imposing a consultation, monitoring or supervision requirement;

9.6.2.5 requiring additional education, training or experience;

9.6.2.6 requiring treatment, rehabilitation or counseling;

9.6.2.7 restricting, limiting, suspending, or terminating one or more Clinical Privileges;

9.6.2.8 changing Medical Staff category or Medical Staff prerogatives; and/or

9.6.2.9 suspending or terminating Medical Staff membership; or

9.6.2.10 defer action for a reasonable time period when circumstances warrant, not to exceed 14 days.

9.6.3 Adverse Recommendation or Action. If the Medical Executive Committee makes an Adverse Recommendation or Action as defined in Section 10.1.2, all further procedures shall be as set forth in Article 10.

9.6.4 Recommendation that is Not Adverse. If the Medical Executive Committee makes a recommendation that is not an Adverse Recommendation or Action, its report shall be forwarded to the Board of Trustees for a final decision. The decision shall be in writing and set forth the bases or reasons for the decision.

9.6.4.1 If the decision of the Board of Trustees is not an Adverse Recommendation or Action, it shall be the final decision. The Hospital President shall send Special Notice of the final decision to the Practitioner within 20 days of issuance of the decision.

9.6.4.2 If the decision of the Board of Trustees is an Adverse Recommendation or Action, all further procedures shall be as set forth in Article 10.

9.7 SUMMARY CORRECTIVE ACTION [75]

9.7.1 Grounds. The Hospital President or any Medical Staff officer as defined in Article 7 has the authority to suspend or restrict all or any portion of a Practitioner's Clinical Privileges,

[74] For purposes of these Bylaws, "probation" means a Practitioner for whom there was a finding of grounds for Corrective Action but who, rather than being subject to any limitation or restriction of Clinical Privileges, is required to refrain from any further actions that would constitute grounds for Corrective Action during the period of probation.
[75] MS.01.01.01 EP 29, 32.

effectively immediately, whenever there is reasonable belief that failure to take such action may result in imminent danger to the health and/or safety of any individual.[76]

9.7.1.1 A summary Corrective Action pursuant to this Section shall be only as necessary to address the imminent danger.

9.7.1.2 If necessary, the Medical Staff President or the Practitioner's Department Chair shall assist any patients of the Practitioner who are hospitalized at the time of the summary Corrective Action to secure alternate coverage from another Member of the Medical Staff.

9.7.1.3 A summary Corrective Action is an interim step in Medical Peer Review and is not a complete or final professional review action in and of itself. It shall not imply any finding of responsibility on the part of the Practitioner for the situation that caused the suspension or restriction. See Section 12 regarding reporting.

9.7.2 Reporting. The individual imposing the summary Corrective Action shall report the action immediately to the Medical Executive Committee, the Hospital President, and the Medical Staff President, and the action shall remain in effect unless modified by the Hospital President or the Medical Executive Committee.

9.7.3 Notice to Practitioner. The Practitioner shall be notified orally of the action and the reasons for the summary Corrective Action by the individual imposing the summary suspension or restriction as soon as possible. Oral notice shall be followed by Special Notice by the Hospital President as promptly as possible which shall set out the reasons for the summary Corrective Action and the procedures below.

9.7.4 Review by Medical Executive Committee. The Medical Executive Committee shall review the events that resulted in the summary Corrective Action within a reasonable time under the circumstances, not to exceed 14 days from the date the action was taken.

9.7.4.1 Prior to or as a part of this review, the Practitioner will be given an opportunity to meet with the Medical Executive Committee with at least three days prior Special Notice of the date, time and place of the meeting. The Practitioner may propose ways other than summary Corrective Action to address the concerns, depending on the circumstances.

9.7.4.2 The Practitioner shall not be entitled to any procedural rights of review at the meeting under these Bylaws or otherwise.

9.7.5 Recommendation by Medical Executive Committee. After considering the events resulting in the summary Corrective Action and the Practitioner's response, if any, the Medical Executive Committee shall determine whether there is sufficient information to warrant a final recommendation or whether it is necessary to commence an Investigation pursuant to Section 9.5 if one is not already underway. The actions that may be taken by the Medical Executive Committee with regard to the summary Corrective Action are:

[76] Health Care Quality Improvement Act, 42 U.S.C. Sec. 11112(c)(2).

9.7.5.1 Affirm or modify the summary Corrective Action without further action or Investigation;

9.7.5.2 Continue or modify the summary Corrective Action pending completion of further Investigation using the procedures in Section 9.5 on an expedited basis to the extent possible;

9.7.5.3 Terminate the summary Corrective Action pending completion of further Investigation using the procedures in Sections 9.5; or

9.7.5.4 Terminate the summary Corrective Action without further action or Investigation.

9.7.6 Review by Board of Trustees. If the Medical Executive Committee's recommendation is to terminate the summary Corrective Action, the action shall be terminated effective immediately, subject to a final decision by the Board of Trustees to affirm, modify or reject the Medical Executive Committee's recommendation.

9.7.6.1 If the Board of Trustees affirms the recommendation of the Medical Executive Committee, the Hospital President shall provide the Practitioner with Special Notice of the final decision of the Board of Trustees pursuant to this section within five days of the decision.

9.7.6.2 If the Board of Trustees determines that summary Corrective Action is still indicated or should be modified, the action shall be immediately reinstated or reinstated as modified, and the Hospital President shall notify the Practitioner as provided in Section 9.7.3. In its recommendation, the Board of Trustees shall indicate whether its recommendation is pending additional Investigation under Section 9.5 on an expedited basis or whether no further Investigation is needed.

9.7.7 Adverse Recommendation and Right to Hearing.

9.7.7.1 If the Medical Executive Committee's recommendation (or the Board of Trustees' reinstatement of the summary Corrective Action as provided in subsection 9.7.6.2 above) is to affirm or modify the summary Corrective Action without further Investigation and the summary Corrective Action is an Adverse Recommendation or Action, all further procedures shall be as set forth in Article 10.

9.7.7.2 If the summary Corrective Action remains in place pending further Investigation under Section 9.5, and that Investigation results in an Adverse Recommendation or Action, all further procedures shall be as set forth in Article 10. The Practitioner shall be entitled to only one hearing concerning results of the summary Corrective Action and the results of the Corrective Action Investigation.

9.7.8 Termination and Option of Rescission. If the Medical Executive Committee recommends termination of the summary Corrective Action, it may also recommend to the Board of Trustees that the action be rescinded.

9.7.8.1 Consideration of rescission of a summary Corrective Action is appropriate only if there is a determination that, based on the facts known at the time the action was taken, the imposition of the action was not indicated.

9.7.8.2 If a summary Corrective Action is rescinded by final decision of the Board of Trustees, while the Practitioner's files will retain a record of the actions taken, the summary

Corrective Action is considered not to have occurred and the Hospital shall not disclose the rescinded action to a third party unless required to do so by law.

9.7.9 Limitation of Procedural Rights of Review. The only procedural rights of review set forth in Article 10 in connection with the imposition of a summary Corrective Action are as set forth in Section 9.7.7.

9.8 TEMPORARY ACTION[77]

9.8.1 Grounds. The Hospital President, with the concurrence of the Medical Staff President, may impose a temporary suspension or restriction of, or condition on, the Clinical Privileges of a Practitioner. The temporary action may not to exceed 14 days, during which time a review or evaluation is conducted to determine the need for further action.

9.8.2 Notice to Practitioner and Automatic Expiration. The temporary action is effective on imposition, and the Hospital President shall notify the Practitioner orally of the action and the reasons for the action as soon as possible. Oral notice shall be followed by Special Notice of the action and a general statement of the reasons for the action. The temporary action shall automatically expire at the end of the 14th day unless earlier terminated by the Medical Executive Committee or the Hospital President.

9.8.3 Not Corrective Action. Although taken in the course of the Medical Peer Review process, a temporary action is not considered Corrective Action and does not entitle the Practitioner to any procedural rights of review under these Bylaws or otherwise.

9.9 VOLUNTARY AGREEMENT

9.9.1 Grounds. Whenever the activities or professional conduct of any Practitioner are of such concern that, in the assessment of the Medical Staff President, most Immediate Past-President, or the President-Elect, further evaluation of the activities or professional conduct is necessary, the Hospital President, together with the Medical Staff President or President-Elect, may ask the Practitioner to voluntarily refrain from utilizing all or certain Clinical Privileges for an agreed period of time while the further evaluation is performed and a decision is made whether further action is indicated (such as initiation of an Investigation for purposes of possible Corrective Action). This action is taken in the course of the Medical Peer Review process.

9.9.2 Not Corrective Action. A voluntary agreement pursuant to this section is not a surrender or suspension of Clinical Privileges, is not considered Corrective Action, and may be terminated by the Practitioner at any time on the giving of at least three days prior written notice to the Hospital President. Nothing in this section prohibits a Practitioner from renewing a voluntary agreement one or more times with the agreement of the Hospital President.

10 PROCEDURAL RIGHTS OF REVIEW[78]

[77] 42 U.S.C. Sec. 11112(c)(1)(B).
[78] MS.01.01.01 EP 34.

10.1 ENTITLEMENT TO PROCEDURAL RIGHTS OF REVIEW[79]

10.1.1 General. A Practitioner is entitled to the procedural rights of review set out below whenever:

10.1.1.1 the Medical Executive Committee takes an Adverse Recommendation or Action;

10.1.1.2 an Adverse Recommendation or Action is taken by the Board of Trustees following a recommendation or action by the Medical Executive Committee that was not an Adverse Recommendation or Action; or

10.1.1.3 an Adverse Recommendation or Action is taken by the Board of Trustees after failure of the Medical Executive Committee to act on an application for appointment or reappointment or a request for Corrective Action.

No other recommendations or actions shall entitle the Practitioner to a hearing.

10.1.2 Adverse Recommendation or Action Defined (Grounds for Procedural Rights of Review). Subject to the provisions in Section 10.1.3 or as otherwise provided in these Bylaws, only the following actions or recommendations when taken provided in Section 10.1.1 constitute an Adverse Recommendation or Action entitling a Practitioner to procedural rights of review under these Bylaws:

10.1.2.1 Denial of appointment to the Medical Staff;

10.1.2.2 Denial of reappointment to the Medical Staff;

10.1.2.3 Termination or revocation of appointment to the Medical Staff;

10.1.2.3 Denial of requested Clinical Privileges;

10.1.2.4 Termination or revocation of Clinical Privileges;

10.1.2.5 Suspension of Clinical Privileges, other than a temporary action pursuant to Article 9, Section 9.7;

10.1.2.6 An observation or proctor requirement if the observer or proctor's approval is required for the Practitioner to exercise Clinical Privileges;

10.1.2.7 An education, training, evaluation, or counseling requirement that must be satisfied prior to exercising Clinical Privileges;

10.1.2.8 A mandatory concurring consultation or supervision requirement (i.e., the consultant or supervisor must concur or approve the Practitioner's course of treatment before the Practitioner may exercise Clinical Privileges); or

[79] MS.10.01.01; 25 Tex. Admin. Code Sec. 133.41(f)(4)(F)(i).

10.1.2.9 Any other restriction or limitation of Clinical Privileges based on competence or professional conduct if such action, when final, would be reportable to the National Practitioner Data Bank.

10.1.3 Not Grounds for Procedural Rights of Review.[80] None of the following recommendations or actions, nor any others so referenced in the Bylaws, shall constitute an Adverse Recommendation or Action or entitle the Practitioner to the procedural rights of review in these Bylaws or otherwise. The Practitioner is entitled to submit a written explanation or rebuttal regarding the recommendation or action which shall be placed in the Practitioner's file.

10.1.3.1 Issuance of a letter of reprimand or admonition, placement on probation, or any other Corrective Action that is not accompanied by any limitation or restriction on the Practitioner's Clinical Privileges;

10.1.3.2 Imposition of any conditions or other requirements, including without limitation proctoring or mandatory consultation, in the course of FPPE on an initial grant of Clinical Privileges;

10.1.3.3 Any limitation, requirement, or restriction of Clinical Privileges imposed equally on all Practitioners with the same or similar Clinical Privileges;

10.1.3.4 Imposition of an observation, proctoring supervision, or consultation requirement that the Practitioner must comply with (e.g., observation of the Practitioner's performance by a peer in order to provide information to a Medical Staff committee), but that does not require the observer, proctor, supervisor, or consultant's approval or concurrence prior to the Practitioner's exercise of Clinical Privileges;

10.1.3.5 Any requirement to complete an educational assessment, or to verify required health status through requested assessment or testing in accordance with the Bylaws or Policy that may be satisfied while the Practitioner continues to exercise Clinical Privileges;

10.1.3.6 Imposition of a requirement for additional education or training or for treatment or counseling that may be satisfied while the Practitioner continues to exercise Clinical Privileges;

10.1.3.7 Imposition of any action pursuant to Section 9.2.1 of these Bylaws or any recommendation or action that is voluntarily accepted by the Practitioner, including without limitation, entry into a voluntary performance improvement agreement or a voluntary agreement pursuant to Section 9.9;

10.1.3.8 Retrospective chart review, conducting a review or Investigation into any matter, or a requirement to appear for a special meeting under the provisions of these Bylaws;

10.1.3.9 Any automatic action, including without limitation, any action under Article 11, or automatic relinquishment of Clinical Privileges, automatic resignation from the Medical Staff, or automatic withdrawal of an application from processing otherwise provided for in these Bylaws;

10.1.3.10 Imposition of a temporary action under Section 9.8 or summary Corrective Action except as provided in Section 9.7.7;

10.1.3.11 Denial of a request for leave of absence or for an extension of a leave of absence;

10.1.3.12 A voluntary surrender or relinquishment of Clinical Privileges by the Practitioner, including voluntary acceptance of a limitation on Clinical Privileges, while under an Investigation or to avoid such an Investigation or a professional review action;

10.1.3.13 Failure to expedite an application, or failure to process an application for Medical Staff appointment, reappointment, and/or Clinical Privileges: (i) due to a determination that the application is not a Complete Application or is untimely, (ii) due to a determination that the Practitioner is not eligible due to a failure to meet minimum or threshold criteria or requirements, a lack of need or resources, closure of a specialty, or because of an exclusive professional services arrangement, or (iii) as otherwise authorized by the Bylaws;

10.1.3.14 Denial of a requested change in Staff category, or lack of eligibility for or transfer to a Staff category due to Patient Contacts or reassignment of Staff category at the time of reappointment as provided in Article 3;

10.1.3.15 Termination or automatic relinquishment of or inability to exercise Clinical Privileges due to an exclusive professional services arrangement of the Hospital;

10.1.3.16 Failure to grant, termination or limitation of temporary Clinical Privileges;

10.1.3.17 Removal or limitation of emergency services call coverage obligations;

10.1.3.18 Denial of appointment or reappointment to the Affiliate Staff or denial or termination of Honorary recognition;

10.1.3.19 Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period under these Bylaws; and

10.1.3.20 Grant of conditional appointment or appointment or reappointment for a duration of less than 24 months.

10.1.4 Actions Pursuant to Contract.[81]

10.1.4.1 Practitioners who are subject to a contract with the Hospital in a medical administrative capacity or pursuant to a contract to deliver medical coverage services to patients of the Hospital are not entitled to the procedural rights of review specified in this Article 10 if their Medical Staff membership or Clinical Privileges are restricted, terminated, or modified pursuant to the terms of a contract with the Hospital.

10.1.4.2 If, however, the Medical Staff membership or Clinical Privileges of a Practitioner under contract are modified, restricted, or terminated pursuant to these Bylaws because of issues relating to professional competence or conduct and the action is reportable to the National Practitioner Data Bank, the Practitioner shall be entitled to the procedural rights of review under this Article 10. In the event of a conflict between the contract and these Bylaws, the terms of the contract shall control.

10.2 NOTICE OF ADVERSE RECOMMENDATION OR ACTION[82]

10.2.1 Notice. The Hospital President shall provide a Practitioner against whom an Adverse Recommendation or Action has been taken Special Notice within five business days of the action. The notice shall:

10.2.1.1 Advise the Practitioner of the nature of and reasons for the Adverse Recommendation or Action, with a statement of the alleged acts and omissions and a list of the specific patient records or other documents (if any) or other subject matter forming the basis for the action;

10.2.1.2 Advise the Practitioner of the Practitioner's right to request a hearing;

10.2.1.3 Specify that the hearing must be requested within 30 days of the date of the Practitioner's receipt of the notice, by submitting a written request to the Hospital President by Special Notice;

10.2.1.4 State that failure to submit a request for the hearing in the manner and within the time required shall constitute a waiver of the Practitioner's right to a hearing and to appellate review and all other rights to which the Practitioner may have been entitled under these Bylaws or otherwise;

10.2.1.5 Summarize the Practitioner's rights during the hearing as specified below in Section 10.7 and include a copy of this Article;

10.2.1.6 State that, following receipt of a properly filed hearing request, the Practitioner will be notified of the time, date and place of the hearing at least 30 days in advance; and

10.2.1.7 If the Adverse Recommendation or Action includes a summary Corrective Action, state that the Practitioner may request that the hearing be expedited to the extent reasonably possible.

[82] 42 U.S.C. Sec. 11112(b)(1).

10.2.2 Waiver.

10.2.2.1 Failure of a Practitioner to submit a request for the hearing in the manner and within the time required shall constitute a waiver of the Practitioner's right to a hearing and to appellate review, and all other rights to which the Practitioner may have been entitled under these Bylaws or otherwise.

10.2.2.2 The Adverse Recommendation or Action shall become effective immediately subject to review and approval by the Board of Trustees at its next regular meeting. The Hospital President shall provide the Practitioner with Special Notice of the Board of Trustees' final decision within 10 days of the decision.

10.3 REQUEST AND PREHEARING PROCEDURES[83]

10.3.1 Request for Hearing. The Practitioner must request the hearing in writing and deliver the request to the Hospital President by Special Notice within 30 days of the Practitioner's receipt of the notice of the right to the hearing under Section 10.2 above. Prior to or in conjunction with requesting a hearing, the Practitioner may request mediation in accordance with Section 10.17 below.

10.3.2 Notice of Scheduling.[84] Following receipt of a proper request for a hearing, the Hospital President shall schedule the hearing as provided below and provide Special Notice to the Practitioner of:

10.3.2.1 The time, place and date of hearing, which shall not be less than 30 days from the date of the notice to the Practitioner (provided that reasonable attempts shall be made to schedule the hearing as soon as practical if the Practitioner waives in writing the right to at least 30 days prior notice of the hearing date and is subject to summary Corrective Action);

10.3.2.2 The list of witnesses, if any, expected to testify in presenting the basis for the Adverse Recommendation or Action;

10.3.2.3 A listing of the patient records and/or other documents (if any) that are being relied on by the Medical Executive Committee or Board of Trustees, whichever issued the Adverse Recommendation or Action; and

10.3.2.4 The requirement that, at least 15 days before the hearing, the Practitioner must forward to the Hospital President by Special Notice a list of the documents and witnesses the Practitioner expects to present to testify in the Practitioner's challenge of the Adverse Recommendation or Action.

10.3.3 Rescheduling. The hearing date may be rescheduled upon mutual agreement of the parties or upon a showing of good cause, as determined by the Presiding Officer of the hearing (see Section 10.6 on Presiding Officer).

[83] MS.01.01.01 EP 34.
[84] 42 USC Sec. 11112(b)(2).

10.3.4 Failure to Set Hearing Date. Regardless of the Practitioner's request for a hearing under the Bylaws, if the Practitioner does not in good faith cooperate with the Hospital to schedule a hearing date and, as a result, a hearing has not been scheduled after a period of 90 days from the date of the Hospital's proposal for a hearing date, the Practitioner shall be deemed to have waived the right to a hearing and to have accepted the Adverse Recommendation or Action, unless both parties agree to a delayed hearing date. The effect of the waiver shall be the same as in Section 10.2.2 above.

10.3.5 Supplementation of Witness and Documents Lists. Either party may supplement the list of witnesses and/or documents on Special Notice to the other party; provided that, in the discretion of the Presiding Officer, the hearing may be postponed if a party objects and demonstrates a reasonable basis for needing additional time to prepare. Each party is responsible for arranging for the attendance of their respective witnesses.

10.3.6 Expert Witnesses. If any expert is to be presented as an expert witness by either party, the expert must be identified as a witness as provided in Section 10.3.2 above and the other party provided with the following in accordance with Section 10.3.8:

10.3.6.1 A copy of the expert's curriculum vitae;

10.3.6.2 A written report from the expert setting forth the substance of the expert's testimony, opinions, and grounds for the opinions;

10.3.6.3 A copy of any literature or references relied upon by the expert in reaching the opinions; and

10.3.6.4 A copy of all documents or other information provided by the party to the expert for review or a list of those documents and information if previously provided to the other party.

No expert witness may be called by a party, nor testimony, opinions or documents submitted for consideration in the hearing, unless disclosed in accordance with this section or the Presiding Officer determines that the failure to disclose was unavoidable.

10.3.7 Access to Documents. The Practitioner shall, upon written request to the Hospital President, be given an opportunity to review (or copies on the payment of the Hospital's reasonable copying costs) the patient records and other documents listed in the Section 10.3.2 notice that are being relied upon in the Adverse Recommendation or Action. The Practitioner is not entitled to access any other documents (including but not limited to committee minutes), except as specifically provided in this Article, or to any rights of discovery in preparation for the hearing. Under no circumstances may a Practitioner access documents pertaining to another Practitioner.

10.3.8 Exchange of Exhibits.

10.3.8.1 At least 15 days prior to the start of the hearing, the Medical Executive Committee or Board of Trustees, whichever recommended the Adverse Recommendation or

Action, and the Practitioner must each provide the other with a list of the documents intended to be presented during the hearing and with a copy of the documents unless they have been previously provided. Any objections to these documents must be made by Special Notice to the Presiding Officer at least seven days prior to the start of the hearing. The ruling on the objections, if any, shall be by the Presiding Officer at a pre-hearing conference and if not, at the start of the hearing.

10.3.8.2 If additional documents need to be presented or are requested during the hearing and the Presiding Officer determines that their need could not have been reasonably anticipated so as to comply with Section 10.3.8.1, they may be utilized in the hearing, provided the other party is given advance notice and an opportunity to review and object to them if indicated.

10.4 HEARING COMMITTEE[85]

10.4.1 Options. The hearing shall be conducted before one of the following as determined and appointed by the Hospital President, in consultation with the Medical Staff President, hereinafter referred to as the "Hearing Committee":

10.4.1.1 an ad hoc committee of at least three Members of the Active Staff or individuals in the same discipline as the affected Practitioner but who are not Members of the Medical Staff, one of whom shall be appointed as the Chair; or

10.4.1.2 an independent hearing officer who is not a member of the Medical Staff.

When considering selection of a hearing officer in lieu of an ad hoc committee, the Hospital President may consider circumstances such as the complexity of the issues and availability of Members to serve on a committee. In appointing individuals to a Hearing Committee, the Hospital President may consult with Medical Staff Chief regarding the number of members, also considering such circumstances as the complexity of the issues and the availability of individuals to serve.

10.4.2 Alternate. When using an ad hoc committee, at least one alternate shall be appointed. The alternate shall be released from any further obligation once the appointed members are present and the hearing has been started.

10.4.3 Qualifications. Members of the Hearing Committee must be able to be impartial and objective and may not:

10.4.3.1 have been involved in requesting Corrective Action against the Practitioner or participated in any Investigation or the Adverse Recommendation or Action;

10.4.3.2 have a conflict of interest; or

10.4.3.3 be a direct economic competitor of the Practitioner; or

[85] MS.01.01.01 EP 35; 42 USC Sec. 11112(b)(3)(A).

10.4.3.4 be professionally associated with or related to the Practitioner.

Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Committee. Employment by, or a contract with, the Hospital or an affiliate of the Hospital shall not preclude an individual from serving on the Hearing Committee.

10.4.4 Notice and Challenges. At least 30 days prior to the hearing, the Hospital President shall give the Practitioner Special Notice of the names of the members of the Hearing Committee and their specialties or subspecialties, with a copy of the notice given to the Representative (see Section 10.5 below).

10.4.4.1 The Practitioner and the Representative shall have the right to challenge the qualifications of the members of the Hearing Committee. Any challenge must be submitted to the Hospital President by Special Notice within 10 days of receipt of the notice under this Section.

10.4.4.2 Although either party shall have the right to challenge the impartiality of any Hearing Committee member or other qualifications, and request their removal, neither party is entitled to veto any member's participation. Timely filed challenges against any Hearing Committee member shall be ruled on by the Presiding Officer. Failure of a party to submit any challenges within the required 10-day period constitutes a waiver of that party's right to challenge or object to the qualifications of the members of the Hearing Committee.

10.4.5 Limitations on Contact.

10.4.5.1 The Practitioner and the Representative (as defined in Section 10.5 below), and their counsel or other representatives, may not contact the Hearing Committee members regarding the merits of the matter once appointed, during the hearing or during any appellate review, except as part of the formal hearing process. Failure to comply may result in Corrective Action.

10.4.5.2 This provision is not intended to restrict discussion with those who may be witnesses in the hearing as long as such contact is not intended to influence their testimony. Any contacts with Hospital employees shall be arranged through the Hospital President.

10.5 REPRESENTATIVE

The Medical Executive Committee or the Board of Trustees, whichever initiated the Adverse Recommendation or Action, shall appoint an individual or individuals to serve as the representative ("Representative") for purposes of the hearing and any appellate review. The Representative shall have the same rights as the Practitioner, and shall utilize Hospital legal counsel or outside counsel appointed by the Hospital President.

10.6 PRESIDING OFFICER

10.6.1 Qualifications and Notice. The Hospital President shall appoint an attorney to preside over the hearing as the Presiding Officer and serve as the counsel to the Hearing Committee. The Presiding Officer may not have provided legal advice to the Hospital with regard to the Adverse Recommendation or Action. The procedures in Section 10.4.4 above shall be used for notification of the name of the Presiding Officer and any challenges. However, the Hospital President shall rule on any challenge to the Presiding Officer.

10.6.2 Authority. The Presiding Officer shall have the authority to implement procedures to maintain order and decorum and to assure that the hearing is conducted in accord with this Article. The Presiding Officer may conduct a prehearing conference to address objections to the documents produced, the proceedings, or other matters to the extent they can be addressed in advance. The Presiding Officer may ask questions of the parties and witnesses during the hearing. The Presiding Officer shall determine the order of the proceedings and shall make all rulings on matters, including procedural and evidentiary issues that arise before, during or following the hearing, up until issuance of the Hearing Committee's report and recommendations. All ruling of the Presiding Officer are final.

10.6.3 Deliberations. The Presiding Officer may be present during the deliberations if requested by the Hearing Committee and assist with preparation of the Hearing Committee's written report, but may not vote.

10.7 RIGHTS OF THE PARTIES[86]

The Practitioner and the Representative shall have the following rights during the hearing:

10.7.1 Be present at the hearing;

10.7.2 Be represented by an attorney or another person of the party's choice;

10.7.3 Have the Hospital make a record of the hearing as provided in Section 10.8 below;

10.7.4 Call, examine and cross-examine witnesses on any matter relevant to the issues;

10.7.5 Present evidence determined to be relevant by the Presiding Officer, regardless of its admissibility in a court of law;

10.7.6 Submit a written statement at the close of the hearing (or a later date set by the Presiding Officer);

10.7.7 Upon completion of the hearing, receive the written report of the Hearing Committee, including a statement of the basis of the recommendation; and

10.7.8 Following exercise or waiver of any appellate review to which the Practitioner is entitled, to receive the final written decision of the Board of Trustees, including a statement of the basis for the decision.

[86] 42 USC Sec. 11112(b)(3)(C).

10.8 RECORD OF HEARING

A verbatim record of the hearing shall be prepared by a certified court reporter retained by the Hospital. The original record shall be maintained by the Hospital and the cost of attendance of the reporter shall be the responsibility of the Hospital. Obtaining a copy of the transcript from the court reporter and payment of any related charges of the court reporter for that copy is the sole responsibility of the Practitioner, as the Hospital is not responsible for providing the Practitioner with a copy of the hearing transcript.

10.9 ATTENDANCE AT HEARING

10.9.1 Practitioner.[87] The personal attendance of the Practitioner for whom the hearing is scheduled is required. If the Practitioner does not testify in the Practitioner's own behalf, the Practitioner may be called and examined by the Representative and/or the Hearing Committee. Failure of the Practitioner to be present during the hearing without good cause, as determined by the Presiding Officer, shall constitute a waiver of the Practitioner's right to a hearing and any further procedural rights of review under these Bylaws or otherwise.

10.9.1 Others. Except for the parties, witnesses (including expert witnesses) may not be present in the hearing other than during their testimony. The Hospital President may designate representatives of the Hospital to attend the hearing as observers.

10.10 HEARING PROCEDURES AND BURDEN OF PROOF

10.10.1 Initial Obligation of Representative. During the hearing, the Representative shall first present evidence in support of the Adverse Recommendation or Action. The Hearing Committee and the Practitioner may question any witnesses that the Representative presents and the Representative if the Representative testifies.

10.10.2 Practitioner's Burden. The Practitioner shall then present any evidence in challenging the Adverse Recommendation or Action and shall carry the burden of proof to show:

10.10.2.1 that there is not sufficient evidence to support the Adverse Recommendation or Action or that it is arbitrary or capricious; and

10.10.3.2 that the Practitioner possesses the necessary qualifications and competence for the Clinical Privileges and/or membership on the Staff.

The Hearing Committee and the Representative may question any witnesses presented by the Representative as well as the Practitioner. It shall be in the Presiding Officer's sole discretion whether to allow presentation of rebuttal evidence.

10.10.3 Recess and Completion Deadline. The Presiding Officer may, at the Presiding Officer's sole discretion and without Special Notice to the parties, recess the hearing for the

[87] 42 USC Sec. 11112(b)(3)B).

convenience of the participants or for the purpose of requesting that the parties obtain additional evidence or present additional witnesses.

10.10.4 Presence of Majority. A majority of the members of the Hearing Committee must be present to conduct the hearing. No member may vote proxy. If a member is absent during a portion of the proceedings, that member may not participate in deliberations until the member has certified in writing that the member has read the transcript for any portions of the hearing during which the member was absent.

10.10.5 Written Statements. Both the Practitioner and the Representative shall have the right to submit to the Hearing Committee for consideration a written statement on any matter(s) pertinent to the Adverse Recommendation or Action at the close of the hearing or by a later time and date designated by the Presiding Officer.

10.10.6 Hearing Closed. Upon conclusion of the presentation of oral and written evidence and submission of any oral or written statements, the hearing shall be closed and no further evidence shall be admitted.

10.11 DELIBERATIONS AND REPORT

10.11.1 Deliberations. Within 15 days of closing the hearing, the Hearing Committee shall deliberate outside the presence of the parties and other participants except for the Presiding Officer as provided in Section 10.6. The Hearing Committee shall be limited to consideration of the evidence presented in the hearing and may not solicit information from third parties.

10.11.1.1 If the Hearing Committee requests additional information from a party, that request shall be in writing to that party and also communicated to the other party. Each party shall be provided with a copy of any responses and permitted to submit any comments to the Hearing Committee on the response, a copy of which shall be provided to the other party as well.

10.11.1.2 The Hearing Committee may also reopen the hearing if necessary on Special Notice to the parties.

10.11.2 Findings and Recommendation. By majority vote, the Hearing Committee shall make findings regarding the basis of the Adverse Recommendation or Action, and recommend that it be affirmed, modified or reversed. Upon completing the deliberations and reaching a recommendation, the hearing shall be adjourned.

10.11.3 Written Report. Within 15 days of adjournment, the Hearing Committee shall prepare a written report of its findings and recommendation, including a statement of the basis of the recommendation. The written report shall be forwarded to the Hospital President. The Hospital President shall forward the written report to the Practitioner by Special Notice and to the Medical Executive Committee or Board of Trustees, whichever initiated the Adverse Recommendation or Action.

10.12 CONSIDERATION BY MEDICAL EXECUTIVE COMMITTEE OR BOARD OF TRUSTEES

10.12.1 Review of Hearing Committee Report. Within 30 days of receipt of the hearing report, the Medical Executive Committee or Board of Trustees, whichever initiated the Adverse Recommendation or Action, shall meet. The Medical Executive Committee or the Board of Trustees shall review the report and issue a written recommendation to affirm, modify or reverse the original Adverse Recommendation or Action, to include a statement of the basis of the recommendation.

10.12.2 Adverse Recommendation or Action Initiated by Medical Executive Committee

10.12.2.1 If the recommendation by the Medical Executive Committee under Section 10.12.1 continues to be an Adverse Recommendation or Action, the Practitioner shall be entitled to request appellate review as provided below before a final decision by the Board of Trustees.

10.12.2.2 If the recommendation by the Medical Executive Committee under Section 10.12.1 is not an Adverse Recommendation or Action, it shall be forwarded to the Board of Trustees for a final decision within 30 days of receipt by the Board of Trustees.

10.12.2.2.1 If the decision by the Board of Trustees is not an Adverse Recommendation or Action, it shall be the final decision of the Board of Trustees. The Hospital President shall provide the Practitioner with Special Notice of the final decision within 10 days of the final decision, with a statement of the basis for the decision.

10.12.2.2.2 If the decision of the Board of Trustees is an Adverse Recommendation or Action, the Practitioner shall be entitled to request appellate review as provided below before a final decision by the Board of Trustees.

10.12.3 Adverse Recommendation or Action Initiated by Board of Trustees.

10.12.3.1 If the recommendation by the Board of Trustees under Section 10.12.1 is not an Adverse Recommendation or Action, it shall be the final decision of the Board of Trustees. The Hospital President shall provide the Practitioner with Special Notice of the final decision within 10 days of the final decision, with a statement of the basis for the decision.

10.12.3.2 If the recommendation by the Board of Trustees under Section 10.12.1 continues to be an Adverse Recommendation or Action, the Practitioner shall be entitled to request appellate review as provided below before a final decision by the Board of Trustees.

10.12.4 Notice of Right to Appellate Review. If the Practitioner is entitled to appellate review, the Hospital President shall provide the Practitioner with Special Notice within five days of the decision, such notice to include:

10.12.4.1 A statement that the Practitioner is entitled to request appellate review of the Adverse Recommendation or Action by filing a written request by Special Notice with the Hospital President within 20 days of the Practitioner's receipt of the notice;

10.12.4.2 A statement that the Practitioner's request for appellate review must include a statement of all of the grounds for appeal as set out in Section 10.13.3 below, and the specific facts or circumstances which justify further review as they relate to each of the grounds for appeal (see Section 10.13.1 for required elements);

10.12.4.3 A statement that failure to include in the appellate review statement the elements required by Section 10.13.1 will result in waiver of the Practitioner's right to appellate review; and

10.12.4.4 A statement that, if the Practitioner wishes to present an oral statement in connection with the appellate review, the Practitioner must so state in the request for appellate review, and that failure to do so will waive the Practitioner's right to any oral statement under Section 10.15.2.

10.13 REQUEST AND GROUNDS FOR APPEAL

10.13.1 Requirements. To be entitled to appellate review, the Practitioner must request the appellate review of an Adverse Recommendation or Action by filing a written statement to this effect by Special Notice with the Hospital President within 20 days of receipt of the notice under Section 10.12.4. The request from the Practitioner must include:

10.13.1.1 a statement of all of the specific grounds for appeal under Section 10.13.3;

10.13.1.2 the specific facts or circumstances which justify further review as they relate to each of the grounds for appeal; and

10.13.1.3 whether the Practitioner requests the opportunity to make an oral statement under Section 10.15.2 below.

Failure to request the opportunity in the request to make an oral statement waives the right to such statement under Section 10.15.2.

10.13.2 Waiver. If appellate review is not requested as required or does not set out the required elements under Section 10.13.1, the Practitioner shall be deemed to have waived the right to an appeal.

10.13.2.1 If the Adverse Recommendation or Action subject to appellate review was issued by the Medical Executive Committee, it shall be forwarded to the Board of Trustees for a final decision within 30 days of receipt by the Board of Trustees. The Hospital President shall provide the Practitioner with Special Notice of the final decision within 10 days of the decision, with a statement of the basis for the decision. A copy shall also be sent to the Medical Executive Committee.

10.13.2.2 If the Adverse Recommendation or Action subject to appellate review was issued by the Board of Trustees, it shall be the final decision of the Board of Trustees. The Hospital President shall provide the Practitioner with Special Notice of the final decision within 10 days of the decision, with a statement of the basis for the decision. A copy shall also be sent to the Medical Executive Committee.

10.13.3 Grounds for Appeal. The grounds for appeal shall be limited to the following:

10.13.3.1 The Adverse Recommendation or Action was not made in the reasonable belief that it will further quality health care[88];

10.13.3.2 There was not a reasonable effort to obtain the facts of the matter in issuing the Adverse Recommendation or Action[89];

10.13.3.3 There was not a reasonable belief that the Adverse Recommendation or Action was warranted by the known facts[90];

10.13.3.4 The Adverse Recommendation or Action was arbitrary or capricious [91]

10.13.3.5 The Adverse Recommendation or Action was not supported by sufficient evidence based on the hearing record or such additional information as may be permitted under Section 10.15.3 below; and/or

10.13.3.6 There was not substantial compliance with Article 10 of these Bylaws so as to deny a fair hearing.

10.13.4 Rebuttal Statement by Representative. The Hospital President shall provide the Practitioner's written statement under Section 10.13.1 to the Representative within three days of receipt and notify the Representative of the opportunity to submit a written rebuttal to any items in the written statement. Any rebuttal statement must be in writing and delivered to the Hospital President within 10 days of the Representative's receipt of the Practitioner's statement. Upon receipt, the Hospital President shall provide a copy of the Representative's rebuttal statement to the Practitioner in a timely manner and prior to any oral statements pursuant to Section 10.15.2.

10.14 APPELLATE REVIEW PANEL

The Chair of the Board of Trustees, in consultation with the Hospital President, shall appoint an Appellate Review Panel (Panel) composed of at least three persons to consider the record upon which the Adverse Recommendation or Action being appealed is based. The Panel shall include at least one Member, who may or may not be a member of the Board of Trustees, and two members of the Board of Trustees. Hospital legal counsel may assist with conducting the appellate review and advise the Panel.

[88] 42 U.S.C. Sec. 11112(a).
[89] Id.
[90] Id.
[91] Woodbury v. McKinnon, 447 F.2d 839 (5th Cir. 1971); see also Laje v. R. E. Thomason General Hospital, 564. F.2d 1159 (5th Cir. 1977) (these cases also included "unreasonable" but that should be incorporated in first three standards).

10.15 APPELLATE REVIEW PROCEDURES

10.15.1 Scheduling. The Chair of the Board of Trustees, or the Hospital President on his behalf, shall schedule the appellate review within 30 days of receipt of the request for appeal.

10.15.2 Oral Statements. At the discretion of the Panel and if properly requested by the Practitioner under Section 10.13.1 above, the Practitioner and the Representative may be permitted to appear before the Panel and make an oral statement, in addition to the written and rebuttal statements. Each party may be accompanied by an attorney. The Panel may, in its discretion, set a time limit for such oral statements and may require that the oral statements be made by the parties, rather than attorneys. If the parties or their attorneys make oral statements, the parties may also be required to answer questions by the Panel.

10.15.3 New Evidence. New or additional evidence shall be permitted in the sole discretion of the Panel and only on a showing that it was not available at the time of the hearing or that any request to admit it at the hearing was unreasonably denied.

10.15.4 Findings and Report. The Panel shall review the matter using the grounds for appeal in Section 10.13.3, and shall set out its written findings in that regard in its report. The Panel may recommend to the Board of Trustees that the matter be referred back to the Hearing Committee or Medical Executive Committee for further consideration, or recommend other appropriate action. The Panel shall make written findings and its recommendation within 15 days of completion of the appellate review process.

10.16 FINAL DECISION BY BOARD OF TRUSTEES

10.16.1 Review. Within 30 days after the Practitioner has been afforded the procedural rights in Article 10, the Board of Trustees shall review the matter and issue a final decision. The Board of Trustees shall consider all recommendations on the action and any subsequent reports and information considered.

10.16.2 Decision; Option for Referral. The Board's final decision shall be in writing and include a statement of the basis of the decision. The final decision of the Board of Trustees shall be effective immediately and shall not be subject to further review. The Board of Trustees may, prior to making a final decision, refer the matter back to the Hearing Committee or Medical Executive Committee for specific action. If so, the referral shall state the actions to be taken and the reasons there for and set a time limit for the action.

10.16.3 Notice to Practitioner. The Hospital President shall provide the Practitioner with Special Notice of the Board of Trustees' final decision within 10 days of the decision, with a statement of the basis for the decision. A copy shall also be sent to the Medical Executive Committee.

10.17 MEDIATION

10.17.1 Statutory Provision. A Practitioner who requests mediation pursuant to Section 241.101(d) of the Texas Health & Safety Code based on either: (i) being subject to an Adverse Recommendation or Action by the Medical Executive Committee or the Board of Trustees as provided in Article 10; or (ii) a belief that the Credentials Committee has not acted on a Complete Application for Medical Staff membership or Clinical Privileges within 90 days of its receipt, shall be provided with an opportunity for mediation as set forth in this Section 10.17. If the requirements of Section 241.101(d) are met, the Practitioner requesting mediation shall be considered and referred to as an "Eligible Practitioner" for purposes of this Section. The Hospital shall have no obligation to offer mediation to Practitioners who are not Eligible Practitioners or to notify an Eligible Practitioner of the statutory right to request mediation.

10.17.2 Request. The Eligible Practitioner must submit a request for mediation by Special Notice to the Hospital President within 14 days of: (i) receipt of the notice of an Adverse Recommendation or Action as required by Section 10.2 above; or (ii) the 90th day from the Credentials Committee's receipt of a Complete Application. If a request for mediation and a request for hearing have been submitted in response to notice of an Adverse Recommendation or Action, the mediation shall be conducted first and the timelines for scheduling the hearing temporarily suspended until the mediation is completed.

10.17.3 Conditions of Mediation.

10.17.3.1 The mediation must be scheduled within 20 days of receipt of the Eligible Practitioner's request, and completed within 75 days of receipt of the request.

10.17.3.2 The Eligible Practitioner and the Hospital will share the costs of the mediator equally. The mediator will be selected by mutual agreement of the Eligible Practitioner and the Hospital President, and must be qualified as required by Section 241.101(d) of the Texas Health & Safety Code unless otherwise agreed by the Eligible Practitioner and the Hospital President.

10.17.3.3 The mediation shall occur either at the Hospital or the mediator's office, and shall be limited to a full-day of mediation unless otherwise agreed by the Eligible Practitioner and Hospital President.

10.17.3.4 The Medical Executive Committee or Board of Trustees, whichever recommended the Adverse Recommendation or Action, shall be represented in the mediation by the Hospital President and the Medical Staff President, or their designees. Attorneys for the parties may attend and participate in the mediation, as may the Chair of the Board of Trustees.

10.17.4 Agreement.

10.17.4.1 The Hospital's representatives at the mediation shall not have the authority to bind the Hospital to any agreement with the Eligible Practitioner. Any agreement reached during mediation shall be characterized as "proposed," and shall be in

writing, signed by the Eligible Practitioner and the Hospital's representatives, and signed by any participating attorneys.

10.17.4.2 A proposed mediation agreement shall be presented to the Medical Executive Committee at the next available opportunity for a recommendation. The Medical Executive Committee's recommendation, along with the proposed mediation agreement, shall then be presented to the Board of Trustees for consideration. If the Board of Trustees approves the proposed mediation agreement, it shall become binding and final, and the Eligible Practitioner will be deemed to have waived all his remaining rights including, if applicable, the right to a hearing under the Bylaws. The Hospital President shall provide the Eligible Practitioner with Special Notice of the approval.

10.17.4.3 If the Board of Trustees does not approve the proposed mediation agreement, the Hospital President will provide the Eligible Practitioner with Special Notice of the lack of approval. In such case, the Eligible Practitioner will retain any applicable procedural rights provided by the Bylaws but has no right to further mediation. Any time lines for procedural rights contained in the Bylaws that were temporarily suspended as a result of the mediation will resume on the date of the Eligible Practitioner's receipt of notice that the proposed mediation agreement was not approved. The time lines for procedural rights shall also resume on the date following the mediation if the mediation does not result in a proposed agreement.

10.17.4.4 Under no circumstances may the mediation agreement require any action not permitted by law or require the Hospital, Medical Staff, or Board of Trustees to violate any legal or accreditation requirement.

10.18 MISCELLANEOUS

10.18.1 Any time periods within which a committee's action is to be taken are intended as guidelines and not to create a right of the Practitioner to have an action taken within the time period. A Practitioner may request waiver of one or more of the time frames specified in this Article for good cause by written submission to the Hospital President. The time periods for action in this Article 10 may be modified by the Hospital President for good cause.

10.18.2 A Practitioner shall be entitled to only one hearing, appeal, and mediation on any Adverse Recommendation or Action.

11 AUTOMATIC ACTION[92]

11.1 GENERAL

11.1.1 Defined. On notice to the Hospital of occurrence of any of the following, automatic action as detailed below shall result, in addition to any other automatic actions set out elsewhere in these Bylaws. An automatic action is not considered an Adverse Recommendation or Action or Corrective Action, does not entitle the Practitioner to any

[92] MS.01.01.01 EP 28, 31.

procedural rights of review under these Bylaws or otherwise, and does not require any action by the Medical Executive Committee or the Board of Trustees. The occurrence of automatic action does not prevent the imposition of Corrective Action for the same or related grounds pursuant to the procedures in Article 9.

11.1.2 Notice of Automatic Action. Except for Section 11.2.6, the Hospital President shall provide the Practitioner with Special Notice of imposition of automatic action. The notice procedures for Section 11.2.6 shall be set out in the Rules and Regulations.

11.1.3 Allegation of Error. If a Practitioner believes an error has been made and that there is no basis for the automatic action, within seven days of receipt of notice of the automatic action, the Practitioner must notify the Hospital President and provide written evidence of the error. The Hospital President shall consult with the Medical Staff President and shall rescind any automatic action if the basis for the action was in error. The Board of Trustees shall be notified of each such rescission.

11.2 TYPES OF AUTOMATIC ACTION

11.2.1 License.

11.2.1.1 Revocation of a Practitioner's professional license by the Texas professional licensing board shall cause all of the Practitioner's Clinical Privileges and Medical Staff membership to automatically terminate.

11.2.1.2 Suspension of a Practitioner's professional license by the Texas professional licensing board shall cause all of the Practitioner's Clinical Privileges and Medical Staff membership to be automatically suspended and to automatically terminate if the license is not reinstated within 30 days of the suspension.

11.2.1.3 If a Practitioner's registration permit for his Texas professional license expires, the Practitioner's Clinical Privileges will be automatically suspended 30 days after the expiration date if the Practitioner has not obtained a new permit by that date. If the Practitioner has not obtained a new permit within 30 days of imposition of the automatic suspension, the Practitioner's Clinical Privileges and Medical Staff membership shall automatically terminate.

11.2.2 Criminal conviction. Conviction, a guilty plea or deferred adjudication, or *nolo contendere* plea for any felony reasonably related to the Practitioner's qualifications, competence, functions, or duties as a medical professional or involving an act of violence, child abuse, or a sexual offense, or a court-martial for such an action, shall cause all of the Practitioner's Clinical Privileges and Medical Staff membership to automatically terminate.

11.2.3 Exclusion. Exclusion of a Practitioner from Medicare, Medicaid, TRICARE, or any other federal or state governmental health care program shall cause all of the Practitioner's Clinical Privileges and Medical Staff membership to automatically terminate. Exclusion or conviction for fraud or abuse under the Medicare, Medicaid or other federal or state governmental shall also result in automatic termination of all Clinical Privileges and Medical Staff membership.

11.2.4 Professional Liability Insurance. Failure of a Practitioner to maintain professional liability insurance of the required amount and type shall cause the Practitioner to be automatically placed on a leave of absence not to exceed 60 days until the Practitioner furnishes documentation to Medical Staff Services of the required insurance, including coverage for any gaps. If the required insurance and gap coverage has not been secured and documentation received by Medical Staff Services at the end of the 60 days, all of the Practitioner's Clinical Privileges and Medical Staff membership shall automatically terminate.

11.2.5 Controlled Substances Registration. Unless the requirement has been previously waived for the specialty by the Medical Executive Committee, a Practitioner who fails to maintain Texas and federal controlled substances registration shall be automatically divested of the right to prescribe medications covered by the certificate as of the date such action becomes effective. If the required registration has not been obtained and documentation received by Medical Staff Services from the appropriate governmental agency of registration at the end of the 60 days, all of the Practitioner's Clinical Privileges and Medical Staff membership shall automatically terminate.

11.2.6 Medical Records. Using the procedures in the Rules and Regulations, a Practitioner's Clinical Privileges shall be automatically suspended for delinquency in completion of medical records ("delinquency" is defined as medical records that are incomplete 15 days or more after patient discharge from the Hospital). The Practitioner's Clinical Privileges shall be automatically terminated along with Medical Staff membership if the Practitioner has not completed the delinquent medical records within fourteen (14) days after being placed on Full Suspension (28 days post discharge). The Health Information Management Services will send notice to the Physician via email or fax and certified mail notifying him/her that such delinquency (ies) will result in the automatic removal from the Medical Staff. A copy of this letter will be sent to the Medical Staff Services Office. Automatic suspension and termination provisions may also be used, as detailed in the Rules and Regulations, for failure to comply with other medical record documentation requirements.

11.2.7 Board Certification. Except when approved by the Medical Executive Committee and the Board of Trustees, if the Practitioner fails to secure or maintain board certification (including recertification if available) or maintain board eligibility as required by these Bylaws, the Practitioner's Clinical Privileges and Medical Staff membership shall be automatically terminated.

11.2.8 Attending Meeting. Failure of the Practitioner to appear at a meeting for which the Practitioner has received Special Notice in accordance with Section 9.3.1.1 or to appear at an alternate meeting under Section 9.3.1.2 shall result in an automatic suspension of Clinical Privileges. Failure to attend a final meeting scheduled as provided in Section 9.3.1.3 will result in automatic termination of the Practitioner's Clinical Privileges and Medical Staff membership.

11.2.9 Providing Information. Failure of a Practitioner to provide information for which the Practitioner has received Special Notice in accordance with Section 9.3.2.1 shall result in an automatic suspension of Clinical Privileges. The Practitioner shall be given Special Notice of the automatic suspension and a final opportunity to provide the requested information as provided in Section 9.3.2.2. Failure to provide the requested information as provided in

Section 9.3.2.2 will result in an automatic termination of the Practitioner's Clinical Privileges and Medical Staff membership. Failure to comply with requested health status examination

and/or testing in accordance with Sections 2.2.6 and 9.3.2.3 and written Policy shall result in automatic suspension of Clinical Privileges.

11.2.10 Misrepresentation, Misstatement or Omission. As provided in Section 2.12, a determination by the Medical Executive Committee, subject to the approval of the Board of Trustees, that a Practitioner has a significant or material misrepresentation, misstatement or omission on an application for Medical Staff membership and/or Clinical Privileges, whether intentional or not, shall result in automatic withdrawal of the application from further processing. If the application has already been processed and the membership and/or Clinical Privileges granted, the Practitioner's Medical Staff membership and all Clinical Privileges shall be automatically terminated.

11.2.11 Action Pursuant to Contract. See Section 4.4.2 on automatic relinquishment of Clinical Privileges for Members not subject to exclusive professional services arrangement.

11.2.12 Mandated Policies. Failure of a Practitioner to comply with Hospital or Medical Staff policies that mandate certain training such as EHR training or HRO Education or vaccines or immunizations shall result in automatic suspensions or terminations of clinical privileges as provided in those policies.

12 MEDICAL PEER REVIEW CONFIDENTIALITY AND IMMUNITY

12.1 MEDICAL PEER REVIEW

12.1.1 Medical Peer Review Committee Status. The Medical Executive Committee, the Departments, Divisions, and all Medical Staff, Department and Division committees (whether standing, special, ad hoc, subcommittee, joint committee, task force, Hearing Committee or Appellate Review Body), as well as the Medical Staff when meeting as a whole, shall be constituted and operate as a "medical peer review committee," "medical committee," and "professional review body," as such terms are defined by Texas and/or federal law, [93] and are authorized by the Board of Trustees through these Bylaws to engage in Medical Peer Review as defined below. This provision shall also apply to any Hospital or other committees engaged in Medical Peer Review at the Hospital, including the Board of Trustees and its committees.

12.1.2 Medical Peer Review Defined. "Medical Peer Review"[94] means the evaluation of medical and health care services, including the evaluation of the qualifications and professional conduct of Members, Practitioners and other individuals holding or applying for Clinical Privileges, and of patient care, treatment, and services provided by them. The term includes but is not limited to:

12.1.2.1 The process of credentialing for initial appointment, reappointment, the granting of Clinical Privileges, and reinstatement from leave of absence;

[93] Tex. Occ. Code Sec. 151.002(a)(8); Tex. Health & Safety Code Sec. 161.031; 42 USC Sec. 11151(11).
[94] Tex. Occ. Code Sec. 151.002.

12.1.2.2 The process of issuing an Adverse Recommendation or Action, including but not limited to Corrective Action, and affording procedural rights of review as provided in the Bylaws;

12.1.2.3 Any evaluation of the merits of a complaint relating to Members, Practitioners or others with Clinical Privileges and issuance of a recommendation or action in that regard;

12.1.2.4 Any evaluation of the accuracy of a diagnosis or quality of the patient care, treatment, or services provided by one of the above individuals or other health care providers within the Hospital, including but not limited to implementation of the Hospital's Performance Improvement Plan and the review of patient care, treatment, or services by another Practitioner, whether or not a Member of the Staff, or another individual with Clinical Privileges;

12.1.2.5 A report made to an individual or a committee engaged in Medical Peer Review or to a licensing agency;

12.1.2.6 Implementation of the duties of a committee engaged in Medical Peer Review by a member, agent, or employee of the committee; and

12.1.2.7 "Medical peer review" as defined in the Texas Medical Practice Act and "professional review activity" as defined by the federal Health Care Quality Improvement Act.[95]

12.1.3 Agents and Members. The Hospital President, other members of Hospital Administration, Medical Staff Services staff, and all other Hospital departments supporting Medical Peer Review activities shall be considered agents of the Medical Staff, Department and Division committees and the Medical Staff and Board of Trustees as applicable when performing authorized functions and responsibilities.

12.1.3.1 Practitioners, whether or not Members of the Staff, and others including outside peer reviewers who are requested by the Medical Executive Committee or another Medical Staff committee, a Department or a committee thereof, or a special or ad hoc committee or task force thereof, or by the Medical Staff or the Board of Trustees to review the patient care, treatment or services of another Practitioner or individual with Clinical Privileges, or who do so as an authorized function of the requesting committee, Department, task force, Medical Staff, or Board of Trustees, shall be considered agents thereof when performing such review in good faith.

12.1.3.2 Any good faith action by an agent or member of the Medical Executive Committee or another Medical Staff committee, a Department or committee thereof, or special or ad hoc committee or task force thereof, or of the Medical Staff or the Board of Trustees, when performing authorized functions and responsibilities shall be considered an action taken on behalf of the committee, Department, task force, Medical Staff, or Board of Trustees as applicable, not an action taken in the agent or member's individual capacity. This shall include, but not be limited to, actions by the Medical Staff, Department and Division officers, the Chief Medical Officer and

[95] Tex. Occ. Code Sec. 151.002(7)-(8); 42 U.S.C. Sec. 11151(10).

other Practitioners serving in medical staff leadership and/or administrative positions, and the Hospital President.

12.2 CONFIDENTIALITY

12.2.1 General. All records and proceedings of the Medical Staff, the Medical Executive Committee, the Departments, Divisions and any committees (whether standing, special, ad hoc, subcommittees, joint committees, or task forces, including a Hearing Committee or Appellate Review Panel under Article 10) thereof, and the Board of Trustees, including but not limited to any minutes of meetings, disclosures, discussion, statements, communications to or from third parties, reviews under Section 12.1.3.1, actions, or recommendations in the course of Medical Peer Review, shall be privileged and confidential to the fullest extent permitted by Texas and federal law. They shall be subject to disclosure only in accordance with written Hospital policies, unless otherwise required by Texas or federal law, and shall be privileged to the fullest extent permitted by Texas and federal law.

12.2.2 Obligation to Maintain Confidentiality. All Members and others holding Clinical Privileges, as well as those applying for such status, and all other individuals participating in, providing information to, or attending meetings of those groups listed in Section 12.1.1 are required to maintain the records and proceedings related to any Medical Peer Review activities as confidential, subject to disclosure only in accordance with Hospital policies, unless otherwise required by Texas and/or federal law.

12.2.3 Waiver. The privilege of confidentiality as to the records and proceedings of those groups listed in Section 12.1.1 may only be waived on the written consent of the chair of the committee, Department, or task force, and the Hospital President.

12.2.4 Minutes. Minutes of all meetings of those groups listed in Section 12.1.1, except for the Board of Trustees, shall be prepared by Medical Staff Services as agents there for, and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer of the meeting and forwarded to the Medical Executive Committee.

12.2.5 Maintenance and Access. All minutes under Section 12.2.4 will be maintained by the Hospital as records and proceedings of a “medical peer review committee,” “medical committee,” and “professional review body,” as such terms are defined under Texas and/or federal law, in a confidential manner to provide maximum protection under the law. They are the property of the Hospital and, except for Board of Trustees’ minutes, are maintained by Medical Staff Services.

12.2.5.1 They will be available for inspection by the Medical Executive Committee, the Hospital President, Chief Medical Officer, the Board of Trustees, and any employees and agents of the Hospital whose authorized functions necessitate access.

12.2.5.2 A member of the Medical Executive Committee, a Department Chair, and other committee or task force members may also inspect the records and proceedings of

their committee or task force which were generated during their service as a member, as long as the member is currently a Member of the Medical Staff.

12.2.5.3 Access is also permitted pursuant to Hospital policy and as required by Texas or federal law, accreditation requirements, or third party contract of the Hospital.

12.2.5.4 Access of a Practitioner to records and proceedings shall be only as required by law, written Medical Staff policy, or as approved by the Hospital President.

12.3 IMMUNITY FROM LIABILITY

12.3.1 Immunity. The Medical Staff and its Members, the Board of Trustees, the Hospital, and any committees, representatives, agents, employees, or members thereof, and third parties as defined below, will have immunity as provided in Section 2.5.2. This immunity shall be to the fullest extent permitted by Texas and federal law and shall include any immunity for any permissive and mandatory reporting provided for by Texas or federal law.

12.3.2 Third Parties. The reference above to third parties shall mean all individuals and entities, including without limitation their representatives, medical staffs, trustees, directors, officers, and employees, who provide information, whether orally or in writing, to the Hospital or the Medical Staff, concerning any matter that might directly or indirectly affect a Practitioner's exercise of Clinical Privileges or Medical Staff membership, or relating to the Practitioner's qualifications for appointment or reappointment to the Medical Staff or practice at the Hospital.

12.3.3 Authorization and Release of Liability. All applicants for appointment to the Medical Staff, reappointment, and/or Clinical Privileges shall execute a release of liability consistent with the immunity and release of liability provisions in these Bylaws and an authorization for the Hospital, the Medical Staff, and third parties to disclose confidential information as necessary for Medical Peer Review in the course of application and at all times thereafter. The effectiveness of the immunity provisions of these Bylaws, however, is not contingent on execution of these authorizations and releases. The immunity provisions in these Bylaws and any releases of liability shall be in addition to and not in limitation of any immunity afforded by Texas or federal law.

12.4 MANDATORY REPORTING AND INVESTIGATION DEFINED

12.4.1 Duty. The Hospital President, in consultation with the Medical Staff President, shall be responsible to comply with any mandatory reporting requirements of the Hospital under Texas and federal law pertaining to Medical Staff membership or Clinical Privileges. [96] Nothing in this section or the other provisions of the Bylaws shall prevent an individual Member or member of the Board of Trustees from making any other report to Texas or federal agencies as permitted or required by law.

[96] 25 Tex. Admin. Code Sec. 133.41(f)(4)(H).

12.4.2 Investigation Defined. An "Investigation" for purposes of mandatory reporting requirements is only:

12.4.2.1 An investigation affirmatively initiated by the Medical Executive Committee following receipt of a request for possible Corrective Action as set forth in Section 9.4.2, based on competence or professional conduct;

12.4.2.2 That period of time following issuance of an Adverse Recommendation or Action (defined in Article 10) based on competence or professional conduct in the course of appointment, reappointment, Clinical Privileges, or Corrective Action under Article 9; or

12.4.2.3 That period of time following issuance of summary Corrective Action under Section 9.7.

FPPE for identified concerns is not considered an Investigation unless it is imposed specifically as a precursor to Corrective Action.

12.4.3 Duration. An Investigation continues until issuance of a final decision by the Board of Trustees, acceptance of a resignation from the Practitioner by the Board of Trustees, or withdrawal of the application from processing. Any other use of the term "investigation" in these Bylaws, Rules and Regulations, any Manuals, or Medical Staff policies does not constitute an Investigation.

12.4.4 Summary Corrective Action. Summary Corrective Action pursuant to Section 9.7 is considered a "professional review action," as that term is defined in the Health Care Quality Improvement Act, when affirmed by the Medical Executive Committee. For purposes of mandatory reporting, the professional review action is considered to have taken effect on the date it was imposed by the individual pursuant to Section 9.7.1.[97]

12.4.5 Automatic Termination of Clinical Privileges. An automatic termination or expiration of a Practitioner's clinical privileges while the Practitioner is under Investigation does not subject the practitioner to mandatory reporting for a surrender of privileges while under Investigation, since the privileges were not surrendered voluntarily. Examples include but are not limited to expiration of temporary clinical privileges, automatic termination pursuant to a contract for professional services, or automatic termination pursuant to Article II.

13. CONFLICT OF INTEREST AND HOSPITAL CONFLICT MANAGEMENT

13.1 Conflict of Interest – Medical Peer Review.

13.1.1 Disclosure. Whenever a Practitioner is participating in Medical Peer Review and/or performing a function for the Medical Staff, the Medical Executive Committee or a Department, Division, or a committee or task force thereof, or the Hospital, and the Practitioner interests could be reasonably interpreted as being in conflict with the interests of the Medical Staff, Medical Executive Committee, Department, Division, or

other committee, Hospital, or individual under review, the Practitioner shall disclose those interests and the potential for conflict to the appropriate decision makers prior to such participation. The chair may require the Practitioner to refrain from any participation in decisions that may be affected by or affect the Practitioner's interests.

13.1.2 Individual Peer Review. A Practitioner shall not be eligible to participate in any meeting, discussion, or deliberation of the Medical Executive Committee, a Department, Division, or committee or task force of which he is a member regarding his Clinical Privileges or Medical Staff membership or any other Medical Peer Review activity involving the Practitioner, except to the extent specifically provided for in the Bylaws, Rules and Regulations, a Manual, or Policy, or when invited by the chair.

13.1.3 Involvement of Family or Business Partners. Any family members or business partners of a Practitioner shall not be eligible to participate in, or be present during, any meeting, discussion, or deliberation of the Medical Executive Committee, a Department, or committee or task force regarding the Practitioner's Clinical Privileges or Medical Staff membership or any other Medical Peer Review activity involving the Practitioner. "Family member" shall mean a Practitioner's: (i) parents or stepparents, including spouses of the same, (ii) ancestors, (iii) spouse, (iv) child or stepchild, grandchild, or great grandchildren, (i) siblings, whether related by whole or half blood, or (vi) the spouse of an individual described in clause (iv) or clause (v), and shall include adoptive relationships of the above.

13.1.4 Hospital and Texas Health System Policies. These provisions shall be in addition to any requirements of the Hospital's conflict of interest policies, as well as those of Texas Health System.

13.2 HOSPITAL CONFLICT MANAGEMENT POLICY FOR LEADERSHIP[98]

13.2.1 Notice of Different Decision. Whenever a decision of the Board of Trustees is contrary to a recommendation of the Medical Executive Committee, the members of the Medical Executive Committee shall be given Special Notice of the decision by the Hospital President.

13.2.2 Request for Appearance. Within five days of the Medical Staff President's receipt of the notice, the Medical Executive Committee, through the Medical Staff President, may file a written request with the Hospital President that a designated representative or representatives of the Medical Executive Committee be given an opportunity to appear before and/or submit a written statement to the Board of Trustees on the decision.

13.2.3 Appearance and Final Decision. If so requested, the Medical Executive Committee representative(s) shall be given prior Special Notice of the time, date and place for the appearance and/or submission of a written statement, which shall be established by the chair of the Board of Trustees. Depending on the nature of the issue, at the discretion of the chair of the Board of Trustees, the process may also include meetings with the Medical Executive Committee or other involved parties and the gathering of additional information, with the overall objective of protecting the safety and quality of patient care.

The Board of Trustees shall consider any information provided by the Medical Executive Committee pursuant to this process in reaching a final decision.

13.2.4 Not Applicable to Individual Peer Review. This provision shall not apply to Medical Peer Review decisions regarding individual Practitioners, including but not limited to those pertaining to appointment, reappointment, Clinical Privileges, or Corrective Action.

14. ADOPTION AND AMENDMENT OF BYLAWS AND ANCILLARY DOCUMENTS

14.1 GENERAL

14.1.1 Bylaws. [99] The Medical Staff is responsible for adopting and amending the Bylaws, which responsibility cannot be delegated. These Bylaws shall be reviewed at least biennially and otherwise at the direction of the Medical Executive Committee or on the request of the Board of Trustees to verify compliance with legal and accreditation requirements and current Medical Staff practice, and identify the need for amendments.

14.1.2 Ancillary Governance Documents. The Medical Staff shall adopt, using the procedures below, Rules and Regulations, Manuals, and Medical Staff policies as may be necessary to implement the processes and requirements set out in these Bylaws. [100] The Rules and Regulations, Manuals, and Medical Staff policies shall be reviewed at least biennially and otherwise at the direction of the Medical Executive Committee or on the request of the Board of Trustees to verify compliance with legal and accreditation requirements and current Medical Staff practice, and identify the need for amendments. Any ancillary governance documents adopted pursuant to this Article shall be subject to and governed by these Bylaws. The definitions in these Bylaws shall be applicable to the Rules and Regulations, the Manuals, and Medical Staff policies, although they may include additional definitions. In the event of a conflict between the Rules and Regulations, a Manual, or a Policy and the Medical Staff Bylaws, these Bylaws shall control.

14.1.3 Hospital Bylaws. The Medical Staff Bylaws, Rules and Regulations, any Manuals, and Medical Staff policies shall not conflict with the bylaws of the Hospital adopted by the Board of Trustees. [101]

14.2 ADOPTION AND AMENDMENT OF MEDICAL STAFF BYLAWS

14.2.1 Procedure. These Bylaws may be amended at a regular meeting or a special called meeting of the Medical Staff (or by mail/facsimile/electronic ballot as provided in Article 8) by majority vote.

14.2.1.1 Notice that an amendment is being proposed shall be provided to the voting Members of the Medical Staff and copies of the proposed amendments shall be available in Medical Staff Services for review at least 10 days prior to the meeting or distribution of the mail/electronic ballot.

[99] MS.01.01.01 EP1-2; 42 C.F.R. Sec. 482.22(c); 25 Tex. Admin. Code Sec. 133.41(f)(4)(A)-(B), Sec. 133.41(k)(3).
[100] MS.01.01.01 EP 25.

14.2.1.2 Adoption or amendment shall require a quorum of at least 2/3 of the voting Members of the Medical Staff at a meeting. Any adoption or amendment approved by the Medical Staff shall be effective only when and if approved by the Board of Trustees.

14.2.1.3 The approved adopted bylaws or amendments shall be distributed to the Members of the Medical Staff.

14.2.2 Initiation of Process. A motion to amend these Bylaws may be made by: the Medical Executive Committee; the Hospital President; or at least 25% of the voting Members of the Medical Staff.

14.2.2.1 All requests must be in writing to the Medical Executive Committee. The Medical Executive Committee may refer the proposed amendment to the Bylaws Committee for review and recommendation within a stated time period.

14.2.2.2 Upon receipt of the review and recommendation of the Bylaws Committee, if any, the Medical Executive Committee shall consider the proposed amendment at its next regular meeting (or a special called meeting) and decide whether to present the proposed amendment for a vote at a regular or special called meeting of the Staff (or by mail/electronic ballot as provided in Article 8) or not to present the amendment.

14.2.2.3 An amendment proposed directly by the Medical Staff as provided above must be presented for a vote to the Medical Staff at a meeting or by mail/electronic ballot as provided above.[102]

14.2.3 Effective Date. Except as provided in Section 14.9, these Bylaws and any amendments pursuant to this Article shall become effective only upon the date of approval by the Board of Trustees.[103] The Bylaws and any amendments shall replace and supersede all previous medical staff bylaws and be upheld by the Board of Trustees, unless otherwise stated in the Bylaws provision or amendment approved by the Board of Trustees.[104] The Medical Staff, individual Members of the Medical Staff, and applicants for Medical Staff membership and/or Clinical Privileges shall comply with and enforce the Medical Staff Bylaws, which shall be distributed to or made available to Members and applicants.[105]

14.3 ADOPTION AND AMENDMENT OF RULES AND REGULATIONS

14.3.1 By Medical Executive Committee.

14.3.1.1 Regular Amendment. The Rules and Regulations may be adopted or amended at a regular meeting (or a special meeting called for such purpose) of the Medical

[102] MS.01.01.01 EP 8, 24.
[103] 25 Tex. Admin. Code Sec. 133.41(f)(4)(B), 133.41(k)(3)(A); 42 U.S.C. Sec. 482.12(a)(4), 482.22(c)(1).

Executive Committee; provided that, at least 14 days prior to the meeting, the Medical Executive Committee must notify the Medical Staff of the proposal. [106]

14.3.1.1.1 The notice shall advise the Members of the opportunity and procedures to submit written comments on the proposal to the Medical Executive Committee for their consideration prior to voting on the proposal. Adoption or amendment shall require the affirmative vote of majority of the voting members present at a meeting of the Medical Executive Committee at which there is a quorum.

14.3.1.1.2 The approved amendments shall be communicated to the Members of the Medical Staff. The procedures for conflict management between the Medical Staff and the Medical Executive Committee on the approved amendment are set out below in Section 14.4.

14.3.1.2 Urgent Amendment. In cases of a documented need for an urgent amendment of the Rules and Regulations to comply with a law or regulations, the Medical Executive Committee may provisionally adopt or amend the Rules and Regulations and forward it to the Board of Trustees for approval without prior notification of the Medical Staff as required in Section 14.3.1.1. [107]

14.3.1.2.1 In such case, the Members of the Medical Staff shall be notified of the amendment within 10 days of approval by the Medical Executive Committee. The notice shall advise the Members of the opportunity and procedures to submit written comments on the proposal to the Medical Executive Committee within 10 days of the notice.

14.3.1.2.2 The procedures for invoking the conflict management process are set out in Section 14.4 below. If the conflict management process is not invoked, no further action is required.[108]

14.3.2 By Medical Staff. The Rules and Regulations may be adopted or amended at a regular meeting (or special meeting called for such purpose) of the Medical Staff or by mail/facsimile/electronic ballot.[109]

14.3.2.1 To be submitted for a vote, a written petition setting out the proposed amendment or changes and signed by at least 25% of the voting Members of the Medical Staff must first be filed in Medical Staff Services.

14.3.2.2 Adoption or amendment at a meeting shall require a 2/3^{rds} affirmative vote of the voting Members of the Medical Staff present and voting at a meeting where a quorum is present; provided that, the Medical Staff has been notified of the proposal at least 20 days prior to the meeting.[110]

[106] MS.01.01.01 EP 9.
[107] MS.01.01.01 EP 11.
[108] MS.01.01.01 EP 11.
[109] MS.01.01.01 EP 8.
[110] MS.01.01.01 EP 9.

14.3.2.3 The procedures for a mail/electronic ballot are set out in Section 8.7.

14.3.2.4 A copy of the proposal must also be submitted to the Medical Executive Committee through Medical Staff Services within the same time frame, and the comments of the Medical Executive Committee presented at the Medical Staff meeting prior to the vote or with the mail/electronic ballot.

14.4 CONFLICT MANAGEMENT PROCESS FOR MEDICAL EXECUTIVE COMMITTEE AND MEDICAL STAFF[111]

14.4.1 Petition. In the event of disagreement between the Medical Staff and the Medical Executive Committee on adoption or amendment of the Rules and Regulations under Section 14.3 above (or of a Manual under Section 14.5 or a Medical Staff policy under Section 14.6 below), implementation of the following conflict management procedures may be requested by submission of a written petition signed by at least 25% of the voting Members of the Medical Staff. The petition must be submitted to Medical Staff Services within 10 days of communication of an approved amendment to the Medical Staff under Section 14.3.1.1.2 or notice to the Medical Staff of an urgent amendment under Section 14.3.1.2.1.

14.4.2 Medical Staff Representatives. The petition must identify the specific disagreement with the amendment and designate at least two voting Members of the Medical Staff who have signed the petition to serve as representatives of the Medical Staff on this disagreement.

14.4.3 Meeting. The Medical Executive Committee shall call a special meeting of the Medical Executive Committee, inviting at least the two representative Members identified, to discuss the disagreement or conflict. The Medical Executive Committee, with the approval of the Hospital President, may use the services of a facilitator or mediator at the meeting.

14.4.4 Good Faith Efforts. The Medical Executive Committee and the Members attending the special meeting will exchange information relevant to the issue and work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Executive Committee, and the safety and quality of patient care delivered at the Hospital.

14.4.5 Final Decision. Within five days of conclusion of the meeting, the Medical Executive Committee will reconsider the proposed change, take a new vote on the issue at a regular or special called meeting, and provide the Medical Staff with notice of the new vote. There shall be no further right to the conflict management process once the new vote is taken.

14.5 ADOPTION AND AMENDMENT OF MANUALS

The process and procedures for adoption or amendment of a Manual shall be the same as for adoption or amendment of the Rules and Regulations under Section 14.3, including the conflict management process in Section 14.4.[112]

[111] MS.01.01.01 EP 10.
[112] MS.01.01.01 EP 8-10.

14.6 ADOPTION AND AMENDMENT OF MEDICAL STAFF POLICIES

14.6.1 Adoption or amendment of a Medical Staff policy may be accomplished:

14.6.1.1 On the affirmative vote of a majority of the members of the Medical Executive Committee at a regular or special meeting of the Medical Executive Committee at which a quorum is present; or

14.6.1.2 By the Medical Staff using the procedures in Section 14.3 above.[113]

14.6.2 On approval or adoption of a Medical Staff policy by the Medical Executive Committee, notice of the policy shall be provided to the Medical Staff.[114] The conflict management process in Section 14.4 shall be implemented on submission of a written petition signed by at least 25% of the voting Members of the Medical Staff within 10 days of the provision of notice of the policy to the Medical Staff.[115]

14.7 APPROVAL OF ANCILLARY DOCUMENTS BY BOARD OF TRUSTEES

14.7.1 The Rules and Regulations and any Manuals, and any amendments thereto, shall be effective only on approval by the Board of Trustees.[116] Medical Staff policies shall be effective on approval by the Medical Staff or the Medical Executive Committee in accordance with the procedures in Section 14.6; provided that, Medical Staff policies dealing with Medical Peer Review activities shall require approval by the Board of Trustees and not be effective until so approved.

14.7.2 The Medical Staff complies with and enforces the Rules and Regulations, any Manuals, and Medical Staff policies approved as provided by this Article, and the Board of Trustees upholds those documents it approves.[117]

14.8 NOTICES TO MEDICAL STAFF

Any notices to the Medical Staff required by this Article 14 shall be deemed delivered to the Practitioner on: (i) deposit with the U.S. mail, (ii) on facsimile, or (iii) on electronic transmission of the notice to the most current address on file with Medical Staff Services.

14.9 TECHNICAL AND EDITORIAL CORRECTIONS

Corrections that are strictly limited to correcting numbering, punctuation, typographical, or inadvertent errors or updating references in the Bylaws, Rules and Regulations, Manuals, or Medical Staff policies, such as titles of positions, committee names, or names of policies, that do not involve a substantive change may be made by Medical Staff Services, effective on the approval

[113] MS.01.01.01 EP 8-10.
[114] MS.01.01.01 EP 9.
[115] MS.01.01.01 EP 10.
[116] 25 Tex. Admin. Code Sec. 133.41(f)(4))B); 42 C.F.R. Sec. 482.12(a)(4).
[117] MS.01.01.01 EP 5, 7.

of the Medical Staff President and the Hospital President, without the necessity of compliance with the procedures in this Article.

14.10 PROHIBITION ON UNILATERAL AMENDMENT[118]

Except as noted under Section 14.6 for certain Medical Staff policies, neither the Medical Staff, the Medical Executive Committee, nor the Board of Trustees may unilaterally adopt or amend the Bylaws, the Rules and Regulations, a Manual or a Policy.

[118] MS.01.01.03.

TEXAS HEALTH HOSPITAL FRISCO
MEDICAL STAFF

2019

RULES AND REGULATIONS

ARTICLE I. PURPOSE

Generally, these Rules and Regulations are intended to establish rules and regulations for the conduct of and processes relating to Practitioners who have applied for or been granted Medical Staff appointment and/or clinical privileges by the Board.

ARTICLE II. ADMISSION

2.1 ADMISSIONS

Patients shall be admitted to or provided services by the Hospital for inpatient, outpatient, observation or other services only on the orders of a member of the Medical Staff with admitting privileges. Patients transferred from another facility must be admitted to a Physician member of the Medical Staff who must acknowledge responsibility for the Patient by signing a Memorandum of Transfer following the arrival of the Patient.

Only qualified medical personnel (Physician, Labor and Delivery Registered Nurses, or other qualified medical personnel as designated by and approved by the Board of Trustees) may perform medical screening examinations or provide management and expeditious care for obstetrical Patients.

A single member of the Medical Staff shall be responsible, unless otherwise designated by the bylaws, policies, procedures, rules, regulations, manuals, guidelines and requirements of the Hospital and its Medical Staff, for:

(a) the medical care and treatment of each Patient in the Hospital (see Section 3.6 for dental and podiatric Patients);
(b) the completeness and accuracy of the medical record;
(c) necessary special instructions; and
(d) transmitting reports of the condition of the Patient to the referring Practitioner and to relatives of the Patient subject to confidentiality limitations.

Whenever these responsibilities are transferred to another member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record. The admitting Physician shall be responsible for verifying the other member's acceptance of the transfer. The admitting Practitioner shall provide the Hospital with any information concerning the Patient that is necessary to protect the Patient, other Patients, or Hospital personnel from infection, disease or other harm, and to protect the Patient from self-harm. All Patients admitted to the Hospital must have written or verbal orders. All members providing services in the emergency room must complete their charts before they leave the Hospital premises.

2.2 UNASSIGNED PATIENTS

Patients presenting to the Emergency Department, or requiring for admission who have no attending member, shall be assigned by the Emergency Department Physician to a member of the staff in the department to which the Patient's illness indicates assignment in accordance with the respective department's emergency department on-call policy.

2.3 ADMISSION ORDERS

Except for emergency admissions, no Patient shall be admitted to the Hospital without an admission order which should include at a minimum an admitting diagnosis, reason for admission and level of care. The provisional admitting diagnosis for emergency admissions shall be provided as soon as possible following the Patient's admission.

2.4 TIMELY VISITATION AFTER PATIENT ADMITTED/TRANSFERRED

The attending Practitioner or his Practitioner designee (i.e., another member of the Staff in good standing with the requisite privileges to care for the Patient) must see the Patient and enter a note in medical record within the applicable time frame provided below or within any shorter time frame if required by the Patient's condition:

(a) Patients designated as emergency cases and those admitted directly to or transferred into an intensive or critical care area from the admitting office, emergency department, or general care area - within 6 hours.

(b) Non-Psychiatric Patients admitted via emergency department to a general care area -- within 12 hours.

(c) Psychiatric Patients and elective admissions -- within 24 hours.

(d) NICU per NICU Admission/Transfer protocol.

(e) OB patients—immediately when notified of delivery or that delivery is imminent.

2.5 ROUNDING ON PATIENTS

2.5.1 Admitting/Attending Practitioner. Upon admission, all patients should be seen by the admitting Practitioner as provided in Section 2.4 hereof. Patients must be rounded on daily by the admitting/attending Practitioner or his/her designee. The Practitioner, rather than the designee, must see the patient upon request of the patient (or his/her decision maker), a Hospital employee, or another Practitioner within twenty-four (24) hours for a non-urgent matter and six (6) hour if medically urgent.

2.5.2 Consulting Practitioner. Patients for whom a consult is requested by the attending Practitioner should be seen by the requested consulting Practitioner within the time period set out in Section 4.6 (24 hours for routine and 6 hours for STAT requests) and rounded on daily thereafter by the consulting Practitioner and/or designee until all clinically relevant issues pertinent to that consultation have been resolved. The Practitioner, rather than the designee, must see the patient upon request of the patient (or his/her decision maker), a Hospital employee, or another Practitioner within twenty-four (24) hours for a non-urgent matter and six (6) hour if medically urgent. The consulting Practitioner or his/her designee must communicate in writing via the medical record when signing off of the case or varying from daily rounding.

2.5.3 Hospice/Palliative Care. Patients receiving inpatient hospice care or palliative care should be seen no less than every three (3) days by the Practitioner, but the Practitioner should be available by telephone at all times between rounding.

2.5.4 Practitioner Responsibility. The Physician is responsible for the oversight of any advanced practice nurse or physician assistant who acts as the Physician's designee.

2.6 RESPONSE TIME

Response time to return calls/pages from the hospital care team for admitted patients by Admitting Provider should be 30 minutes or less.

ARTICLE III. PATIENT CARE DOCUMENTATION

3.1 HOSPITAL RECORDS

All medical records are the property of the Hospital and shall not leave the premises of the Hospital except upon receipt of a court order, subpoena, or statute. Release of the medical records at the Patient's request shall require a consent for release of these records in accordance with Hospital policy.

3.2 ACCESS TO RECORDS

With the exception of mental health records to which there is limited access as set forth below, access to all medical records of a Patient shall be accorded to staff members in good standing and who are rendering care to the Patient or are prospective providers of care for the purpose of securing their service or who require the information for purposes of authorized Medical Peer Review, preserving the confidentiality of personal information concerning individual records of the Patient.

3.3 MEDICAL RECORDS INFORMATION

It is the responsibility of the attending Practitioner to prepare a complete, accurate, timely, and legible medical record for each Patient and to document in this electronically in the electronic medical record. This record shall include:

identification data;
complaint and reason for admission;
history of present illness;
past medical history including allergies;
family history;
review of systems;
physical examination;
conclusions or impressions drawn from medical history and physical examination;
provisional or admitting diagnosis;
evidence of known advance directives;
evidence of informed consent when required by organization policy;
all orders;
treatment goals, plan of care and revisions to plan of care;
all special, diagnostic and procedural reports, tests and results, including consultation, clinical laboratory, radiology, pathology, and others;
all reassessments;
every medication ordered or prescribed;
every dose of medication administered (including the strength, dose, or rate of administration, administration devices used, access site or route, known drug allergies, and any adverse drug reaction);
every medication dispensed or prescribed on discharge;
record of communication with the Patient regarding care, treatment and services;
clinical observations, including results of therapy and treatment, nursing notes, medications records, vital signs and other information necessary to monitor the Patient's condition;
medical or surgical treatment;
operative reports;
progress notes;
final diagnosis;
condition on discharge;
discharge summary with outcome of Hospitalization, disposition of care, and provisions for follow up care;
any medications dispensed or prescribed on discharge;
discharge plan and discharge planning evaluation;
patient-generated information, if applicable;
follow-up or autopsy report when available;
Physician queries.

For Patients receiving continuing ambulatory care services, the medical record shall contain a summary list of all significant diagnoses, procedures, drug allergies, and medications.

Records of Patients who have received emergency care contain the following additional information:

(a) time of arrival;
(b) whether the Patient left against medical advice;

(c) any emergency care, treatment and services provided to the Patient before arrival;
(d) the conclusions at termination of treatment including final disposition, condition, and instructions for follow-up care.

No medical record shall be deemed complete until all information is entered in the electronic medical record, except on order of the Clinical Information Committee. See Section 5.1 of the Bylaws on specific rules and regulations to the extent of relinquishment of admitting privileges and/or staff privileges to assure the timely completion of records both for documentation and for timely submission of various claims for payment by the Hospital.

3.4 HISTORY AND PHYSICAL

The attending Physician is responsible for obtaining an adequate history and physical examination (H&P). A complete H&P, provided by a member of the Hospital Medical Staff, shall be available on the medical record no later than twenty-four (24) hours after admission and prior to surgery or a procedure requiring anesthesia services.

If a H&P as been performed within thirty (30) days prior to admission, this report or a durable, legible copy of this report can be placed in the medical record at the time of admission provided there is documentation of an updated examination and any changes placed in the medical record 24 hours after admission and prior to surgery or a procedure requiring anesthesia services. If there are no changes, the Physician should enter the following or a similar statement in the medical record: "This patient has been examined, the previous H&P has been reviewed and there have been no changes in the patient's medical status. The necessity for the procedure or care is still present." The Physician should re-date and sign the document. Any History and Physical Examination performed over thirty (30) days prior to admission will be not accepted.

H&Ps must be recorded and placed on the chart before any surgical procedure or procedure requiring anesthesia services is undertaken unless the surgeon states that any delay incurred for this purpose would constitute a hazard to the Patient.

The H&P for inpatient admissions and transfers should include: date and time of assessment, chief complaint, present illness, past history including previous surgery, family history, comprehensive physical examination, medications and allergies, clinical impression and plan of treatment. The H&P for outpatient records should include: date and time of assessment, chief complaint, present illness, past history including previous surgery, family history, abbreviated physical examination, medications and allergies, impression, and plan of treatment.

When an H&P is provided by a Physician who is not a member of the Hospital's Medical Staff, the attending Practitioner may include that H&P in the Patient's chart provided the attending Practitioner documents an updated examination as explained above.

A medical consultation will suffice for the H&P if all elements of the H&P, as indicated above, are included and it meets the time requirements above.

Members of the Allied Health Professional staff may perform all or part of the medical history and physical examination, if granted such privileges.

In addition to the H&P, an adequate admission note shall be written upon admission. For an emergency admission, a brief description of the Patient's condition should be immediately noted in / affixed to the chart pending availability of the complete H&P.

3.5 ORAL AND MAXILLOFACIAL SURGEONS

An Oral and Maxillofacial Surgeon who has successfully completed an accredited postgraduate residency program in Oral/Maxillofacial Surgery and who demonstrates current competence in

performing a complete H&P examination may be granted the privileges to do so and to assess the medical risks of the proposed procedure to the Patient. Consultation will be obtained when appropriate. In all circumstances, a Physician member of the Medical Staff must be responsiblefor any medical or psychiatric problem that is identified at admission or that may arise during Hospitalization and is not specifically within the scope of practice of the Oral and MaxillofacialSurgeon.

3.6 DENTISTS AND PODIATRISTS

By preadmission arrangement or immediately following admission, a Physician member of the Medical Staff must perform a H&P on a dental/podiatric Patient. When significant medical abnormality is present, the final decision on whether to proceed must be agreed upon by the Dentist/Podiatrist and the Physician consultant. The applicable Department Chair will decide the issue in case of dispute. In all instances, a Physician member of the Medical Staff must be responsible for the care of any medical problem that may be present at admission or that may arise during Hospitalization and is not specifically within the scope of practice of the Dentist or Podiatrist.

Dentists are responsible for the part of their Patient's H&P examination that relates to Dentistry. The H&P report provided by the Dentist will also include the indication for the surgery and the indication for the type of anesthesia requested.

Podiatrists are responsible for the part of their Patient's H&P examination that relates to podiatry. The H&P report provided by the Podiatrist will also include the indication for the surgery and the indication for the type of anesthesia requested.

3.7 RE-ADMISSION WITHIN 30 DAYS

If the Patient is re-admitted within 30 days for the same or related problem, an interval H&P examination may be used provided that the original information is available.

3.8 PROGRESS NOTES

Pertinent progress notes must be recorded at the time of observation and must be sufficient to permit continuity of care and transferability of the Patient. Final responsibility for an accurate description in the medical record of the Patient's progress rests with the attending Practitioner Whenever possible, each of the Patient's clinical problems must be clearly identified in the progress notes and correlated with specific orders, with reasons for instituting various tests or treatment given and results of test and treatments record. If documentation exists outside the Hospital which substantiates the reason for admission or for a procedure, the attending Practitioner should indicate the nature and content of that documentation. Progress notes by the attending or covering Practitioner must be written at least daily except on day of discharge in which case the last note should be within 24 hours.

3.9 SYMBOLS AND ABBREVIATIONS

Clinical abbreviations, acronyms and symbols may be used only if found in Stedman's Abbreviations, Acronyms, and Symbols, and will be taken in the context of the relevant body system being referenced in the documentation.

No abbreviations will be accepted in or on:

(a) Consent Forms, and
(b) Final Diagnosis(es) Section of Discharge Summary or other diagnostic statements.

The Clinical Practice Committee and the Clinical Information Committee approves and publishes a list of "Do Not Use" abbreviations in medical record documentation which may not be used.

3.10 CHANGES IN EXISTING ORDERS

If an existing order is changed, a line should be drawn through the order and the initials of the Practitioner deleting the order should be documented.

3.11 AUTHENTICATION

All medical record entries must be dated, timed and authenticated by the responsible Medical personnel at the time of entry. Only authorized individuals make entries in the medical record. Authorized individuals include Practitioners, PAs, APNs, and CRNAs.

ARTICLE IV. CARE OF THE PATIENT

4.1 DIAGNOSTIC AND THERAPEUTIC ORDERS

4.1-1 PATIENT ORDERS

A. Medical Staff Members All orders shall be given by a Physician, Oral/Maxillofacial Surgeon, Dentist, Podiatrist, Advance Practice Nurse (APN), or Physician Assistant (PA) licensed in Texas and shall be electronic (preferred) or in writing unless exempted from this requirement by these Rules & Regulations. Orders shall be entered or written clearly and completely, timed, dated, and authenticated. It is the responsibility of the Practitioner or AHP issuing the order to designate testing priority (i.e. Stat, ASP, Timed) in his order, if not routine. After normal business hours, emergency procedures maybe scheduled through the Administrative Supervisor. Faxed orders will be accepted.

Orders which are illegible, improperly written or ambiguous will not be carried out until rewritten or understood by the caregiver responsible for carrying out the order.

B. Orders from Non-Medical Staff Members. Physicians, Oral/Maxillofacial Surgeons, Dentists or Podiatrists, Optometrists, Chiropractors, APNs and PAs who are not members of the Medical Staff or do not have Allied Health Clinical Privileges at the Hospital but who are (a) responsible for the care of the patient; (b) licensed in the state of Texas and acting within their scope of practice under Texas laws; and (c) not on the exclusion list of the Office of Inspector General (OIG), and, in the case of APNs and PAs, the supervising physician is also not on the OIG exclusion list may order diagnostic tests and therapy for their office patients on an outpatient basis only for the following services:

1. Laboratory
2. Neurodiagnostics
3. Nutritional Counseling
4. Pulmonary Noninvasive Diagnosis
5. Phlebotomy
6. Rehabilitation Services (Physical Therapy, Occupational Therapy, Speech Therapy, and Cardiac Rehab)
7. Patient education and counseling services
8. Diabetic Education
9. Electrocardiogram
10. Echocardiogram
11. Transesophageal echocardiogram
12. X-rays
13. MRI

In addition, any Physician, Oral/Maxillofacial Surgeon, Dentist, Podiatrist, Optometrists, Chiropractors, APN or PA who is not on the Medical Staff or does not have Allied Health Clinical Privileges but who meets the qualifications above is granted the authority by the

Medical Staff to order radiology procedures.

If the Texas license of the ordering Physician, Or/Maxillofacial Surgeon, Dentist, Podiatrist, Optometrists, Chiropractors, APN or PA can be verified, Hospital will assume that the individual is acting within the scope of his/her Texas license.

4.1-2 VERBAL ORDERS

All verbal and telephone orders should be authenticated as close to the time of issuance as possible, but in all instances, (except as indicated below) should be authenticated the earlier of the following:

(a) the next time the Practitioner provides care to the Patient or documents in the record;
(b) within 48 hours of when the order was written

Do Not Resuscitate Orders must be authenticated by the ordering Physician within twenty-four (24) hours of issuance and shall be issued in accordance with Hospital policy.

No verbal or telephone orders will be permitted for administration of chemotherapy.

Verbal and telephone orders must be communicated personally by a Physician, Oral/Maxillofacial Surgeon, Dentist, APN or PA or through his licensed designee and may be taken only by a duly authorized person functioning within his/her defined sphere of competence. A "duly authorized person" must be a member of the Medical Staff, or an employee who is a registered nurse, a licensed vocational nurse, a registered pharmacist, a respiratory care Practitioner, a licensed physical therapist, occupational therapist, speech therapist, radiologic technologist, dietitian, social worker or medical technologist. Questions about verbal orders must be resolved prior to administration of a medication.

Verbal or telephone orders should be limited to emergent situations where immediate written or electronic communication is not feasible.

The duly authorized person receiving the verbal or telephone order from the Physician, Oral/Maxillofacial Surgeon, Dentist, Podiatrist, APN or PA or through his licensed designee shall read back the order to the Practitioner or AHP to assure accuracy. Inpatient verbal orders shall be entered directly into the electronic record. The Physician, Oral/Maxillofacial Surgeon, Dentist, Podiatrist, APN or PA shall authenticate the verbal or telephone order. Orders may be signed by a covering Physician, Oral/Maxillofacial Surgeon, Dentist, or Podiatrist. A Nurse Practitioner or Physician Assistant may only sign off on orders they have written.

4.1-3 ORDERS BY ALLIED HEALTH PROFESSIONALS

Allied Health Professionals (AHP) who are granted privileges may write orders only as delineated by the approved applicable Hospital AHP privilege form.

4.2 PHYSICIAN RESPONSIBILITY FOR SERVICES PROVIDED BY ALLIED HEALTH PRACTITIONERS

Each Physician is responsible for the daily, continuing care of his Patients at the Hospital. The Hospital requires that all services provided by Allied Health Practitioners, as defined in the Medical Staff Bylaws, to Patients at the Hospital be under the direction and supervision of a Physician member of the Medical Staff as further detailed on the clinical privilege delineation for the AHP.

A Physician who utilizes the services of an Allied Health Practitioner in the care of his Patients at the Hospital agrees, by accepting Medical Staff appointment and/or clinical privileges at the

Hospital, to provide appropriate direction and supervision of services rendered by Allied Health Practitioners, to his Patients and that the Physician is responsible for the care and treatment rendered by Allied Health Practitioners under his direction and supervision.

4.3 ADMISSION LABORATORY/RADIOLOGY PROCEDURES

There are no requirements for routine laboratory/radiology work on admission to the Hospital. Laboratory/Radiology results, if done in a licensed laboratory/radiology facility (State License) may, at the discretion of the attending Practitioner and/or anesthesiologist, be incorporated into the patient record.

4.4 AUTOMATIC CANCELLATION OF ORDERS

When the Patient goes to surgery or is transferred to another patient care area or level of service all previous orders are automatically discontinued except for a DNR or an order that complies with a Patient's advanced directive. All other orders must be re-written pursuant to Section 4.1 of the Rules & Regulations.

The use of terms "renew", "repeat", and continue orders" alone without reference to the specific order to which they refer is not acceptable.

4.5 PRE-PRINTED ORDERS

Members of the Medical Staff may develop pre-printed admission orders for Patients with common admitting diagnoses. However, such orders shall be made specific for each individual Patient by written or telephone instructions before being implemented for that Patient Preprinted orders must be dated, timed and authenticated by the ordering Practitioner on the last page.

4.6 CONSULTATION

With respect to seriously ill Patients in which the diagnosis is obscure, or when there is a doubt as to the best therapeutic measures to be utilized, consultation is recommended. Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment rests with the attending Practitioner. It is strongly suggested that all Patients admitted to the Medical/Surgical ICUs receive consultation from a Physician board certified in critical care who routinely treats Patients in the critical care setting. A psychiatric consultation should be obtained for psychiatrically unstable Patients.

Consultation is required for termination of a Patient's pregnancy after the first trimester. The Physician obtains written consultation from a committee of not less than two active Medical Staff members selected by the Chair of the OB/GYN Department. Documentation of this consultation must be included in the Patient's medical record.

The responsibility for obtaining all consultations rests with the attending / treating Practitioner. Consultations must be requested on a Practitioner -to-Practitioner basis or, by the Practitioner completing the consultation request form which must include the reason for the consultation. A Physician on call, other than a Psychiatrist, must respond to a non-urgent request for a consultation within twenty four (24) hours. A Physician on call, other than a Psychiatrist, must see the patient for a consultation within six (6) hours if the need for a consult is medically urgent as determined by the Physician requesting the consult. For all other consults, the Consulting Physician, other than a Psychiatrist or Dermatologist, must see the patient for a consultation within six (6) hours if the need for a consult is medically urgent as determined by the Physician requesting the consult.

4.7 TREATMENT OF FAMILY MEMBERS

Members of the Medical Staff shall not write any orders or participate in the Patient's care involving a member of his/her immediate family (spouse, parents/in-laws, children, or significant other) or for any Patient for which the Physician holds Power of Attorney.

Members of the Medical Staff shall not be allowed to participate in, or be in attendance at, any major surgical procedure (with the exception of cesareans) involving any member of his/her immediate family (spouse, parents/in-laws, children, or significant other) or for any Patient for which the Physician holds Power of Attorney.

In the event of an emergency, isolated setting or when no other qualified Practitioner or appropriate healthcare personnel is available, treatment of a family member may be initiated and continued until such time as the Patient's care can be assumed by other appropriate qualified healthcare personnel.

ARTICLE V. MEDICATION ADMINISTRATION

5.1 DRUG STANDARD

Drugs used shall, as a minimum standard, meet the requirements of the US Pharmacopoeia National Formulary, New and Non-official Drugs, with the exception of drugs for approved clinical investigations. Additional standards may be required by the Pharmacy & Therapeutics Committee. Patients may continue medications prescribed prior to the Hospitalization as long as their Physician has been so notified and gives an order to that effect consistent with the Pharmacy & Therapeutics Committee policy and all such medication is noted in the medical record. All medications must be administered through the Pharmacy.

Drugs administered to Patients in the Hospital must be obtained from the Hospital Pharmacy. Exceptions to these rules shall be charted by the Practitioner in the Patient's medical record.

Investigational Drugs shall be handled in strict compliance with F.D.A. regulations. The Practitioner shall obtain approval for the use of investigational drugs through the Texas Health Resources Institutional Review Board. Such drugs shall be dispensed from the Hospital Pharmacy upon the authority of the investigator authorized to conduct the study.

5.2 DOSAGE TIME

Controlled substances, antibiotics or other drugs or agents as designated by the Pharmacy & Therapeutics Committee that are ordered without time limitation of dosage shall be reviewed by the attending Practitioner after seventy-two (72) hours. It is preferred that orders for controlled substances be written as closed orders with a definite duration. Drugs shall not be discontinued without notifying the attending Practitioner. Medications are given at routine administration times unless specified otherwise.

ARTICLE VI. SPECIAL TREATMENT PROCEDURES

6.1 RESTRAINTS

Procedures regarding the application of restraints are defined in the Hospital policy on Patient restraints. This policy is available on all patient care units and all Patient procedural areas from the nursing/departmental supervisor of the area.

ARTICLE VII. SURGICAL AND HIGH-RISK PROCEDURES

7.1 PRE-OPERATIVE RECORDS FOR OPERATIVE AND HIGH-RISK PROCEDURES

AND/OR THE ADMINISTRATION OF MODERATE OR DEEP SEDATION OR ANESTHESIA

The Patient's medical record shall contain a History and Physical Examination as outlined in Article III, Section 3.4 of these Rules & Regulations.

History and physical examinations must be recorded and placed on the chart before any surgical or high-risk procedures and/or the administration of moderate or deep sedation or anesthesia is undertaken unless the operating Practitioner documents in the medical record that any delay incurred for this purpose would constitute a hazard to the Patient.

The surgeon should place a provisional diagnosis and, if applicable, the clinical stage of a tumor, in the Patient's pre-operative record.

7.2 PRE-OPERATIVE ASSESSMENTS AND EDUCATION FOR THE ADMINISTRATION OF MODERATE OR DEEP SEDATION OR ANESTHESIA

The Practitioner must complete a pre-sedation or pre-anesthesia assessment on any Patient for whom moderate or deep sedation or anesthesia is planned. If the Patient will have deep sedation or anesthesia, the assessment must be completed within 48 hours prior to surgery by an anesthesiologist or other Member with privileges to administer the sedation or anesthesia.

Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered, the Practitioner must provide the Patient with pre-procedural education, according to his or her plan for care. The Practitioner must reevaluate the Patient immediately before administering moderate or deep sedation or anesthesia.

7.3 CONSENT REQUIRED

It is the responsibility of each member of the Medical Staff to obtain the informed consent from the Patient or his legal representative, except in emergencies as defined by the informed consent policy. Informed consent should be obtained prior to the commencement of a procedure or Patient transfer to another facility. The risks and benefits of the procedure and the risk and benefits should be documented by the Practitioners on the consent form. A copy of the informed consent must be placed on the medical record.

When two primary surgeons are co-surgeons performing separate procedures, each surgeon is responsible for obtaining his own separate consent form. Patient permission should be obtained for any vendor or outside party to be present in the procedure or the operating room in accordance with THR policy.

7.4 POST OPERATIVE AND HIGH-RISK PROCEDURES RECORDS AND/OR RECORDS AFTER THE USE OF MODERATE OR DEEP SEDATION OR ANESTHESIA

Operative and procedure reports must be entered into the medical record immediately after surgery and/or high risk procedures and/or the administration of moderate or deep sedation or anesthesia and before the Patient is transferred to the next level of care. If the Practitioner performing the operation or high-risk procedure accompanies the Patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or area of care.

The operative or other high-risk procedure report must include the following information:

(a) The name(s) of the licensed independent Practitioner(s) who performed the procedure and his or her assistant(s) or other Practitioners who performed surgical tasks;
(b) The name and Hospital identification number of the Patient;
(c) Pre-operative diagnosis;

(d) The name of the procedure performed;
(e) A description of the procedure and techniques;
(f) Type of anesthesia used;
(g) Complications, if any;
(h) Findings of the procedure;
(i) Any estimated blood loss;
(j) Any specimen(s) removed or altered;
(k) Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any;
(l) Surgeons or Practitioners name(s) and a description of the specific significant surgical tasks that were conducted by Practitioners other than the primary surgeon/Practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues);
(m) The postoperative diagnosis;
(n) Date and times of the procedure.

The completed operative or procedure report shall be authenticated by the Practitioner who performed the procedure.

When the completed operative report cannot be entered or placed in the medical record immediately after surgery, a progress note must be entered in the medical record immediately before the Patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis. The operative report must be completed and in the medical record within twenty-four (24) hours after surgery.

Postoperative documentation records the Patient's vital signs and level of consciousness; medications (including intravenous fluids), blood, blood products, and blood components; any unusual or unanticipated events or postoperative complications, including blood transfusion reactions; and management of such events. Postoperative documentation also records the Patient's discharge from the post-sedation or post anesthesia care area by the responsible Practitioner or according to discharge criteria, as well as the name of the Practitioner responsible for discharge.

7.5 POST OPERATIVE ASSESSMENTS FOR THE ADMINISTRATION OF MODERATE OR DEEP SEDATION OR ANESTHESIA

The anesthesiologist, or Member administering deep sedation or anesthesia must document a post anesthesia evaluation within forty-eight (48) hours following surgery. For outpatients, the post anesthesia evaluation must be performed prior to discharge.

7.6 TISSUE EXAMINATION AND REPORTS

All tissue removed during a procedure (with the exception of those stated below) shall be promptly labeled as to patient and anatomic site upon being passed from the operative field, packaged in preservative as designated, and sent for pathological examination by a pathologist on the Medical Staff. Each specimen must be accompanied by a requisition stating pertinent clinical information and, to the degree known, the preoperative and postoperative diagnoses. The pathologist shall document receipt and make such examination as necessary to arrive at a pathological diagnosis. Any authenticated report of the pathologist's examination shall be made a part of the medical record. Gross only examination may be requested for traumatized or accessory digits, bunions; hammertoes; row carpectomies; radial heads removed for acute trauma; extraocular muscles removed in repair of strabismus; nasal septa; varicose veins.

The pathologist is authorized to initiate microscopic examination if in the pathologist's opinion such examination is indicated either by the gross appearance or the clinical history.

Tissues and articles removed during a procedure which may be sent for pathological examination at the discretion of the operating surgeon shall be limited to: foreign bodies; artifacts; therapeutic radiation sources; prostheses not contributing to Patient illness, injury or death; foreskin from infants; ribs removed exclusively for enhancing operative exposure in Patients without a history of malignancy; normal bone from osteotomies; unused normal bone and tissue removed for purposes of autologous tissue grafts (e.g. tendons, nerves, saphenous veins); normal tissue removed as a result of cosmetic surgery that is not contiguous with a lesion and that is taken from a Patient who does not have a history of malignancy (e.g., fat from liposuction; skin from eyelids); placentas from routine and uncomplicated deliveries which do not meet departmental criteria for examination; teeth without attached soft tissue.

7.7 ANESTHESIA CARE

When utilizing a Certified Registered Nurse Anesthetist, the directing/supervising anesthesiologist must:

a. concurrently medically direct no more than three Certified Registered Nurse Anesthetists in the performance of the technical aspects of anesthesia care;

b. be responsible for the pre-anesthetic medical evaluation of the Patient, prescription and implementation of the anesthesia plan, and personal participation in the most demanding procedures of the plan (including without limitation induction and emergence);

c. follows the course of anesthesia administration at frequent intervals, remaining physically available on site for the immediate treatment of emergencies and providing indicated post-anesthesia care;

d. not simultaneously provide 1:1 care to other Patients; and

e. clearly and explicitly establishes that the attending surgeon or attending proceduralist has approved the assignment of a Certified Nurse Anesthetist to provide professional anesthesia services to his/her Patient, on a case-by-case basis or by mutual agreement on a regular and/or periodic basis.

The Practitioner or Certified Registered Nurse Anesthetist administering anesthesia will maintain a complete anesthesia record. Evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the Patient's condition will be documented in the medical record in accordance with Hospital policy and these Rules. The risks and benefits of anesthesia administration must be documented in the pre-anesthesia record as well as on the Anesthesia Consent form.

7.8 FOLLOW-UP CARE

Postoperative patients may be moved directly to the Critical Care Unit on the discretion of the anesthesiologist.

A note must be documented using the hospital's Immediate Post Anesthesia Note template immediately after a procedure by the anesthesiologist/anesthetist at the transition of the level of care from the procedural area (i.e. OR to PACU, Cath Lab to ICU, etc).

If the patient is an inpatient and unable to participate in the immediate post anesthesia assessment (i.e. verbalize or indicate they understand), a follow-up note must be documented by the anesthesiologist/anesthetist or their appropriately credentialed designee, within 48 hours of the procedure utilizing the hospital's EHR template.

The medical record shall document the use of approved discharge criteria to determine the patient's readiness for discharge.

ARTICLE VIII. INFECTION CONTROL

8.1 GENERAL AUTHORITY

The Infection Control Committee has the authority to institute any appropriate control measure or study when there is reasonably felt to be a danger to Patients or personnel from an infectious source.

8.2 REPORTING OF INFECTIONS/COMMUNICABLE DISEASES

Every Medical Staff member should report promptly to the infection control department infections which develop after discharge and which may have been acquired during the Patient's Hospitalization.

8.3 HANDWASHING

All members of the Medical Staff are expected to comply with the Hospital's established hand-washing protocols.

ARTICLE IX. IMMEDIATE QUESTIONS OF CARE

9.1 CHAIN OF COMMAND

If a nurse or other health care professional involved in the care of a Patient has any reason to doubt or question the care provided to the Patient or feels that appropriate consultation is needed and has not been obtained, such individual shall, pursuant to Hospital policy, contact a Patient's attending Practitioner to resolve a clinical problem. If the problem does not resolve, the Patient's medical record should be evaluated to determine other Practitioners involved with the Patient's care (consulting Practitioners). The clinical nurse or other health care professional should contact another nurse or health care professional in their unit for advice and who may in turn contact the Patient's attending Practitioner. If the problem is not resolved, the Director or, in his/her absence, the House Supervisor, should be contacted. They, in turn, should assess the situation and may:

Contact the Patient's attending Practitioner
Contact the Chair of the appropriate Medical Staff Department
Contact the Vice Chair of the appropriate Medical Staff Department (if Chair is not available)
Contact the Medical Staff President
Contact the Chief Medical Officer
Contact the President Elect of the Medical Staff (if President is not available)
Contact the Administrator on Duty

In the event a Medical Staff officer is unavailable to perform an assigned function, such as a chief of department, the order of Medical Staff officer succession to perform the function is as follows:

President
President-Elect
Immediate Past President

ARTICLE X. DISCHARGE

10.1 DISCHARGE SUMMARY

A Patient shall be discharged from the Hospital by order of the Patient's attending Physician or his designee. When a Patient is transferred within the same organization from one level of care to another and the caregivers change, a transfer summary may be substituted for the discharge summary. A transfer summary briefly describes the Patient's condition at time of transfer, and the reason for the transfer. When the caregivers remain the same, a progress note will suffice. In all instances, the content of the discharge summary shall contain the reason for Hospitalization, significant findings, instructions to the Patient and family, as appropriate, be sufficient to justify the diagnosis and treatment, include follow-up instructions and shall state the condition of the Patient, outcome of Hospitalization, disposition of care, final diagnosis, complications and procedures performed at the time of discharge. In cases where a short-stay discharge instruction sheet is given to the Patient, a copy of that instruction sheet should also be placed on the Patient's chart. All summaries shall be authenticated by the responsible Practitioner. In cases where a Patient is in the Hospital less than 48 hours, the final progress note signed by the Patient's attending Physician may serve as the discharge summary if the summary contains the outcome of the hospitalization, the case disposition and any provisions for follow-up care.

10.1-1 A Patient transferred to another facility shall be personally examined and evaluated to determine medical need by the Practitioner authorizing the transfer. The Practitioner shall determine and order life support measures as medically appropriate, determine and order utilization of appropriate personnel and equipment for transfer, and be responsible for securing a receiving Physician and Hospital appropriate to the Patient's needs. The Physician shall comply with documentation requirements in the Memorandum of Transfer per Hospital policy.

10.1-2 The discharge summary for newborns should include the weight and condition of the infant at discharge.

10.2 PATIENTS WHO LEAVE AGAINST MEDICAL ADVICE (AMA)

Should a Patient leave the Hospital against the advice of the attending Practitioner or without proper discharge, a notation of the incident shall be made in the Patient's medical record and the Patient will be asked to sign the acknowledgment form indicating that he understands he is leaving against medical advice. If the Patient refuses to sign the acknowledgment form, appropriate documentation regarding same shall be made in the medical record.

10.3 PATIENT TRANSFERS

No Patient will be transferred without such transfer being approved by the responsible Practitioner or other Practitioner in the absence of the responsible Practitioner for any reason. Transfers shall be made in accordance with Hospital policy.

10.4 FINAL DIAGNOSIS

A final diagnosis shall be made available to the Medical Records Department within seventy-two (72) hours of the availability of the completed chart to the attending Practitioner.

10.5 UTILIZATION REVIEW

Patients with extended Hospitalization should have the reasons documented by the attending Physician in the progress notes. Discharge planning should be initiated as soon as the need for such services is determined.

10.6 HOSPITAL DEATHS

In the event of a death, the deceased shall be pronounced dead by the attending Physician or his designee within a reasonable period of time. The body may not be released to the morgue or a funeral home until an entry has been made and signed in the deceased's medical record by a Physician member of the Medical Staff. All other matters with respect to release of the body, reporting of deaths, and issuance of a death certificate are carried out in accordance with current Hospital policy and local law.

10.7 AUTOPSIES

It is the responsibility of every member of the Medical Staff to secure autopsies whenever appropriate. The Medical Staff is involved in the use of criteria for autopsies. The following criteria shall be used: 1) in those cases where the exact cause of the clinical event which led to death is uncertain, 2) or where insight into the cause, nature or course of a disease process may be obtained. Written consent for autopsy must be obtained from the deceased Patient's next of kin or as otherwise permitted by law. The requesting Physician should list any specific questions on the permit that could be clarified during the postmortem examination. Policy and procedures for autopsy are defined in the Administrative Policy Manual.

10.8 MEDICAL RECORD DELINQUENT PROCEDURES

Primary Suspension for H&P and Operative Report delinquencies

1. History and Physicals shall be completed within twenty-four (24) hours after patient physically arrives for admission but prior to surgery or any procedure requiring anesthesia and Operative Reports shall be completed within twenty-four (24) hours of completion of the procedure.

2. Physician will receive telephone notification of delinquencies on the next business day after the medical record entries were due ("Telephone Notice").

3. If the H&Ps and Operative Reports are not completed by 8:00 a.m. on the first business day following the Telephone Notice, the Physician will be placed on Primary Suspension automatically.

4. The HIM department will send notice to the Physician ("Primary Suspension Notice") via email or fax notifying him/her of the Primary Suspension and that Full Suspension will be imposed if delinquent entries are not completed within fourteen (14) days of imposition of Primary Suspension.

5. Notice will also be sent to the Hospital Medical Staff Services Office.

6. A Physician who remains on Primary Suspension for fourteen (14) days without completion of the delinquencies shall automatically be placed on Full Suspension. Notice will be sent to the Physician and to the Hospital Medical Staff Services Office via email or fax.

Primary Suspension: (Definition)

1. Physicians placed on Primary Suspension may not:
    a. Admit patients (except for previously scheduled admissions or elective surgery)
    b. Schedule elective surgery for new inpatients or outpatients
    c. Treat ambulatory care patients
    d. Administer anesthesia
    e. Provide consultation to other Physicians.
2. The suspended Physician may admit emergent patients and may continue to provide care for all patients admitted prior to the date of suspension.
3. A Physician placed on Primary Suspension shall fulfill his/her emergency room call rotation obligation.

Full Suspension for All Delinquencies

1. All Medical Record entries shall be completed in the time frames set forth in the Rules and Regulations and/or Medical Staff policies. Records are considered complete when all required signatures, reports, dictations, response to coding queries and orders have been completed, timed, dated, and signed

2. Any medical record entry not completed within seven (7) days after patient discharge shall be considered delinquent.

3. Notice of pending suspension will be faxed or emailed to the Physician on Tuesday following the seventh day after discharge, notifying the Physician of the delinquency(ies) and notifying him/her that he/she will be placed on Full Suspension automatically if delinquencies are not completed within the next seven (7) days, i.e. fourteen (14) days post-discharge ("First Notice").

4. Notice will also be sent to the Hospital Medical Staff Services Office.

5. Any medical records not completed by fourteen (14) days post-discharge shall result in the Physician automatically being placed on Full Suspension.

6. Notice shall be sent to the Physician ("Suspension Notice") via email or fax notifying him/her of the Full Suspension and that automatic relinquishment of medical staff membership and clinical privileges may result if delinquent records are not completed in the time frames defined below. Notice will also be sent to the MedicalStaff Office.

Full Suspension: (Definition)

1. Physicians placed on Full Suspension may not:
    a. Exercise any of his/her Clinical Privileges unless an exception is granted for taking call.
    b. The Physician must arrange for coverage of any patients currently receiving inpatient treatment.
    c. An exception may be made, at the discretion of the Hospital President, or his/her designee, to allow the suspended Physician to cover ER call days scheduled prior to the suspension if the impact of removing the suspended Physician from the call schedule would create a risk to patient care or an undue burden on other Physicians in that specialty. In such event, the suspended Physician may treat patients emergently in the ER and provide ongoing care in the case of required admission in response to calls, but all other full suspension restrictions shall remain in place. The Hospital President's decision not to exercise such discretion is not an adverse action under the Bylaws and does not entitle the Physician to a hearing or other procedural right.

Reinstatement After Suspension:

1. Once Primary Suspension is imposed, privileges may be reinstated only upon completion of all missing H&Ps and Operative Reports.

2. Once Full Suspension is imposed, privileges may be reinstated upon completion of all incomplete and delinquent medical records available to the Physician.

3. Reinstatement will occur upon re-analysis of incomplete records to ensure that all deficiencies, including signatures, have been completed. To facilitate reinstatement of privileges, it is recommended the Physician document the dictation job number in a

progress note and the Physician should contact the HIMS department once all deficiencies are completed.

Chart Availability

1. No Physician shall be suspended, and no suspension shall be continued for an incomplete medical record that is not available to the Physician for completion.

2. If there is a delay in the assignment of the deficiency to the Physician, the delay will be reflected in the timing of the suspension.

Automatic Relinquishment of Privileges

1. If a Physician on full suspension has not completed the delinquent medical records within fourteen (14) days after being placed on Full Suspension (28 days post discharge), The Health Information Management Services will send notice to the Physician via email or fax and certified mail notifying him/her that such delinquency (ies) will result in the automatic removal from the Medical Staff. A copy of this letter will be sent to the Medical Staff Services Office.

ABSENCES

Vacation and planned absence

1. Vacation or other planned absences do not excuse a Physician from medical record completion requirements.
2. To avoid suspension for records that become delinquent while the Physician is on vacation or planned absence, the Physician must notify HIMS prior to the Physician's time off, and the following requirements are met:
    a. Notify HIMS of the planned time off, including commencement and return dates, at least two (2) business days prior to the start of the planned time off; and
    b. Complete all medical records that are available to the Physician as of forty-eight (48) hours prior to commencement of time off (example: If Physician's time off commences at 5 p.m. Friday, all records available to Physician at 5 p.m. the preceding Wednesday must be completed prior to the start of the time off).
    c. Failure to complete H&Ps, and Operative Reports prior to the absence will NOT be excused under this section.
    d. A Physician who has given the proper notification of planned time off will have five (5) business days following his/her return to complete any records that became delinquent during the planned time off.
    e. A Physician who takes planned time off without providing proper notification will be required to meet regular medical record completion requirements.

Unplanned Absence

1. A Physician who has an unplanned time off due to illness or a family emergency may be granted extra time to complete delinquent medical records at the sole discretion of the Medical Records Committee or Medical Staff Chief of Staff or designee based on individual circumstances.

ADVANCED PRACTICE PROFESSIONALS

1. Physicians approved to supervise PAs or APNs are responsible for the PAs or APNs to complete medical records according to the timeline outlined in the Rules and Regulations.
2. Failure of the PA or APN to timely complete medical records may result in the supervising Medical Staff Member being placed on suspension in accordance with Rules & Regulations or policy.

ARTICLE XI. PROVISION OF EMERGENCY CARE

11.1 PARTICIPATION IN THE ON-CALL ROSTER

Each member of the Medical Staff shall participate in coverage to the Emergency Department in his respective specialty per his department's policy which is subject to periodic review and approval by the Medical Executive Committee and Board of Trustees.

Unless specifically exempted by the Medical Executive Committee and the Board of Trustees for good cause shown, each member of the Staff assigned to the ED on-call roster agrees that, when he is the designated Practitioner on call, he will accept emergency transfers from other Hospital emergency departments in accordance with the Emergency Medical Treatment and Active Labor Act and responsibility during the time specified by the published schedule for providing care to any Patient in any unit of the Hospital referred to the service for which he is providing ED on-call coverage including providing in-house consultations as requested. If there is a conflict with the published schedule, it is the Staff member's responsibility to arrange appropriate coverage arrangements and notify the Medical Staff Office within five days. All Practitioners on call must respond to call within 30 minutes. If the Practitioner assigned to the ED on-call roster is delegating his service to a covering Practitioner it is the Practitioner's responsibility to ensure that the covering Practitioner is a member of the Hospital Medical Staff and has privileges adequate to discharge responsibilities and respond in the above noted time frame.

11.2 PROVISION OF EMERGENCY SERVICES

Each member of the Medical Staff must assure timely, adequate professional care for his Patients in the Hospital or for Patients currently under his care presenting themselves to the emergency room by being available or having available an eligible, alternate Practitioner with whom prior arrangements have been made.

A Practitioner remotely managing a Patient must be within the metropolis in order timely respond to the Patient's needs. In the event the Practitioner is outside of the metropolis, the Practitioner must relinquish any patient management to his/her covering Physician and must not attempt to manage the Patient. If the Patient is likely to need a procedure, direct assessment, or bedside intervention by the Practitioner, the Practitioner must be within 30 minutes of the Hospital if managing the Patient. If the Practitioner is not within 30 minutes of the Hospital, the Practitioner must relinquish management to his/her covering Physician.

There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community.

In a disaster, all Active staff members shall be assigned to posts as needed in accordance with the Hospital's Disaster Management Plan. It is the Physician's responsibility to report to his assigned stations as requested.

TEXAS HEALTH HOSPITAL FRISCO
ORGANIZATION & FUNCTIONS MANUAL OF THE MEDICAL STAFF

ARTICLE I. PURPOSE

This Organization and Functions Manual ("Manual") has been created pursuant to and under the authority of the Medical staff Bylaws of Texas Health Presbyterian Hospital Frisco. The purpose of the manual is to further describe the current structure of the Medical Staff and to define the mechanisms that the Medical Staff will utilize to accomplish the functions as outlined in the current Medical Staff Bylaws.

ARTICLE II. CLINICAL DEPARTMENTS AND OFFICERS

2.1 REQUIREMENTS FOR AFFILIATION WITH DEPARTMENTS

Each Department is a separate organizational component of the Medical Staff, and every Staff member must have a primary affiliation with the Department which closely reflects his professional training, experience, and current practice. A Practitioner may be granted clinical privileges in one or more of the other Departments and his exercise of clinical privileges within the jurisdiction of any Department is always subject to the Department decisions as reflected in Department minutes of that department and the authority of the Department Chair.

2.2 FUNCTIONS OF DEPARTMENTS

(a) Each Department shall recommend to the Credentials Committee written criteria for membership and the assignment of clinical privileges within the Department and its divisions. Such criteria shall be consistent with and subject to the bylaws, policies, procedures, rules and regulations of the Medical Staff and the Hospital. These criteria shall be effective when approved by the Board of Trustees. (b) Each Department shall participate in the Medical Staff mechanism for monitoring and evaluation of the quality and appropriateness of care within the Department. The findings and conclusion of monitoring and evaluation shall be presented at departmental meetings or in some other manner designed to communicate such findings and conclusions. Written reports shall be maintained reflecting the results of all evaluations performed and actions taken.

(c) Each Department shall report results of evaluations to the appropriate Medical Staff committees. Copies of these reports shall be confidential and maintained as directed by the Medical Executive Committee and the Hospital President.

(d) Each Department shall provide adequate emergency Department coverage via written policy developed by the Department and approved by the Medical Executive Committee and the Board of Trustees.

(e) The minutes of each Department meeting shall reflect the conclusions, recommendations and actions of the activities in compliance with the above provisions and shall be made available to the Medical Executive Committee and the Board of Trustees.

(f) Each Department shall establish a mechanism for accomplishing peer review, for reviewing initial applications and reappointment applications, and for advising the Department Chair as requested.

2.3 TERM OF OFFICE AND ELIGIBILITY FOR RE-ELECTION

The term of office of a Department Chair and Department Vice-Chair is two (2) Medical Staff years. A Department Chair or Department Vice-Chair may succeed himself but for no more than two (2) consecutive terms. This limitation on the maximum number of terms may be waived if, in the selection process provided, it is determined that such waiver is in the best interest of the Department, the Hospital and its Patients. Department Chairmen and Vice-Chairmen assume

office on the first day of the Medical Staff year following their election, except that an officer selected to fill a vacancy assumes office immediately up selection.

2.4 ATTAINMENT OF OFFICE

(a) Any Department Chair or Vice-Chair who has served a two-year term shall have the option to request that his name be placed in nomination to be elected to serve an additional two-year term subject to the limitations of Section 2.3 above.

(b) Should a Department Chair decline the opportunity to succeed himself, the then Vice-Chair shall have the option, but is not required, to have his name placed in nomination to be elected as Chair.

(c) No later than the third scheduled Department meeting of each year, except if a Department meets monthly or bi-monthly, in which case, the 3rd to last meeting, the Department will nominate candidates for Chair and Vice-Chair subject to Sections (a) and (b) above.

(d) Within two weeks of the meeting at which nominations are made, a ballot will be prepared and mailed, either by US Post, Campus delivery system, or electronically, to all members of the Department eligible to vote pursuant to Article III of the Medical Staff Bylaws.

(e) A date by which ballots must be received, which shall not be less than twenty-one (21) days from the date the ballot is deposited in the US Mail or in the Campus delivery system or electronically, will be indicated on the ballot. Ballots may be returned by mail in the self-addressed envelope included with the ballot, by fax to the Medical Staff Office, or electronically.

(f) Immediately following the due date, the ballots received will be tabulated and the candidate for each office (Chair and Vice-Chair) receiving a majority of the votes cast shall be elected.

(g) The results of the election shall be reported to the Medical Executive Committee and the Board of Trustees for approval and confirmation that the officers elected satisfy the qualifications for the position.

(h) Those Departments whose Chair serves as a result of a contract for services between his group and the Hospital are exempt from these election procedures. However, prior to November of each year, those Departments shall report to the Medical Executive Committee and to the Board of Trustees the name of the individual who will be serving as Chair and Vice Chair of the Department for the coming Medical Staff year.

2.5 MEDICAL DIRECTORS OF SPECIAL UNITS

A unit medical director contracted by the Hospital shall have the responsibility and authority to carry out the duties assigned to him by the contract or job description if applicable. Each medical director is responsible for overseeing the care of Patients in the unit and may intercede in the care of a Patient when and to the extent he deems necessary.

ARTICLE III. MEDICAL PEER REVIEW

3.1 MEDICAL PEER REVIEW COMMITTEE STATUS

Each committee (whether Staff or Department, standing, special, subcommittee, or joint committee, hearing committee or appellate review body), as well as the Medical Staff when meeting as a whole, shall be constituted and operate as a “medical peer review committee,” “medical committee,” and “professional review body,” as such terms are defined by State and/or Federal law, and is authorized by the Board of Trustees through these Bylaws to engage in Medical Peer Review as defined below. This provision shall also apply to any Hospital or other committees engaged in Medical Peer Review at the Hospital.

3.2 MEDICAL PEER REVIEW DEFINED

"Medical peer review" means the evaluation of medical and health care services, including the evaluation of the qualifications and professional conduct of Practitioners and other individuals holding or applying for clinical privileges, and of patient care, treatment, and services provided by them. The term includes but is not limited to:

(a) the process of credentialing for initial appointment, reappointment, the granting of clinical privileges, and reinstatement from leave of absence;

(b) the process of issuing an Adverse Action, including but not limited to corrective action, and affording procedural rights of review as provided in the Medical Staff Bylaws and the Fair Hearing and Appellate Review Plan;

(c) any evaluation of the merits of a complaint relating to a Practitioner or AHP holding clinical privileges and issuance of a recommendation or action in that regard;

(d) any evaluation of the accuracy of a diagnosis or quality of the patient care, treatment, or services provided by one of the above individuals or other health care providers within the Hospital, including but not limited to implementation of the Hospital's quality assurance plan and the review of patient care, treatment, or services by another Practitioner, whether or not a member of the Staff;

(e) a report made to an individual or a committee engaged in Medical peer review or to a licensing agency;

(f) implementation of the duties of a committee engaged in Medical peer review by a member, agent, or employee of the committee; and

(g) "Medical peer review" as defined in the Texas Medical Practice Act and "professional review activity" as defined by the Federal Health Care Quality Improvement Act.

3.3 AGENTS AND MEMBERS

The Hospital President, other members of Administration, the Medical Staff Office, and all other Hospital departments supporting Medical Peer Review activities shall be considered agents of the Staff committees and the Staff as applicable when performing the authorized functions and responsibilities of the committees. Practitioners, whether or not members of the Staff, who are requested by a Staff committee or the Board to review the patient care, treatment, or services of another Practitioner and/or who do so as an authorized function of the Staff or a Staff committee, Department or Department committee, or the Board shall be considered agents of the committee or the Board when performing such review in good faith. Any good faith action by an agent or member of the Staff or a Staff committee, Department or Department committee, or the Board when performing such functions and responsibilities shall be considered an action taken on behalf of the Staff, appropriate Staff committee, Department, appropriate Department committee, or the Board as applicable, not an action taken in the agent's or member's individual capacity. This shall include, but not be limited to, actions by a Staff or Department officer, Practitioners serving in medico-administrative positions, and the Hospital President.

3.4 CONFIDENTIALITY

3.4.1 GENERAL- All records and proceedings of the Staff, all Departments, all Staff and Department committees (whether standing, special, subcommittees, or joint committees, or a hearing committee or appellate review body), and the Board, including but not limited to any minutes of meetings, disclosures, discussion, statements, actions, or recommendations in the course of Medical Peer Review, shall be privileged and confidential, subject to disclosure only in

accordance with written Staff and Hospital policies, unless otherwise required by State and/or Federal law, and shall be privileged to the fullest extent permitted by State and/or Federal law.

3.4.2 OBLIGATION TO MAINTAIN CONFIDENTIALITY- All Staff members and others holding clinical privileges, as well as those applying for such status, and all other individuals participating in, providing information to, or attending meetings of the Staff, Staff committees, Departments or their committees, or the Board, or serving as agents or members thereof, are required to maintain the records and proceedings related to any Medical peer review activities as confidential, subject to disclosure only in accordance with Staff and Hospital policies, unless otherwise required by State and/or Federal law.

3.4.3 WAIVER- Waiver of the privilege of confidentiality as to the records and proceedings of any meeting or committee subject to this Section shall require the written consent of the chair of the committee or presiding officer and the Hospital President.

3.4.4 MAINTENANCE AND ACCESS- The records and proceedings of all meetings and committees subject to this Section shall be the property of the Hospital and maintained by the Medical Staff Office. They will be available for inspection by the Medical Executive Committee, the Hospital President, the Board, and any employees and agents of the Hospital whose authorized functions necessitate access. A member of a Staff committee, Department, or Department committee may also inspect the records and proceedings of that Staff committee, Department, or Department committee which were generated during his/her service as a committee or Department member, as long as he/she is currently a member of the Staff. Access is also permitted pursuant to Hospital policy and as required by State and/or Federal law, accreditation requirements, or third-party contract of the Hospital. Access of a Practitioner to records and proceedings that address the Practitioner shall be only as required by law or as approved by the Hospital President.

3.5 IMMUNITY FROM LIABILITY

3.5.1 IMMUNITY- The Staff and its members, the Board, the Hospital, and any committees, representatives, agents, employees, or members thereof, and third parties as defined below, will have absolute immunity. This immunity shall be to the fullest extent permitted by State and Federal law and shall include any permissive and mandatory reporting provided for by State and Federal law.

3.5.2 AUTHORIZATIONS AND RELEASES- All applicants for appointment to the Staff, reappointment, and/or clinical privileges shall execute a release of liability consistent with the immunity and release of liability provisions in these Bylaws and an authorization for the Hospital, the Staff, and third parties to disclose confidential information as necessary for Medical peer review in the course of application and at all times thereafter; provided that, the effectiveness of the immunity provisions of these Bylaws is not contingent on execution of these authorizations and releases. Further, the immunity provisions in these Bylaws and any releases of liability shall be in addition to and not in limitation of any immunity afforded by State and Federal law.

3.6 MANDATORY REPORTING

The Hospital President, in consultation with the Medical Staff President, shall be responsible to comply with any mandatory reporting requirements of the Hospital under State and/or Federal law pertaining to Staff membership and/or clinical privileges. Nothing in this section or the other provisions of the Bylaws shall prevent an individual Staff member or member of the Board from making any other report to State and/or Federal agencies as permitted or required by law.

3.7 CONFLICT OF INTEREST – MEDICAL PEER REVIEW

3.7.1 DISCLOSURE- Whenever a Practitioner is participating in Medical Peer Review and/or performing a function for the Staff or a Department, or a committee thereof, or the Hospital, and

the Practitioner's personal or professional interests could be reasonably interpreted as being in conflict with the interests of the Staff, Department, committee, Hospital, or individual under review, the Practitioner shall disclose those interests and the potential for conflict to the appropriate decision makers prior to such participation. The appropriate chairperson or the Medical Staff President, with the approval of the Hospital President, or the Hospital President may require the Practitioner to refrain from any participation in decisions that may be affected by or affect the Practitioner's interests.

3.7.2 DISQUALIFICATION-A Practitioner shall not be eligible to participate in, or be present during, any meeting, discussion, or deliberation of a committee or Department of which he/she is a member regarding his/her clinical privileges or Staff membership or any other Medical peer review activity involving the Practitioner, except to the extent specifically provided for in the Bylaws, Rules and Regulations, a Manual, or Staff policy, or when invited by the chairperson.

Any family members or business partners of a Practitioner shall not be eligible to participate in, or be present during, any meeting, discussion, or deliberation of any committee or Department regarding the Practitioner's clinical privileges or Staff membership or any other Medical Peer Review activity involving the Practitioner. "Family member" shall mean a Practitioner's (i) parents or stepparents, including spouses of the same, (ii) ancestors, (iii) spouse, (iv) child or stepchild, grandchild, or great grandchildren, (v) siblings, whether related by whole or half blood, or (vi) the spouse of an individual described in clause (iv) or clause (v), and shall include adoptive relationships of the above.

ARTICLE IV. MEDICAL STAFF MEETING PROCEDURES

4.1 MEDICAL STAFF MEETINGS

The regular Medical Staff meetings will be held on call of the Medical Executive Committee, with at least one (1) meeting annually before the end of the medical staff year.

4.2 SPECIAL MEETINGS

A special meeting of the Medical Staff may be called by the Medical Staff President, the Hospital President, President of the Board of Trustees, the Board of Trustees or its authorized committee, or pursuant to a petition signed by at least twenty-five (25) of the members of the Active Staff in good standing. The request for the special meeting must state the reason for or business to be conducted at the meeting and that shall be the only business conducted at the meeting. A special meeting shall be held within ten (10) days of a proper request.

4.3 DEPARTMENT AND COMMITTEE MEETINGS

Department and committees may, by resolution provide the time for holding regular meetings. A Department must meet at least semi-annually or more frequently as necessary. The frequency of committees is as required by the Bylaws for each committee and otherwise as established by the resolution creating a committee.

4.4 SPECIAL MEETINGS OF DEPARTMENT OR COMMITTEES

A special meeting of any Department or committee may be called, respectively by the Department Chair or committee chair, or, or one-fourth of the current voting members of the Department or committee in good standing but not less than two. The Medical Staff President may also call a special meeting of a Department or committee. The request for the special meeting must state the reason for or business to be conducted at the meeting and that shall be the only business conducted at the meeting. A special meeting shall be held within ten (10) days of a proper request.

4.5 ATTENDANCE REQUIREMENTS

Practitioners are encouraged but are not required to attend Medical Staff Department, general Medical Staff, or committee meetings.

4.6 NOTICE OF MEETINGS

Written notice of a meeting shall be provided to all Provisional Active and Active members at least ten (10) days prior to the meeting.

4.7 QUORUM

(a) For any meetings, unless otherwise provided in the Bylaws or this Manual, a Quorum shall constitute the members present and voting.

4.8 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a Quorum is present is the action of the group. Action may be taken without a meeting by the Medical Staff, Department or committee by presentation of the question to each member eligible to vote, in person or by mail, and their vote returned to the chairman of the group or the Medical Staff President in the case of a Medical Staff vote. Such vote shall be binding so long as the question is voted on by at least the number of voting members of the group that would constitute a Quorum. There is no voting by proxy or absentee ballot.

4.9 AGENDA AND PROCEDURE

Except as provided above for special called meetings, the Medical Staff President for Medical Staff meetings and the Department or committee chairman shall establish the agenda for each meeting. Meetings will be conducted according to the current edition of Robert's Rules of Order. In the event of conflict between the Bylaws and Robert's Rules of Order, the Bylaws shall control.

ARTICLE V. COMMITTEE STRUCTURE

5.1 COMMITTEE CHAIRMAN

All committee chairmen shall be appointed by the Medical Staff President in consultation with the Medical Executive Committee. All committee chairmen shall be selected from among persons appointed to the Active Staff.

5.2 COMPOSITION AND APPOINTMENT OF MEMBERS

A Medical Staff committee created in the Bylaws or otherwise is composed as stated in the description of the committee. Medical Staff members of each committee, except as otherwise provided in these bylaws, shall be appointed by the Medical Staff President following consultation with the Medical Executive Committee and must be members in good standing. Allied health professionals and representatives from Administration and Hospital Departments as are appropriate to the functions to be discharged may be appointed by the Hospital President. Each designated member of a committee participates with vote, unless the statement of committee composition designates the position as non-voting. The Hospital President or his designees shall be members ex officio without vote, of all Medical Staff committees unless the statement of committee composition designates the position as voting. The Medical Staff President may, in consultation with the committee chairman, make additional appointments to any committee as

deemed necessary for the committee to carry out its functions.

5.3 TERM, PRIOR REMOVAL AND VACANCIES

Except as otherwise expressly provided, each appointed committee member serves a one-year term, coinciding with the Medical Staff Year, unless he sooner resigns or is removed from the committee or the Medical Staff, and may be reappointed to the committee for an unlimited number of terms.

A Practitioner serving on a committee, (except one serving Ex-Officio), may be removed by the Medical Staff President from the committee for failure to maintain himself in good standing as a Staff member or if he is unable to meet the responsibilities and obligations of the committee. A vacancy in any committee is filled for the un-expired portion of the term in the same manner in which original appointment is made.

ARTICLE VI. MEDICAL STAFF COMMITTEES[1]

6.1 GENERAL

6.1.1 STATUS- All Medical Staff committees shall be established and operate as medical peer review committees/medical committees/professional review bodies, as further detailed in Article 12.

6.1.2 STANDING COMMITTEES- Standing committees shall report to the Medical Executive Committee unless otherwise provided in these Bylaws. Other standing committees of the Medical Staff or of the Medical Executive Committee may be established in writing by the Medical Executive Committee, subject to the approval of the Board of Trustees, and shall not require amendment of these Bylaws.

6.1.3 SPECIAL AND AD HOC COMMITTEES- Standing committees and their chairs have the authority to form special or ad hoc committees and task forces to assist in the performance of authorized functions. Any such formation shall be reflected in writing with a statement of the purpose of the committee or task force.

6.1.4 MEMBERS AND ATTENDANCE- The members of Medical Staff committees shall be appointed by the Medical Staff President and the chairs shall be members of the Active Staff, unless otherwise provided in these Bylaws. Since the Board uses a system of triad leadership, the Hospital President, Chief Medical Officer and Chief Nursing Officer may attend any Medical Executive Committee or other Medical Staff committee meeting, whether standing, ad hoc, special, or a task force, including a meeting in executive session.[2]

6.2 MEDICAL EXECUTIVE COMMITTEE[3]

6.2.1 GENERAL- The Medical Executive Committee shall serve as the governing committee of the Medical Staff. By approval of these Bylaws, the Medical Staff delegates and authorizes the Medical Executive Committee to represent and act on its behalf on all matters and in between meetings of the Medical Staff, subject to any limitations imposed by these Bylaws and in a manner consistent with these Bylaws.

6.2.2 DUTIES- The Medical Executive Committee shall be the primary group accountable to the Board of Trustees for ensuring fulfillment of Medical Staff functions of governance, leadership and performance improvement, as well as managing the activities of growth,

[1] 42 C.F.R. Sec. 482.22(c)(3); MS.01.01.01 EP 12.
[2] MS.02.01.01 EP 2 (the standard references the CEO or his or her designee).
[3] MS.01.01.01 EP 20-23, MS.02.01.01.

profitability, quality, safety, and disease management around patients who seek care across the Hospital continuum. Specific duties of the Medical Executive Committee shall include, but not be limited to:

6.2.2.1 Making recommendations to the Board of Trustees as to:

6.2.2.1.1 the Medical Staff structure,

6.2.2.1.2 the process used to review credentials and delineate Clinical Privileges,

6.2.2.1.3 Practitioners who should be appointed to the Medical Staff and/or granted Clinical Privileges,

6.2.2.1.4 the delineation of Clinical Privileges for eligible Allied Health Professionals,

6.2.2.1.5 the process by which Practitioners may be subject to Corrective Action,

6.2.2.1.6 the mechanism for affording procedural rights of review in the event of an Adverse Recommendation or Action,

6.2.2.1.7 participation of the Medical Staff in Medical Peer Review activities, and

6.2.2.1.8 the results of its review and actions on reports from the Departments, standing Medical Staff committees, and other committees or assigned groups;

6.2.2.2 Receiving and acting on the reports from the Departments, all standing Medical Staff committees or others concerning Medical Peer Review activities and the discharge of delegated Medical Staff responsibilities;

6.2.2.3 Periodically reporting results and recommendations concerning Medical Staff functions, as well as the status of Hospital accreditation, to the Medical Staff;

6.2.2.4 Coordinating the activities of the Departments, Medical Staff committees, and other groups within the Medical Staff organization;

6.2.2.5 Initiating and pursuing Corrective Action or other intervention in accordance with these Bylaws when indicated;

6.2.2.6 Providing oversight for the organization of inpatient, outpatient, ambulatory, and community clinical services through the Hospital and the Medical Staff, and establishing policies and procedures for the efficient, safe, and high-quality operations of the Hospital and the Medical Staff;

6.2.2.7 Determining reasonable emergency services call coverage responsibilities and schedules and ensuring that the Departments provide for timely and adequate call coverage for the Hospital's emergency department for each of the specialty areas within the Departments as directed by the Board of Trustees; and

6.2.2.8 Addressing issues of Practitioner health or impairment in accordance with written Policy, which Policy shall provide a process separate from the Corrective Action process unless Corrective Action is warranted*; and*

6.2.3 COMPOSITION

The Medical Executive Committee shall be comprised of the following:

(a) All Department Chairmen;
(b) The Medical Staff President
(c) The Medical Staff President-Elect

(d) The Immediate Past Medical Staff President
(e) The Secretary-Treasurer of the Medical Staff
(f) The Chair of the Credentials Committee
(g) Up to three (3) members-at-large who are members of the Medical Staff nominated by the Medical Staff President-Elect and approved by the Medical Executive Committee at its December meeting
(h) Two (2) past Presidents of the Medical Staff, ex officio with you, appointed by the current President of the Medical Staff
(i) The Hospital President or his designees shall serve on the Medical Board, Ex-Officio, without vote.

6.2.3.1 Medical Staff Members. The Medical Executive Committee shall have as voting members the elected officers of the Medical Staff and at least 5 but not more than 10 Members of the Active Staff.

6.2.3.1.1 Members shall be selected on the basis of the following behavioral and technical competencies: accountability, aspiration and passion for leadership, conflict management, engaged in the Hospital's vision, integrity, judgment, legal/ethical/political awareness, skillful communication, and trust and respect.

6.2.3.1.2 All disciplines and specialties from the Active Staff categories are eligible for membership on the Medical Executive Committee.[4] A majority of the voting members of the Medical Executive Committee must be Physicians.[5]

6.2.3.1.3 Members shall be elected by the voting Members of the Medical Staff from a ballot of qualified candidates, either at a Medical Staff meeting or by mail ballot using the procedures in Article 8. The candidates shall be proposed by the Nominating Committee.

6.2.3.1.4 Medical Executive Committee members may not hold a similar position at another health care entity during service on the Medical Executive Committee.

6.2.3.2 Hospital Members. The Medical Executive Committee shall also include as non-voting members: Hospital President, Chief Medical Officer, and Chief Nursing Officer. The Hospital President may invite other Hospital staff, including Medical Staff Services, to attend meetings as support and resources for the Medical Executive Committee

6.2.3.3 Chair. The Medical Staff President shall chair the Medical Executive Committee.

6.2.3.4 Terms. Except for the Medical Staff officers, whose terms shall be their terms of office, membership terms shall be 2 years and staggered. Members may serve consecutive terms.

6.2.3.5 Removal of Members. The procedures for removal of a Medical Staff officer are set out in Section 7.7. Any other Medical Staff Member of the Medical Executive Committee may be removed for cause on 2/3^{rds} vote of the Medical Executive Committee or for cause on 2/3^{rds} vote of the Board of Trustees. Only the Board of Trustees may remove the Hospital President, Chief Medical Officer, or Chief Nursing Officer, and only the Hospital President may remove another member appointed under Section 6.2.3. 2..

[4] MS.02.01.01 EP 3.
[5] MS.02.01.01 EP 4; 42 C.F.R. Sec. 482.22(b); 25 Tex. Admin. Code Sec. 133.41(k)(2)(B).

6.2.4 MEETINGS AND REPORTING

6.2.4.1 The Medical Executive Committee shall meet at least 10 times each year on a monthly basis and otherwise on the call of its Chair or the Hospital President.

6.2.4.2 For a quorum, at least half of the voting Members of the Medical Executive Committee must be present in person, or by teleconference, videoconference or other appropriate means by which all participants can hear each other.

6.2.4.3 Affirmative action shall require majority vote of the voting members present, as defined above, in the presence of a quorum.

6.2.4.4 The Medical Executive Committee shall report to the Board of Trustees after each meeting.

6.3 BEHAVIORAL EVENT REVIEW COMMITTEE

6.3.1 Duties. The Behavioral Event Review Committee shall be responsible for evaluating reports of disruptive behavior and determining the appropriate disposition of the issue in accordance with the Medical Staff's Code of Conduct Policy. The committee will report its activities and findings on a quarterly basis.

6.3.2 Composition. The Behavioral Event Review Committee shall be composed of the Immediate Past President of the Medical Staff or President-Elect serving as Chair, the Chief Medical Officer, and two other Members from the Medical Executive Committee. The Director of Medical Staff Services shall provide support for the committee, including without limitation, conducting validation of issues brought to the committee.

6.3.3 Meetings. The Behavioral Event Review Committee will meet as needed on the call of the Chair.

6.4 BYLAWS COMMITTEE

6.4.1 Duties. The Bylaws Committee shall:

6.4.1.1 Maintain the Medical Staff Bylaws and Rules and Regulations, any Manuals, and Medical Staff policies on an ongoing basis to reflect the current Medical Staff organization and function, and compliance with regulatory and accrediting requirements;

6.4.1.2 Conduct a review of the Bylaws, Rules and Regulations, any Manuals, and Medical Staff policies as set forth in Article 14;

6.4.1.3 Maintain current knowledge of legal and regulatory requirements pertinent to the Bylaws and other governance documents, and refer questions to Hospital legal counsel; and

6.4.1.4 Draft revisions to the Bylaws and ancillary governance documents as are necessary for submission to the Medical Executive Committee in accordance with the procedures in Article 14.

6.4.2 Composition. The Bylaws Committee shall be composed of at least 5 members to include: Medical Staff Chief, Medical Staff Vice-Chief, and Medical Staff Secretary. The Medical Staff Secretary shall serve as Chair and the Chief Medical Officer shall serve as a non-voting member.

6.4.3 Meetings. The Bylaws Committee shall meet at least annually and otherwise as needed to accomplish its duties.

6.5 CREDENTIALS COMMITTEE

6.5.1 Duties. The Credentials Committee shall:

6.5.1.1 Coordinate the credentialing and privileging process for Practitioners and AHPs in accordance with the Bylaws;

6.5.1.2 Review the recommendations of the Department Chairs regarding appointment, reappointment and/or Clinical Privileges;

6.5.1.3 Make recommendations to the Medical Executive Committee regarding appointment, reappointment and/or Clinical Privileges, including Staff category and Department assignment; and

6.5.1.4 Make recommendations to the Medical Executive Committee for criteria for Clinical Privileges.

6.5.2 Composition. Voting members will consist of the Chair, and 8 additional members of the active medical staff. Non-voting members will include the Medical Staff Secretary, Hospital President, Chief Medical Officer, and Manager of Medical Staff Services.

6.6 NOMINATING COMMITTEE

6.6.1 Duties. The Nominating Committee shall solicit qualified and interested candidates for elected office, and review and document their qualifications and experience. If acceptable, the Nominating Committee shall nominate those Members for election as provided in the Bylaws.

6.6.2 Composition. The Nominating Committee shall be composed of at least three Members of the Active Staff, with preference to Immediate Past Presidents, with one designated as Chair. The President of the Medical Staff and the Chief Medical Officer shall be non-voting members of the committee.

6.6.3 Meetings. The Nominating Committee shall meet as necessary to accomplish its duties.

6.7 PEER REVIEW COMMITTEE

6.7.1 Duties. The Peer Review Committee shall perform the duties in the Medical Staff policies on Peer Review, including FPPE and OPPE. Receive, review, and/or take action based on the results of peer review committee reports. These recommendations may include the formation of Ad-hoc committees, focused reviews, and outside expert reviews for a specific physician(s).

6.7.2 Composition. The Peer Review Committee shall be composed of at least 5 Members of the Active Staff, with one designated as Chair. The Chief Medical Officer, the Chief Nursing Officer, and the Director of Quality Improvement and Patient Safety shall serve as non-voting members.

6.7.3 Reporting. In addition to reporting to the Medical Executive Committee, the Peer Review Committee shall also notify the appropriate Department Chair of any action taken as to a Member of the Department.

6.8 PHYSICIAN HEALTH AND REHABILITATION COMMITTEE

6.8.1 Duties. The Physician Health and Rehabilitation Committee shall provide assistance and support to Practitioners and AHPs on health issues and coordinate the evaluation and intervention if indicated of reports of impairment, in accordance with Policy. The Policy shall provide for identifying and managing matters of Practitioner health which is separate from the Corrective Action process in Article 9.

6.8.2 Composition. The Physician Health and Rehabilitation Committee shall be composed of at least 5 Members of the Active Staff, with one designated as Chair. The Chief Medical Officer shall serve as a non-voting member.

6.8.3 Meetings. The Physician Health and Rehabilitation Committee shall meet as needed.