MEDICAL STAFF BYLAWS

and

RULES AND REGULATIONS

November 17, 2021

Texas Health Presbyterian Hospital Dallas
Medical Staff Bylaws

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TEXAS HEALTH PRESBYTERIAN HOSPITAL DALLAS
BYLAWS OF THE MEDICAL STAFF

PREAMBLE

These Bylaws are adopted to organize the Medical Staff of Texas Health Presbyterian Hospital Dallas and to provide a framework for the Medical Staff to discharge the responsibilities delegated to it by the Board of Trustees, with a reasonable degree of freedom and confidence, for oversight of the quality of medical care delivered at the Hospital.

NAME

The physicians, dentists, oral surgeons, and podiatrists practicing at Texas Health Presbyterian Hospital Dallas hereby organize themselves into a self-governing body hereafter known as the Medical Staff of Texas Health Presbyterian Hospital Dallas in conformity with these Bylaws.

PURPOSES

The Medical Staff is organized for the following purposes:

1. To create a structure which allows its members to provide care for all patients admitted or treated in any area of the Hospital;

2. To support education in medicine and related health sciences for all individuals who provide patient care at Texas Health Presbyterian Hospital Dallas;

3. To provide a means through which the Medical Staff may participate in the Hospital policy making and planning processes and effectively communicate with the Hospital Board of Trustees;

4. To make recommendations to the Board of Trustees regarding appointment and reappointment to the Medical Staff and the granting of Clinical Privileges;

5. To establish rules and regulations, policies and procedures for Medical Staff self-governance and to define Officers of the Medical Staff and clinical departments and their responsibilities;

6. To improve patient care, participate in the development of processes of care and objectively measure the quality of care provided by Medical Staff Members and Allied Health Professionals who provide patient care;

7. To serve as the primary means of reviewing and reporting to the Board of Trustees the appropriateness of the professional performance, clinical competence and ethical conduct of Medical Staff Members, Allied Health Professionals, and others exercising Clinical Privileges in the Hospital and to advise the Board of Trustees concerning the efforts to improve the quality, patient safety, efficiency and cost effectiveness of health care provided in the Hospital.

8. To balance efforts to protect patients' clinical needs with the judicious use of resources; and

9. To enhance the ability of the Hospital to achieve its mission and vision.

ARTICLE I
MEDICAL STAFF MEMBERSHIP;
ALLIED HEALTH MEMBERSHIP

1.1 Nature of Medical Staff Membership

Membership on the Medical Staff of Texas Health Presbyterian Hospital Dallas is a privilege which shall be extended only to professionally competent physicians, dentists, oral surgeons, and podiatrists who continuously meet the qualifications, standards and requirements set forth in these Bylaws and in such policies as are adopted from time to time by the Board of Trustees.

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.

1.2 Qualifications for Membership

1.2.1 To be eligible for membership on the Medical Staff, an individual must:

(a) Licensure:

Have a current**,** license to practice medicine, dentistry, or podiatry in the State of Texas and have never had a license revoked or suspended by any state licensing agency and meet such other requirements stated in the Medical Staff Credentialing and Privileging Policy;

(b) DEA and controlled substance registration:

If applicable to his/her practice, have a current, Drug Enforcement Agency registration and Texas Department of Public Safety controlled substance registration;

(c) Proximity to the Hospital:

Be located (office and residence) close enough to the Hospital to provide timely call coverage and continuous care for his/her patients in the Hospital and to fulfill their Medical Staff responsibilities;

(d) Professional training and experience:

Be able to document their education, background, experience, training and demonstrated ongoing clinical competence;

(e) Health status:

(1) Physical or Mental Impairment: To be free of or have under adequate control any physical or mental health impairment that interferes with, or presents a reasonable probability of interfering with, the practitioner's ability to satisfy any of the qualifications of Medical Staff membership or his/her ability to exercise all or any of the Clinical Privileges requested or granted.

(2) Substance/Chemical Abuse: To be free from abuse of any type of substance or chemical that interferes with, or presents a reasonable probability of interfering with, the practitioner's ability to satisfy any of the qualifications for Medical Staff membership or his/her ability to exercise all or any of the Clinical Privileges requested or granted.

(f) Professional and ethical conduct:

(1) To be of high moral character; and
(2) To adhere to generally recognized standards of medical and professional ethics.

The word "character" is intended to include the applicant's mental and emotional stability. The applicant shall have the burden of producing enough positive evidence to support the favorable consideration of the application.

(g) Cooperativeness:

Ability to work cooperatively with others in the Hospital environment, to include refraining from conduct which constitutes a pattern of disruption so as to adversely affect the quality or efficiency of patient care services in the Hospital.

(h) Medicare and other government programs; exclusions:

1) Has never been excluded from or convicted of fraud or abuse under the Medicare, Medicaid, or other federal or state governmental or private payer program;

2) Has never been, and is not currently, involuntarily excluded from participation in the Medicare, Medicaid, TRICARE, or other federal or state governmental health care program;

(i) Call coverage:

Agree to fulfill all responsibilities regarding call coverage if applicable;

(j) Electronic Health Record (EHR):

Each Practitioner with Clinical Privileges must successfully complete the Hospital's training on EHR. If the Practitioner has already completed EHR training at another Texas Health Resources wholly owned hospital where they currently exercise privileges, they will not be required to repeat initial training.

(k) Board certification requirements effective January 11, 2010 (the "Effective Date")

(1) Applicants and Members.

All Members whose initial appointment to the Medical Staff is on or after the above Effective Date, are required to be board certified in their primary specialty of practice throughout their Medical Staff membership or be in active pursuit of board certification. A Member in active pursuit of board certification must become board certified within five (5) years of initial appointment to the Medical Staff.

Each Department may establish rules consistent with or more stringent than the requirements under this subsection (j)(1).

(2) Members appointed to the Medical Staff before the Effective Date, who are not board certified are not subject to these board certification requirements as long as Medical Staff membership is continuously maintained. However, should a Member obtain board certification on or after the above date, board certification must be maintained as required above. Emeritus Staff and Affiliate Staff Members are exempt from these board certification requirements.

(3) Any Member failing a board certification or recertification exam shall notify the Hospital's Medical Staff Services within five (5) days of receiving notice of his/her failure of such exam.

A Member, not exempt under Subsection (2) above, who fails to accomplish or maintain board certification as required under this Subsection (j) will not be eligible for reappointment to the Medical Staff and renewal of privileges. Failure to be reappointed and loss of membership and privileges does not entitle the Member to the due process rights under Articles IX and X of these Bylaws.

(4) Request for waiver. A Member whose board certification lapses or who has a compelling reason for not being board certified, e.g. unforeseen hardship may apply through the Credentials Committee for a waiver of these board certification requirements. Any waiver must be approved by the by the Medical Executive Committee and Board of Trustees and may be granted in rare circumstances. Failure to make a timely application for certification or re-certification should not be

considered a hardship or extenuating circumstance. A waiver may be approved if the Member is otherwise in good standing with the Medical Staff to include without limitation a satisfactory quality record with the Hospital and fulfillment of all other requirements appropriate to the Member's membership category.

(5) To meet the requirements of this subsection, board certification must be recognized by the American Board of Medical Specialists (ABMS), American Osteopathic Specialty Board, American Dental Association, the American Board of Foot and Ankle Surgery, or American Board of Podiatric Orthopedics, as appropriate to the Member's discipline.

(k) Professional Liability Insurance Coverage:

Carry professional liability insurance coverage in at least the amounts required by Hospital's Board of Trustees.

1.2.2 <u>No Entitlement to Appointment</u>***.***

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

1.2.3 No individual shall be denied appointment on the basis of sex, race, religion, color or national origin.

1.3 <u>Advanced Practice Professionals and Allied Health Professionals</u>

1.3.1 <u>General</u>. Certain individuals may be authorized to provide health care in the Hospital pursuant to Clinical Privileges for Advanced Practice Professionals (APPs) or authorized to provide services to Hospital patients as Allied Health Professionals (AHPs). The process for reviewing applicants and granting Clinical Privileges to an APP or a Scope of Service to an AHP shall be set out in Hospital policy.

Any grant of Clinical Privileges or authorization to practice under a Scope of Service shall be in accordance with the Medical Staff credentialing and privileging process and shall be subject to any required Member delegation, direction and/or supervision as set out in Hospital policy following consultation and recommendation by the Medical Executive Committee.

APPs and AHPs are not eligible for Medical Staff membership or any of the procedural rights of review afforded to Members under these Bylaws or otherwise. Any review rights shall be limited to those set out in the Hospital policy.

1.3.2 <u>Supervising and Sponsoring Medical Staff Members.</u>

(a) Except for those employed by the Hospital, each APP and AHP must be engaged by a Member either as an employee or independent contractor of the Member or the Member's practice group. All Members using the services of APPs and/or AHPs shall provide the required delegation, direction, supervision, and/or sponsorship as set forth in these Bylaws, the Medical Staff Rules and Regulations, Hospital policy, the APP's/AHP's delineation of Clinical Privileges and/or Scope of Service as applicable. Each Member retains full responsibility for the performance and care provided by the APP or AHP in the Hospital.

(b) **Improper Use.** Use by a Member of an APP or AHP in a manner not permitted by the APP's/AHP's Clinical Privileges or Scope of Service may be grounds for corrective action against the Member.

1.4 Conditions and Duration of Appointment

1.4.1 The Board of Trustees shall grant applicants to the Medical Staff an initial appointment for a period of up to twenty-four (24) months from the date of appointment. The term of reappointment shall be for a period of up to twenty-four (24) months from the appointment date and may be for a period of less than twenty-four (24) months.[1] A term of less than twenty-four (24) months is not an Adverse Recommendation or Action and shall not entitle the practitioner to any procedural rights of review under these Bylaws or otherwise.

1.4.2 An appointment and/or reappointment may be subject to the Practitioner's compliance with specific conditions which relate to compliance with the qualifications for Medical Staff.

1.4.3 The Chair of the department or departments in which the Member has Clinical Privileges shall evaluate the Member during the initial appointment and shall provide information and a recommendation to the relevant committees of the Medical Staff and the Hospital as to clinical competence and general behavior and conduct in the Hospital. Clinical Privileges shall be modified to reflect clinical competence at the end of the twenty-four (24) month period.

1.4.4 Appointment to the Medical Staff shall confer on the appointee only such Clinical Privileges as have been granted by The Board of Trustees in accordance with these Bylaws. An applicant shall be deemed ineligible for Membership in the absence of any approved Clinical Privileges, with the exception of appointees to the Affiliate and Emeritus categories, who shall be exempt from this requirement.

1.4.5 Any physician, dentist, podiatrist or oral surgeon who has a contractual relationship with the Hospital or an administrative position that requires Membership and/or privileges shall comply with all qualifications set forth in these Bylaws and shall be required to submit an application in the same manner as all other applicants.

ARTICLE II
MEDICAL STAFF CATEGORIES

2.1 The Medical Staff

(a) The Medical Staff shall consist of the following categories: Active, Associate, Affiliate, and Emeritus. Each Member approved for appointment to the Medical Staff must be assigned to a specific Medical Staff category and clinical department.

(b) Initial appointment to the Active and Associate Staff categories will be for twenty-four (24) months. Each member of the medical staff is required to complete Focused Professional Practice evaluation (FPPE).

(c) At reappointment, a Member who does not meet the criteria for continuing in the same category may be reassigned to the appropriate category if the Member meets the eligibility requirements for such category.

(d) Appointees to the Active and Associate staffs must maintain at least a minimum level of Clinical Privileges and meet the requirements of the Medical Staff *Credentialing & Privileging* and *Peer Review* policies including demonstrating training and the areas of general competencies for Ongoing Professional Performance Evaluation (OPPE): patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

(e) Appointees to Affiliate and Emeritus staff are granted membership without admitting or Clinical Privileges.

(f) Each Member may receive Medical Staff and Hospital communications as is appropriate for his or her category, attend Hospital-sponsored continuing medical education and other educational activities, use the Hospital library, and attend meetings of the Medical Staff and of his or her

[1] 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.

respective department.

2.1.1 Active Staff

(a) Qualifications: Appointees to this category must:

(1) continuously meet the qualifications for Membership as stated in Article I, Section 1.2.1 of these Bylaws and those relevant for assignment to the appropriate clinical department;

(2) admit or otherwise be involved in at least twenty-four (24) "Patient Contacts during the initial twenty-four (24) month appointment period and at least twenty-four (24) "Patient Contacts" during each subsequent twenty-four (24) month term of reappointment; or

provide teaching and/or research services under an agreement with the Hospital as further detailed in the Medical Staff *Credentialing & Privileging* policy. (The Member shall notify Medical Staff Services if his/her agreement with the Hospital to provide teaching or research services terminates.); and

(3) be trained and competent to use the Hospital's electronic health record system.

(b) Prerogatives: Active Staff members may:

(1) exercise such Clinical Privileges as are granted by the Board of Trustees;

(2) vote on all matters presented by the Medical Staff, the Member's department, and any committees to which the Member is assigned and is a voting member; and

(3) hold Medical Staff and departmental office and may be appointed to and/or serve as the Chair of committees in accordance with any qualifying criteria set forth in these Bylaws and the Medical Staff Rules & Regulations.

(c) Responsibilities: Appointees to this category shall:

(1) contribute to the organizational and administrative affairs of the Medical Staff by participating in Medical Staff activities and functions including but not limited to: participation on Medical Staff and Hospital committees, in quality, patient safety, and performance improvement initiatives, peer review, risk management, utilization management, and other monitoring activities and Medical Staff functions as may be required;

(2) participate and support the educational activities of the Hospital as reasonably requested and assigned; and

(3) fulfill meeting attendance requirements, if any, as established by these Bylaws, their department Rules & Regulations or policy, or as otherwise specified by the Medical Executive Committee or Board of Trustees.

(d) Failure to Meet Qualifications under Subsection 2.1.1(a):

(1) If at the time of reappointment, an Active Staff Member who is past the initial twenty-four (24) month appointment term who has not met either of the qualifications under Subsection 2.1.1(a)(2) and/or has not had completed his/her Focused Professional Practice Evaluation (FPPE) process but has satisfied all other qualifications of membership will be automatically reassigned to another appropriate Medical Staff category at the beginning of the next appointment term or the Member may resign from the Medical Staff.

2.1.2 Associate Staff

(a) Qualifications: Appointees to this category must:

(1) continuously meet the qualifications for Medical Staff membership as stated in Article I, Section 1.2.1 of these Bylaws and those relevant for assignment to the appropriate clinical department;

(2) admit or otherwise be involved in no more than twenty-three (23) Patient Contacts during a twenty-four (24) month appointment period and no more than twenty-three (23) Patient Contacts during each subsequent twenty-four (24) month term of appointment;

(3) be trained and competent to use the Hospital's electronic health record system;

(4) provide Ongoing Professional Practice Evaluation (OPPE) data and/or see that OPPE data is provided in connection with one (1) or more non-Hospital facilities at which the Member practices as may be required under the Medical Staff *Credentialing & Privileging* policy; and

(5) maintain the equivalent of active staff category and privileges at another Joint Commission accredited hospital or at a surgery center accredited by the American Association for Accreditation of Ambulatory Surgical Facilities; or

have an OPPE satisfactory to the applicable Department Chair and the Credentials Committee at the time of reappointment. (Applicable to Members who have completed their initial appointment period.)

(b) Prerogatives: Appointees to this category may:

(1) exercise such Clinical Privileges as are granted by the Board of Trustees;

(2) not vote on Medical Staff or department matters, hold office, or chair any committee; and

(3) be appointed to any committee at the discretion of the Medical Staff President based on need for expertise and experience that cannot be readily fulfilled by the Active Staff and in such case, may vote on such committee matters unless otherwise specified in the committee descriptions in Article VIII of these Bylaws.

(c) Responsibilities: Appointees to this category shall:

(1) contribute to the organizational and administrative affairs of the Medical Staff by participating in Medical Staff activities and functions including but not limited to: participation in quality, patient safety, and performance improvement initiatives, peer review, risk management, utilization management, and other monitoring activities and Medical Staff functions as may be required;

(2) fulfill any meeting attendance requirements as established by these Bylaws, Medical Staff and department Rules & Regulations, the Medical Executive Committee, and/or the Board of Trustees; and

(3) participate and support the educational activities of the Hospital as reasonably requested and assigned.

(d) Failure to meet qualifications under Subsection 2.1.2(a):

(1) If at the time of reappointment, an Associate Staff Member who is past the initial twenty-four (24) month appointment term who has not met either of the qualifications under Subsection 2.1.2(a)(2) and/or has not had completed his/her Focused Professional Practice Evaluation (FPPE) process but has satisfied all other qualifications of membership will be automatically reassigned to another appropriate Medical Staff category at the beginning of the next appointment term or the Member may resign from the Medical Staff.

(e) Automatic Loss of Eligibility for Reappointment:

Non-reappointment to the Associate Staff as a result of incomplete OPPE data from the Associate Staff Member's current admitting hospital and/or non-admitting facility as required by Medical Staff policy, e.g. the *Credentialing & Privileging* policy, is not an Adverse Recommendation or Action and does not entitle the Member to any procedural rights of review.

2.1.3 Affiliate Staff

(a) Qualifications: Appointees to this category must:

(1) continuously meet the relevant qualifications for Medical Staff membership as stated in Article I, Section 1.2.1 of these Bylaws and for assignment to an appropriate clinical department; and

(2) be trained and competent to use the Hospital's electronic health record system if they have a need to view their patient's medical records.

Reappointment to this category is entirely discretionary and subject to intervals and criteria established by the Medical Executive Committee and approved by the Board of Trustees.

(b) Prerogatives: Appointees to this category may:

(1) make courtesy rounds on their patients;

(2) not be granted any Clinical Privileges at Hospital;

(3) order therapeutic and diagnostic procedures to be performed at the Hospital on an outpatient basis in accordance with Hospital policy;

(4) not vote on Medical Staff or department matters, may not hold office, or Chair any committee;

(5) serve without vote on committees at the discretion of the Medical Staff President based on need for expertise and experience; and

(6) view their patients' records, subject to electronic health record requirements and Hospital policy.

(c) Responsibilities: Appointees to this category shall:

(1) continuously meet the basic qualifications for Membership as stated in Article I, Section 1.2.1 of these Bylaws and for the assigned clinical department; and

(2) comply with applicable federal and state laws and regulations, the Bylaws, Rules & Regulations, and policies of the Medical Staff and Hospital policies.

2.1.4 Emeritus Staff

(a) Qualifications:

Appointees to the Emeritus Staff category shall consist of those Members who have retired from clinical practice, who are of outstanding reputation, and have provided distinguished and verifiable service to the Hospital. They must have transferred from another category as defined in this Article II. Emeritus Staff members may not vote or hold office. Emeritus Staff status is entirely discretionary and subject to recommendation by the Department Chair, Medical Staff President, or Medical Executive Committee and approval by the Board of Trustees.

(b) Prerogatives:

Emeritus Staff members may serve without vote on committees at the discretion of the Medical Staff President based on need for expertise and experience. Participation is voluntary and not a requirement to maintain Emeritus Staff appointment.

(c) Responsibilities:

Emeritus Staff is an honorary category with no specific responsibilities. Emeritus Staff members are expected to serve as advocates of the Hospital and the Medical Staff.

ARTICLE III
CLINICAL DEPARTMENTS AND DIVISIONS

3.1 Departments and Divisions

The Medical Staff shall be organized into clinical departments. Each clinical department shall have a Chair and a Vice-Chair and shall be represented on the Medical Executive Committee by its Chair. A department can be further divided into clinical divisions, as appropriate, which are directly responsible to the department. A department must have at least five Active medical staff members. Additional departments or divisions of departments, as required from time to time, may be established by the Board of Trustees after considering recommendations from the Medical Executive Committee.

Current clinical departments and divisions are as follows:

Anesthesiology
Emergency Medicine
Family Medicine
General Surgery
- Colon & Rectal Surgery
- Pediatric Surgery
- Oral Maxillofacial Surgery
- Thoracic Surgery
- Trauma Surgery
- Vascular Surgery

Internal Medicine
- Allergy
- Cardiology
- Dermatology
- Endocrinology
- Gastroenterology
- General Internal Medicine
- Geriatric Medicine
- Hematology/Oncology
- Infectious Disease
- Nephrology
- Pulmonology/Critical Care
- Rheumatology

Medical Imaging
- Radiation Oncology

Neurology & Psychiatry
Neurosurgery
Obstetrics & Gynecology
Ophthalmology
Orthopedic Surgery
- Physical Medicine

Otolaryngology
Pathology
Pediatrics
Plastic Surgery
Podiatry
Urology

3.2 Departmental Assignment

The Medical Executive Committee shall, after consideration of the recommendations of the clinical departments and Credentials Committee, recommend initial departmental assignments for all Members and for all other approved Members with Clinical Privileges.

3.3 Department Functions

3.3.1 Developing Criteria for Granting Privileges.

Each clinical department shall provide the expertise for developing and recommending to the Medical Executive Committee written criteria for assignment of Clinical Privileges, based on demonstrated

training and experience within the department and each of 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. The department shall forward its written criteria for assignment of Clinical Privileges to the Credentials Committee which in turn shall recommend the criteria to the Medical Executive Committee and the Board of Trustees for approval.

3.3.2 Quality and Safety Monitoring.

Each department shall participate in the Medical Staff mechanism for monitoring and evaluation of quality, patient safety, and appropriateness of care within the department. Findings and conclusions from monitoring and evaluation shall be presented at departmental meetings or in some other manner designed to communicate such findings and conclusions.

The department shall forward its summary review of focused professional performance evaluations (FPPE) and of ongoing professional performance evaluations (OPPE) on each Member and any concerns about the performance of a departmental member to the Clinical Risk Review Committee (CRRC). The CRRC shall evaluate its plan to address any concerns identified. The CRRC will provide its review with any recommendation back to the department. Results of the CRRC's evaluation for FPPE and OPPE will be forwarded to the Performance Improvement Oversight Committee) PIOC and the Medical Executive Committee and shall be included in the Quality and Safety Monitoring report submitted to the Board of Trustees

3.3.3 Educational Activities**.**

Each department shall support performance improvement and patient safety education relevant to the clinical services provided by the department. Educational activities may consist of a review and presentation of relevant clinical topics at regularly scheduled departmental meetings or may consist of approved Continuing Medical Education activities on relevant clinical topics conducted outside of departmental meetings.

3.3.4 Coverage.

Each department shall provide adequate call coverage as approved by the Medical Executive Committee.

Coverage refers to:

a) being available to respond to requests for care of emergency department patients;

b) being available to respond to requests for hospital to hospital transfers in compliance with the Hospital's policy on transfers when no accepting physician has been specified to accept the patient; and

c) responding to a Member's request for inpatient consultation outside the usual and customary referral process which Members may have with one another.

3.3.5 Department Advisory Committees.

Each department shall determine the need to establish an Advisory Committee as a standing committee. A Standing department Advisory Committees shall be comprised of department staff members who have been elected to such committee by members of the department. The Advisory Committee shall assist the Chair and the Vice-Chair in completing the function of their offices and those of the department. The size, composition and functioning of the committee shall be at the discretion of the department. The Department Chair and Vice-Chair shall serve as voting members of the Advisory Committee.

The functions of the Advisory Committee shall be to:

(a) review initial applications for Medical Staff membership.

(b) review reappointment applications for membership.

(c) establish credentials criteria for new procedures.

(d) evaluate requests for professional review activities involving department members.

(e) advise the department Chair as requested.

3.3.6 A special meeting of a department may be called by or at the request of the Chair, the President, or by a petition signed by not less than one-fourth (1/4) of the voting members of the department. In the event a department must act on a question without being able to meet, the voting members may be presented with the question, in person or by mail, and their vote returned to the department Chair. The results shall be binding as long as the question is voted on by a majority of the department members eligible to vote.

3.4 Designated Department Chairs

Any clinical department on a majority department vote may request the Hospital President in consultation with the Medical Staff President and Chief Medical Officer to appoint a Department Chair ("Designated Department Chair") for a clinical department that requires additional administrative leadership duties due to Graduate Medical Education, clinical research, or other strategic needs. A Designated Department Chair must meet the qualifications in Section 3.5.1. The term of a Designated Department Chair shall be three years and they may serve consecutive terms. Any contract between the Hospital and the Designated Department Chair shall require the performance of the duties under Section 3.6

3.5 Department Chair & Vice Chair

Each department shall have a Chair and Vice-Chair. The Chair shall have responsibilities as listed below. When the Chair is a Designated Department Chair, then the Department Vice Chair must be elected from members of the department. The departments of Emergency Medicine, Pathology, Radiation Oncology and Radiology are Hospital-based departments, staffed by physicians through exclusive written agreements with a single physician entity.

The Chair of each department staffed by physicians through exclusive written agreements shall be a representative of the physician entity, and each of such Chairs shall select the Vice-Chair of each applicable department.

3.5.1 Each Chair and Vice-Chair, including a Designated Department Chair, shall be a member of the Active Staff who is qualified by training, experience, and demonstrated ability for the position. Nominations of the Chair shall be based on professional competence, participation at the Hospital, and administrative and leadership abilities. The Chair and Vice-Chair of every department shall be certified by an appropriate specialty board.

3.5.2 The following shall be the procedure for election of department Chairs and Vice-Chairs other than a Designated Department Chair:

(a) The election of a department Chair and Vice-Chair shall be for a three (3) year term. Nominations for each of the positions of Chair and of Vice-Chair shall be made by the department. These nominations shall be ratified by the Medical Executive Committee. Following such ratification, ballots shall be distributed to active members of the department for voting. The results of the election shall be submitted to the Medical Executive Committee and the Board of Trustees for final approval. In the event the election results end in a tie, a run-off election will occur prior to submission to the Medical Executive Committee. A majority vote of votes will determine the election. In the event this process is unable to produce a decision, the Board of Trustees shall appoint a Search Committee from among members of the Medical Staff and the Board of Trustees to make a recommendation to the Board of Trustees.

(b) The election of a Chair and Vice-Chair after the initial three (3) year term of office shall follow the same procedure.

(c) After election and ratification, recommendation for removal of a department Chair or Vice-Chair from office may occur for cause by a two-thirds vote of the Medical Executive Committee or the department members eligible to vote in the department. Just cause may include, but not be limited to failure to carry out the usual and expected duties of the office, failure to remain a member in good standing of the Medical Staff, failure to comply with applicable laws, regulations and the Joint Commission standards or Medicare Conditions of

Participation, failure to comply with professional ethics, or failure to observe Medical Staff Bylaws, policies or procedures. Any removal requires both the approval of the Medical Executive Committee and the Board of Trustees.

(d) The Medical Executive Committee has established the process for staggered terms for department Chairs and Vice-Chairs.

(e) The three (3) year term for elected department Chairs and Vice-Chairs shall begin in January 1 consistent with the Medical Staff Year. The Medical Executive Committee, by a two-thirds (2/3) majority vote at a duly called meeting at which a quorum is present may approve a start date other than January 1 for Chairs and Vice-Chairs and may approve a term for a period longer than three (3) years not to exceed four (4) years.

3.6 Department Chair Responsibilities

The department Chair shall have the responsibility for performing the following functions:

(a) All clinically related activities of the department;

(b) All administratively related activities of the department, unless otherwise provided for by the Hospital;

(c) Continuing surveillance of the professional performance of all Members in the department who have delineated Clinical Privileges;

(d) Recommending to the Medical Staff the criteria for Clinical Privileges that are relevant to the care provided in the department;

(e) Recommending Clinical Privileges for each department member;

(f) Assessing and recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the department or the organization;

(g) The integration of the department or service into the primary functions of the organization;

(h) The coordination and integration of interdepartmental and intradepartmental services;

(i) The development and implementation of policies and procedures that guide and support the provision of services;

(j) The recommendations for a sufficient number of qualified and competent persons to provide care or service;

(k) The determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care services;

(l) The continuous assessment and improvement of the quality of care and services provided;

(m) The maintenance of quality control programs, as appropriate;

(n) The orientation and continuing education of all persons in the department or service;

(o) Recommendations for space and other resources needed by the department or service; and

(p) Represent the department as a voting member of the Medical Executive Committee.

3.7 Responsibilities of Department Vice-Chairs

The Department Vice-Chair shall:

(a) Function in an advisory capacity to the department Chair, particularly in the area of patient safety, performance monitoring, and quality improvement;

(b) Serve as acting Chair when the department Chair is not available and assume the responsibilities of that position;

(c) Be available to serve as the representative of the department on the Medical Executive Committee in the absence of the Chair;

(d) Serve for a three (3) year term in the respective departments; and

(e) Have other authority and responsibilities as delegated by the department Chair.

3.8 Chair and Vice-Chair of Surgical Services

In addition to the Chair of each surgical department, there shall be a Chair and Vice-Chair of Surgical Services. The person so nominated shall be ratified by the Medical Executive Committee and approved by the Board of Trustees. The term of office shall be in accordance with the terms of the Chair's contract with the Hospital. The Chair's term of office shall be in accordance with these Bylaws. Removal of the Chair of Surgical Services can be initiated by a two-thirds (2/3) majority vote of all Chair of surgical departments, in the manner as set forth in these Bylaws, but no such removal shall be effective unless and until it has been ratified by the Medical Executive Committee and approved by the Board of Trustees.

3.8.1 The responsibilities of the Chair of Surgical Services shall include:

(a) Act as Chair of the Surgical Services Committee;

(b) Promote operational efficiency and effectiveness of surgical resources;

(c) Assist in the development, implementation and enhancement of mechanisms for measuring the quality of Surgical Services;

(d) Develop and support programs to promote development of surgical services;

(e) In conjunction with Department Chair, resolve interdepartmental and inter-disciplinary professional conflicts;

(f) Monitor compliance with all regulatory agencies as they pertain to the Hospital's surgical service activities; and

(g) Assist the respective surgical department chairmen in the performance of their responsibilities when necessary or requested.

3.8.2 The responsibilities of the Vice-Chair of Surgical Services shall include:

(a) Representing the Chair on committees in his/her absence; and

(b) Assisting the Chair in delegated duties.

ARTICLE IV
PROCEDURE FOR INITIAL APPOINTMENT/REAPPOINTMENT; BASIC RESPONSIBILITIES ACCOMPANYING MEDICAL STAFF APPOINTMENT

4.1 Definitions

4.1.1 Complete Application - A "complete application" as used herein is defined as follows:

(a) The application form has been filled out and signed by the applicant;

(b) All questions on the form have been answered to the satisfaction of the Credentials Committee and/or other applicable Medical Staff Committees and supplemental information as indicated has been included (e.g. malpractice claims, military separation record (DD214), copies of licenses, DEA, DPS certificates, case lists, CME etc.);

(c) 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 committees have been received;

(d) Questions/Issues raised during the processing of an application, if any, have been resolved to the department Chair's satisfaction;

(e) 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 competency and acceptable performance.

4.1.2 Hospital and its Authorized Representatives. The Hospital and any of the following individuals who have any responsibility for obtaining or evaluating the applicant's credentials or acting upon the individual's application or conduct in the Hospital: The members of the Board of Trustees and their appointed representatives; the Hospital President and/or his/her designee; other Hospital employees; consultants to the Hospital; the Texas Health Resources Legal Department, and all departments, sections, committees, or Medical Staff Members and/or their agents.

4.1.3 Third Parties/Other Parties. All individuals, including Medical Staff Members, and members of the medical staffs of other hospitals or other physicians or health practitioners, nurses or other organizations, associations, partnerships and corporations or government agencies, whether hospitals, health care facilities or not, from whom information has been requested by the Hospital or its authorized representatives.

4.2 Duties and Obligations of Applicants and Members

Every applicant for initial appointment or reappointment to the Medical Staff and every Member shall acknowledge and agree:

4.2.1 to provide continuous care and supervision to all patients within the Hospital for whom he/she has responsibility;

4.2.2 to comply with assigned call coverage responsibilities according to Hospital, Medical Staff and Departmental policies and to provide care to applicable patients treated as a result of a call coverage assignment without regard to ability to pay;

4.2.3 to abide by the Medical Staff Bylaws, Medical Staff Rules & Regulations and policies of the Medical Staff and Hospital, as shall be in force from time to time, and acknowledge that he/she shall be subject to review as part of the Hospital's performance improvement activities;

4.2.4 to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned by the Medical Executive Committee;

4.2.5 to provide the Credentials Committee or Medical Executive Committee with current information regarding all questions on the application form at any time, and to provide new or updated information that is pertinent to any question on the application form as soon as a change or new information becomes available;

4.2.6 to agree to be bound by these Bylaws, and the Medical Staff Rules & Regulations in all matters relating to consideration of the application without regard as to whether or not appointment to the Medical Staff and/or Clinical Privileges are granted;

4.2.7 to disclose current and past health status sufficient to determine the applicant's ability perform requested privileges (with reasonable accommodation, if any) and to fulfill the requirements of Membership as defined in these Bylaws.

4.2.8 to appear for personal interviews in regard to the application;

4.2.9 to disclose a) whether he/she has been the subject of voluntary or involuntary termination of membership, suspension, reduction or loss of Clinical Privileges; b) whether probation, involuntary leave of absence or proctoring requirements have been imposed by any hospital or health care facility; c) any resignation from a hospital or health care facility pending an investigation; and/or d) any pending investigation or actions taken based on professional competence or conduct that could

result in an adverse action, or actions taken by any licensing agency, certification board, professional society, or government agency, including exclusion from the Medicare, Medicaid, or any other governmental program.

that any misrepresentation or misstatement in, or omission from, the application, whether intentional or not, or discovery of such misrepresentation, misstatement or omission after appointment or clinical privileges have been granted, shall result in automatic action under Section 9.8;

4.2.11 to disclose any prosecution, criminal conviction, plea of guilty, deferred adjudication, or no contest pertaining to any felony or misdemeanor (including motor vehicle violations);

4.2.12 to abide by generally recognized ethical and professional standards applicable to his/her profession; and

4.2.13 to disclose any pending or completed action, whether voluntary or involuntary, involving denial, revocation, cancellation, suspension, reduction, limitation, lapse, cancellation, imposition of proctoring, or probation relating to any of the following, and any non-renewal or relinquishment of or withdrawal of an application for any of the following to avoid investigation or possible disciplinary or adverse action:

(a) license or certificate to practice any health-related profession in any state or country;

(b) DEA or a state-controlled substance registration;

(c) membership or fellowship in local, state or national health or scientific professional organizations;

(d) faculty appointment at any medical or other professional school;

(e) appointment, medical staff membership, employment or membership status, or clinical privileges at any other hospital, clinic or health care facility;

(f) participation in a managed care agreement.

(g) to disclose any final judgments or settlements relating to any professional liability claims involving the applicant or Member.

4.2.14 A history and physical examination (H&P) must be completed on all patients no more than thirty (30) days prior to admission and no later than twenty-four (24) hours following admission. The H&P shall be entered in the medical record within twenty-four (24) hours after the patient's admission. If an H&P has been performed within the thirty (30) days prior to admission, the H&P report or a legible copy of the report may be used provided the H&P is updated and any changes are noted in the admission note or on the H&P within twenty-four (24) hours after admission but prior to surgery or any procedure requiring anesthesia. If there are no changes, the statement "nothing has changed" or "no changes" will be documented and the H&P re-dated and signed. Any H&P performed over thirty (30) days prior to admission will not be accepted.

4.2.15 H&Ps must be recorded and entered in the medical record before any surgery or procedure requiring anesthesia is performed unless the surgeon documents in the medical record that any delay to record the H&P would be a hazard to the patient. For emergency admissions, a brief description of the patient's condition should be immediately entered in the medical record pending completion of the H&P. H&Ps (including any updated H&Ps) shall be completed by a physician or Allied Health Professional with appropriate Clinical Privileges. An H&P completed by a physician who is not a Member may be used and included in the patient's medical record provided it is co-signed by the admitting physician. H&Ps shall also comply with the requirements stated in the Rules & Regulations.

4.3 <u>Applicant's Burden of Providing Information</u>

4.3.1 Any applicant applying for appointment or reappointment to the Medical Staff and/or for Clinical Privileges shall have the burden of providing complete information that the Hospital or its Medical Staff deems necessary to evaluate the applicant's experience, competence, character, ethics, ability to work cooperatively with others, physical and mental health status, and other relevant factors to

determine the applicant's qualifications for Membership, staff category, and privileges. The applicant shall have the burden of providing evidence that all information provided, and statements made on the application are correct. An application may become incomplete at any time if the need arises for new, additional, or clarifying information.

4.3.2 The applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the Clinical Privileges and Staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. This burden may include submission to a medical or psychological examination,

at the applicant's expense, if deemed appropriate by the Medical Executive Committee, which may select the examining physician.

4.3.3 The applicant or Member has a duty to advise the Hospital of any change with respect to information previously submitted by him or her related to his or her credentials. The applicant or Member shall report to the Hospital any change in information, including but not limited to any adverse action and/or professional review activity by a licensure board, federal or state health care program, or another healthcare facility within ten (10) calendar days of actual knowledge of the action. For purposes of this section, adverse action shall mean any action based on professional competence or conduct that affects the licensure, membership or Clinical Privileges of an applicant or Member.

4.3.4 Failure to completely respond and comply with a request by the department Chair and/or Credentials Committee, within twenty-one (21) calendar days for new, additional, or clarifying information, assistance, or an interview regarding any portion of the application, shall be deemed a voluntary withdrawal of the entire application for appointment or reappointment depending upon the nature and extent of the additional information, assistance or interview deemed necessary.

Failure to respond completely and comply with a request, within twenty-one calendar (21) days for new, additional, or clarifying information, assistance or an interview to support a request for Clinical Privileges shall be deemed a voluntary withdrawal of the application for the Clinical Privileges which are the subject of the request for additional information, assistance or the interview.

4.3.5 An applicant whose application is deemed withdrawn shall be notified in writing of the withdrawal and that the application will not be processed. An applicant whose application is deemed withdrawn is not entitled to any of the procedural rights or processes outlined in Articles IX and X of these Bylaws.

4.4 <u>Privileged Peer Review Information; Authorization to Obtain, Release Information</u>

4.4.1 <u>Privileged peer review information</u>.

Information submitted by the applicant is considered peer review information and shall be privileged to the fullest extent permitted by law. Such privilege shall extend to the Hospital, the Medical Staff and their authorized representatives, and to any third parties.

4.4.2 <u>Authorization for Release of Information by Third Parties</u>.

By signing and submitting an application, the applicant specifically authorizes the Hospital, the Medical Staff and their authorized representatives to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter reasonably having a bearing on the individual's satisfaction of the criteria for initial and continued appointment to the Medical Staff. This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be relevant to such questions. In addition, the applicant specifically authorizes said third parties to release said information to the Hospital and its authorized representatives upon request.

4.4.3 <u>Authorization to Release Information to Third Parties</u>

The applicant specifically authorizes the Hospital, the Medical Staff and their authorized representatives to release such information to other Hospitals, health care facilities and their agents,

who solicit such information for the purpose of evaluating the applicant's professional qualifications pursuant to the applicant's request for appointment, reappointment, and/or Clinical Privileges.

4.5 Submission of Initial Appointment Application

4.5.1 Initial Application.

Applications for appointment to the Medical Staff shall be in hard copy providing legible information and original signatures as indicated, and shall be submitted on forms recommended by the Credentials Committee and approved by the Medical Executive Committee in addition to submission of a completed standard Texas Department of Insurance application form required under Texas law. These forms shall be available by request from the Hospital's Medical Staff Office.

The application shall contain a request for specific Clinical Privileges desired by the applicant, shall be accompanied by the application fee, and shall require detailed information concerning the applicant's professional qualifications. The specific information to be included in the application and the procedure to be followed may be further defined by the Credentials Procedure Manual approved by the Credentials Committee and Medical Executive Committee.

4.5.2 Application Review/Recommendation Process.

When an application is deemed to be a complete application, as defined herein, the application shall be forwarded to the Chair of the appropriate department(s) for review of the application for Membership and requested Clinical Privileges, if applicable.

4.5.3 Department Chair Procedure.

The Chair of each department in which the applicant seeks Clinical Privileges shall, within thirty (30) days of receipt, provide the Credentials Committee with specific written recommendations for approving or disapproving the application and the Clinical Privileges requested. The Chair's recommendations shall be made a part of the Credentials Committee's report for submission to the Medical Executive Committee. As part of the process of making this recommendation, the department Chair or members of the departmental Advisory Committee, where applicable, may require a meeting with the applicant to discuss any aspect of the application, qualifications and the requested Clinical Privileges.

4.5.4 Temporary Privileges for Applicants.

(a) Criteria. Subject to the Applicant meeting the conditions below, temporary Clinical Privileges for Applicants may be granted only to 1) Practitioners with a pending application for initial appointment to the Medical Staff, and 2) Members requesting new Clinical Privileges. 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.

To be eligible for temporary privileges, the Applicant must have:

(i) no current or previously successful challenge to licensure or registration;

(ii) not been subject to involuntary termination of Medical Staff membership at another health care facility; and

(iii) not been subject to involuntary limitation, reduction, denial, or loss of Clinical Privileges at another health care facility.

(b) After the application is deemed Complete and a favorable recommendation has been made by the Department Chair and the Credentials Committee, the Hospital President may grant a Practitioner temporary Clinical Privileges upon the Medical Staff President's recommendation for a period not to exceed one hundred twenty (120) days while awaiting Medical Executive Committee and Board of Trustees' approval. Temporary clinical privileges may not be renewed.

(c) Termination of Temporary Clinical Privileges.

Temporary privileges shall expire at the end of the time period for which they are granted and shall automatically terminate a) upon a final decision of the Board of Trustees, or b) upon issuance of an Adverse Recommendation or Action by the Medical Executive Committee or the Board. Temporary privileges shall be automatically modified to conform to the Medical Executive Committee's or the Board's recommendation that the Practitioner be granted Clinical Privileges that are different from the privileges requested.

The Hospital President or his designee 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 may be effected by any person entitled to impose a precautionary suspension under Article IX. In the event of termination of temporary privileges, the Department Chair shall assist the Practitioner's patients then in the Hospital to select another Practitioner.

(d) 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.

4.5.5 Credentials Committee Procedure.

(a) The Credentials Committee shall review the application, supporting documentation and any recommendations from the Chair of the clinical department in which privileges are sought, and whether the applicant meets all of the necessary qualifications for the staff category and Clinical Privileges requested.

(b) As part of this process, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician or physicians satisfactory to the Committee and shall require that the results be made available for the Committee's consideration.

(c) If, after considering the recommendations of the applicable department Chair or Chairs, the Credentials Committee's recommendation for appointment is favorable, the Credentials Committee shall recommend to the Medical Executive Committee department assignment and Clinical Privileges.

(d) As part of the review process, the Credentials Committee may require the applicant to meet with the Committee to discuss any aspect of his/her application, his/her qualifications and his/her Clinical Privileges.

4.5.6 Credentials Committee Report.

The Credentials Committee shall make a written report and recommendation with respect to the applicant to the Medical Executive Committee, with a copy to the Hospital President or his/her designee, within thirty (30) days of receipt of a complete application

4.5.7 Medical Executive Committee Procedure.

(a) At its next regular meeting, after receipt of the application, and the Credentials Committee report and recommendation, the Medical Executive Committee shall determine whether to recommend to the Board of Trustees that the applicant be appointed to the Medical Staff, that his/her application be deferred for further consideration, or that his/her application for staff appointment or Clinical Privileges be denied. The recommendation and report of the Medical Executive Committee shall be promptly forwarded to the Board of Trustees with a copy to the Hospital President. All recommendations to appoint must also recommend the Clinical Privileges to be granted, which may be qualified by any probationary conditions relating to such Clinical Privileges.

(b) When the recommendation of the Medical Executive Committee is an Adverse Recommendation to the applicant with respect to either appointment or Clinical Privileges, the Hospital President or his/her designee shall promptly so notify the applicant by certified mail, return receipt requested. The Hospital President or his/her designee shall then hold the application until after the applicant has exercised or has been deemed to have waived his/her right to a hearing as provided in these Bylaws, after which the Hospital President shall forward the recommendation of the Medical Executive Committee, together with the application and any necessary supporting documentation, to the Board of Trustees unless the applicant has requested mediation as set forth in Section 4.1.14 below.

4.5.8 Board of Trustees.

At its next regular meeting after receipt of a recommendation from the Medical Executive Committee, the Board of Trustees shall review the recommendation.

(a) If the Board of Trustees' decision is not adverse to the applicant, the Hospital President shall promptly notify the applicant of the decision.

(b) If the Board of Trustees' decision is adverse in any respect, the Hospital President shall inform the applicant by written notice of the decision.

(c) If the Board of Trustees' decision is to refer the recommendation back to the Medical Executive Committee for further consideration, the referral should state the reason(s) for such referral and set a time limit within which a subsequent recommendation must be made back to the Board of Trustees. If the Medical Executive Committee's subsequent recommendation after referral is an Adverse Recommendation to the applicant, the Adverse Recommendation shall be processed as provided in Article X of these Bylaws.

In any event, the Board of Trustees shall take final action not later than the sixtieth (60th) day after the date on which the recommendation of the Credentials Committee is received. The Hospital must notify the applicant of the final action not later than the twentieth (20th) day after the date on which the final action is taken. If the Hospital has failed to take action on a Complete Application within the timeframe outlined in this Section, if requested, the Hospital will participate in mediation before an impartial third party in accordance with Article X of these Bylaws.

4.5.9 Appointment to Category and Department.

Appointments shall be made upon recommendation by the applicable clinical department and section, Credentials Committee and the Medical Executive Committee, and shall be to one of the approved categories of the Medical Staff. All Members shall be appointed to a specific department and section but shall be eligible for Clinical Privileges in other departments. All initial appointments to the Medical Staff and Clinical Privileges, regardless of the category of the staff to which the appointment is made, shall be for a period of twenty-four (24) months from the date of the appointment in order to evaluate the Member's performance.

4.6 Reappointment Process

4.6.1 Each Member who wishes to be reappointed to the Medical Staff shall complete and sign a reappointment application form required by these Bylaws and in accordance with the procedures stated in the Credentials Procedure Manual.

A Member who maintains a contractual relationship with the Hospital shall be required to comply with the reappointment process required under these Bylaws and the Credentials Procedure Manual.

4.6.2 Members over age 70.

Members who request privileges after age 70 shall be required to have a history and physical exam performed by an examining physician prior to reappointment. The examining physician shall have an active primary care practice or perform executive physical examinations in a clinic setting, shall not be a partner of the applicant and shall be capable of evaluating the Member's physical ability to perform privileges being requested and to work cooperatively in a hospital setting. The Credentials Committee shall require the examining physician to provide a written report in a prescribed general

format approved by the committee for it to determine if the Member has any limitations that may need to be considered by the Board of Trustees at the time of reappointment. The reappointment application will be considered incomplete without the report.

A Member may request consideration for conflict resolution pursuant to Section 4.4 below in the event the assessment indicates the need for a reduction or relinquishment of privileges, the Chair agrees, and the Member disagrees. The examining physician shall be available to discuss in person the written report with the ad hoc committee when requested to be present. Any final action for reduction or relinquishment of privileges or denial of reappointment shall be subject to appellate review as specified in Article X of these Bylaws.

4.6.3 The applicable clinical department shall forward the completed and signed reappointment application to the Credentials Committee prior to the expiration of the Member's then current appointment.

The applicable clinical department shall forward a recommendation to the Credentials Committee within a suitable time frame to allow review and approval by the Medical Executive Committee and Board of Trustees prior to expiration of the Member's appointment period. If a Member fails to submit a timely reappointment application without good cause, Membership and privileges shall cease with the expiration of the current appointment. Continued appointment, if granted, shall be for a period of not more than two (2) years.

4.6.4 Factors to be Considered for Reappointment or Change in Staff Category

Factors to be considered when recommending a Member for reappointment or a change in staff category or privileges, where applicable, shall include without limitation:

(a) ethical behavior, clinical competence, clinical judgment, and technical skill in the treatment of patients, including the results of professional practice and evaluation activities conducted by the Hospital and the Medical Staff and information on the Member's compliance with performance improvement requirements, if any.

The six (6) competencies chosen to guide evaluation are Patient Care, Medical Knowledge, Practice Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism and System-Based Practice as delineated in the Medical Staff Peer Review policy.

In the event an Active or Associate Staff Member has not met the qualifications set forth in Section 2.1.1(a) or 2.1.2(a), respectively, and is not eligible for another Medical Staff category, the Member will be deemed to have resigned at the end of his/her appointment term. In such instance, the Member will not be eligible for reappointment or new or continued privileges for a period of one (1) year from the effective date of the deemed resignation. Such Member may apply as a new applicant at any time after the one (1) year period.

(b) attendance at Medical Staff meetings and participation in Medical Staff duties, including committee assignments and coverage responsibilities;

(c) compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Hospital;

(d) behavior at the Hospital (as guided by the Medical Staff's Code of Conduct policy);

(e) physical and mental health status indicating the applicant's ability to perform Medical Staff duties and exercise the requested privileges competently and safely and to work cooperatively with others in the hospital setting;

(f) any drug, chemical, alcohol or behavioral problem which could affect the ability to exercise the requested Clinical Privileges or provide professional care or information on treatment for use of or dependency on any of these;

(g) capacity to satisfactorily treat patients as indicated by the results of the Hospital's performance improvement and professional and peer review activities;

(h) current ability to safely and competently exercise the Clinical Privileges requested and perform the responsibilities of Medical Staff appointment;

(i) satisfactory completion of such continuing education requirements as may be imposed by law, the appropriate clinical department or the Medical Staff;

(j) any pending or completed action, whether voluntary or involuntary, involving denial, revocation, cancellation, suspension, reduction, limitation, lapse, cancellation, or probation of any of the following, and any non-renewal or relinquishment of or withdrawal of an application for any of the following to avoid investigation or possible disciplinary or adverse action:

    (1) license, registration, or certificate to practice any health-related profession in any state or country;

    (2) DEA or a state-controlled substance registration;

    (3) membership or fellowship in local, state or national health or scientific professional organizations;

    (4) faculty appointment at any medical or other professional school;

    (5) appointment, membership or employment status prerogatives or Clinical Privileges at any other hospital, clinic or health care facility;

    (6) participation in a managed care agreement;

(k) final judgments or settlements relating to any professional liability claims involving the Member;

(l) continuous professional liability insurance coverage (as defined in the Definitions section above);

(m) verification of current licensure by the Texas Medical Executive Committee;

(n) verification of such other registrations or certification as required by these Bylaws, or Medical Staff policy;

(o) morbidity and mortality data and relevant Member specific data as compared to aggregate data, when available;

(p) any prosecution, deferred adjudication, plea of guilty, no contest, or conviction of a felony or a misdemeanor (including motor vehicle violations);

(q) references;

(r) expected level of involvement in patient care at the Hospital;

(s) name of a Member for patient care back-up coverage purposes;

(t) evidence of the applicant's agreement with the confidentiality, immunity, and release provisions of these Bylaws and the Medical Staff Rules and Regulations;

(u) documentation of continuing medical education in accordance with the requirements of the Texas Medical Executive Committee with at least fifty (50) percent of required hours earned pertaining to the Member’s specialty of practice;

(v) specialty or subspecialty board certification indicating the field certified in and the board issuing the certification, re-certification, or status in the certification process according to the particular board's requirements; and

(w) any other reasonable indicators of continuing qualifications.

4.6.5 Department Procedure.

(a) In accordance with the Credentials Procedure Manual, prior to the end of the current appointment period, the Credentials Committee shall transmit to the Chair of each department a current list of all members who have Clinical Privileges in that department, together with the Clinical Privileges each then holds, accompanied by copies of their applications. As described by the Credentials Procedure Manual, after an application is received, the Chair of the appropriate department shall transmit to the Credentials Committee the list of individuals recommended for reappointment. The recommendations shall include (1) any changes in staff category or Clinical Privileges for each Member; (2) non-reappointment recommendations for those who applied for changes and those who did not; and (3) the reasons for (1) and (2) above.

(b) Recommendations for increase or decrease of Clinical Privileges by the department Chair shall be based upon relevant recent training and upon evaluation of patient care provided, review of the records of patients treated in this Hospital by the Member and review, as required, of all other appropriate available records of the Medical Staff including the results of Medical Staff monitoring and evaluation activities that evaluate the member's participation in the delivery of medical care.

(c) If the recommendation is a reduction in privileges, the department Chair and the Advisory Committee, where applicable, shall meet with the Member to present the reason(s) for the reduction and provide the Member the opportunity to respond.

(d) If the recommendation of the department Chair is different from that of the Advisory Committee, both recommendations with the supporting rationale shall be forwarded to the Credentials Committee.

4.6.6 Credentials Committee Procedure.

(a) The Credentials Committee, after receiving recommendations from the Chair of each department, shall review all pertinent information available including all information provided from other committees of the Medical Staff and from Hospital Administration for the purpose of determining its recommendations for staff reappointment, for change in staff category, and for the granting of Clinical Privileges for the ensuing appointment period.

(b) The Credentials Committee may require that a person currently seeking reappointment provide information regarding his/her physical or mental health status or procure a physical and/or mental examination by a physician or physicians satisfactory to the Committee, either as part of the reapplication process or during the appointment period, to aid it in determining whether Clinical Privileges should be granted or continued, and make the results available for the Committee's consideration. In such case, the Credentials Committee Chairman will notify the Member’s Department Chairman. Failure of the person seeking reappointment to provide such information or to procure such an examination within thirty (30) days after being requested to do so in writing by the Credentials Committee could result in termination of Medical Staff membership at the end of the appointment period due to failure to complete the reappointment requirements of the Credentials Committee.

(c) The Credentials Committee shall prepare a list of persons currently holding appointment who are recommended for reappointment without change in staff category and Clinical Privileges. Recommendations for non-reappointment and for changes in category or privileges, with supporting data and reasons attached, shall be reported separately.

(d) The Credentials Committee shall transmit its report and recommendations to the Medical Executive Committee in time for it to consider this report at its next meeting unless delayed for good cause. When non-reappointment, non-promotion of an eligible Member, or a change in Clinical Privileges is recommended, the reason for such recommendation shall be stated, documented and included in the report. The Chair of the Credentials Committee or his/her designee shall be available on request to the Medical Executive Committee or to the Board of Trustees, or its appropriate committee, to answer any questions that may be raised with respect to the recommendation.

(e) If during any appointment period a Member shall fail to meet the activity levels defined by these Bylaws for the applicable category, it shall result in a recommendation for appointment to a category appropriate to the activity level of the Member. Members who do not meet the minimum activity level as defined shall not be recommended for reappointment.

4.6.7 Adverse Recommendation.

Any recommendation by the Medical Executive Committee denying reappointment, denying a requested change in staff category that remains in compliance with category definitions in Article II of these Bylaws or Clinical Privileges or recommending reduction of existing Clinical Privileges shall entitle the affected Member to the procedural rights provided in these Bylaws, if such action is grounds for a hearing as defined in section 10.2.1. and is not a deemed resignation for failure to use the Hospital, failure to complete the reappointment application in a timely manner, or as otherwise provided herein. The Hospital President shall then promptly notify the Member of the recommendation by certified mail, return receipt requested. The recommendation shall not be forwarded to the Board of Trustees until the Member has exercised or has been deemed to have waived his right to a hearing as provided in these Bylaws, after which the Board of Trustees shall be given the Medical Executive Committee's final recommendation and shall act on it.

4.7 Basic Responsibilities Accompanying Medical Staff Appointment

Each Member, regardless of assigned Medical Staff category including Members exercising temporary privileges shall:

(a) provide his/her patients with care at the level of quality and efficiency professionally recognized as appropriate at facilities, such as the Hospital;

(b) abide by these Bylaws and the Rules & Regulations of the Medical Staff and applicable departments, and all other lawful standards, policies, and procedures of the Medical Staff and Hospital;

(c) discharge such Staff, committee, Department, and Hospital functions for which he is responsible by Medical Staff category, appointment, election or otherwise;

(d) be available, if requested, for an interview as required by these Bylaws;

(e) prepare and complete in timely, accurate and legible fashion the medical and other required records for all patients he admits or in any way provides care to in the Hospital;

(f) participate in quality improvement and patient safety initiatives regarding measuring, assessing and improving the accurate, timely and legible completion of patients' medical records;

(g) provide or arrange for appropriate and timely medical coverage and care for patients for whom he/she is responsible;

(h) meet the Emergency Department and other call coverage responsibilities of these Bylaws and the applicable department or division;

(i) to provide and update the information requested on the original application and subsequent re-applications or privilege request forms within five (5) days of the Member's knowledge of any change in the information provided on the most current application form and to provide all information requested by the Hospital or its Medical Staff including the information required under Section 4.2 above; and

(j) any changes in health status which might impair the Member's ability to treat patients and/or which might require special accommodation on the part of the hospital in order to allow the Member to continue treating patients must be reported within three (3) days of such change.

Failure to satisfy any of these basic obligations is grounds for non-reappointment or for such professional review action as deemed appropriate by the Board of Trustees pursuant to these Bylaws, as applicable.

4.8 Conflict Resolution

Whenever possible, any conflict regarding specific Medical Staff privileges should be resolved between the Member requesting privileges and his/her department Chair prior to submission for Clinical Privileges to the Credentials Committee. In addition, whenever possible, jurisdictional disputes which develop related to privileges considered to be within the province of two (2) or more departments should be resolved by direct negotiations between the involved department Chairs prior to submission of Clinical Privileges to the Credentials Committee to attempt resolution of the conflict. Should the conflict result in an impasse, the President will appoint an ad hoc committee of no fewer than five (5) members with the concurrence of the involved parties. The Credentials Committee Chair will preside over the ad hoc committee. The recommendation(s) of the ad hoc committee will be brought to the Credentials Committee for recommendation.

ARTICLE V
CLINICAL PRIVILEGES

5.1 General

5.1.1 Appointment or reappointment to the Medical Staff shall not confer any Clinical Privileges or right to practice in the Hospital. Each Member who has been appointed to the Medical Staff shall be entitled to exercise only those Clinical Privileges specifically granted by the Board of Trustees.

(a) The Clinical Privileges recommended to the Board of Trustees shall be based upon the applicant's education, training, experience, demonstrated competence and judgment, references, and other relevant information, including an appraisal by the Chair of the clinical department in which such privileges are sought. The Member must not have a health problem that would prohibit him from performing the Clinical Privileges granted.

(b) In addition, information to be considered in the granting of Clinical Privileges shall include whether the applicant has:

(1) had any current or previously successful challenge to licensure or registration;

(2) been subject to termination of Medical Staff membership at another health care facility, whether voluntary or involuntary;

(3) been subject to limitation, reduction, denial or loss of Clinical Privileges at another health care facility, whether voluntary or involuntary; and

(4) had professional liability claims or lawsuits against him/her.

(c) Physicians in training in an ACGME approved residency program may be granted limited privileges at the request of an Active Staff member and approved by the Department and Medical Executive Committee. Limited privileges include:

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

(2) Initial assessment, and documentation of patient’s history;

(3) Order diagnostic studies;

(4) 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.

5.1.2 The applicant shall have the burden of establishing his/her qualifications for and competence to exercise the Clinical Privileges he/she requests. If the necessary information to establish this competence is not available at the Hospital, the applicant shall obtain this information from an acceptable health care facility and provide it to the Hospital before such privileges are granted or renewed.

5.1.3 The recommendations of the of the Chair of the clinical department in which privileges are sought shall be forwarded to the Credentials Committee and thereafter processed as a part of the initial application to the Medical Staff, a reappointment application, or as an isolated request for new privileges.

5.2 Requests for Changes in Clinical Privileges

5.2.1 Whenever during the term of his or her appointment to the Medical Staff a Member desires to change his or her Clinical Privileges (whether an increase or decrease), he or she shall apply in writing to the Chair of his or her clinical department on the appropriate form, specifying the changes he or she wishes to make.

The application shall state in detail the specific changes in Clinical Privileges desired and the applicant's recent training and experience which justify the change in privilege. If a decrease in 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 privileges with his or her recommendations to the Credentials Committee. Thereafter, it will be processed in the same manner as an application for initial Clinical Privileges, if the request is made during the term of appointment, or as a part of a reappointment application, if it is made at that time.

5.2.2 Recommendations for changes in Clinical Privileges submitted to the Credentials Committee 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 this or other hospitals and a review of all other records and information from applicable departments of the Medical Staff which evaluate the Member's medical practice and support the changes in privileges. The recommendation for such change in privileges may carry with it requirements for focused professional practice evaluation (FPPE), supervision, or consultation for such periods or time as are thought necessary.

5.3 Clinical Privileges for D.D.S. Oral Surgeons, Dentists, and Podiatrists

5.3.1 Clinical Privileges for D.D.S. Oral Surgeons and Dentists.

(a) The scope and extent of surgical procedures that a D.D.S. oral surgeon or dentist may perform in the Hospital shall be specified by the Division of Oral Maxillofacial Surgery and recommended in the same manner as other Clinical Privileges. Procedures performed by D.D.S. oral surgeons or dentists shall be under the overall authority of the Chair of General Surgery. A physician Member with appropriate Clinical Privileges shall obtain a medical history and perform a physical exam or by an oral surgeon with privileges to take patient medical histories and to perform physical exams before a procedure is performed. A designated physician shall be responsible for the medical care of the patient throughout the hospital stay.

(b) The oral surgeon or dentist shall be responsible for the dental care of the patient, including the dental history and dental exam as well as all appropriate elements of the patient's record. Oral surgeons and dentists may write orders within the scope of their license and their Clinical Privileges, consistent with the Medical Staff rules and regulations and in compliance with these Bylaws. The Oral Maxillofacial Surgery Division shall develop guidelines which shall be approved by the General Surgery Department and the Medical Executive Committee to define those activities where a physician is required to attend the patient.

5.3.2 Clinical Privileges for Podiatrists.

(a) The scope and extent of surgical procedures that a podiatrist may perform in this Hospital shall be specific and recommended to the Board of Trustees in accordance with the provisions of these Bylaws. Surgical procedures performed by podiatrists shall be under the overall authority of the Chair, Department of Podiatry. A physician Member with appropriate Clinical Privileges shall obtain a medical history and perform a physical exam on the patient before podiatric surgery is performed. A designated physician shall be responsible for the medical care of the patient throughout the hospital stay.

(b) The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric exam as well as all appropriate elements of the patient's record. The podiatrist may write orders within the scope of his/her license and consistent with the Medical Staff rules and regulations and in compliance with these Medical Staff Bylaws. All podiatrists shall abide by the podiatry protocols established by the Medical Staff and approved by the Board of Trustees.

5.3.3 Physician co-admitters.

Dentists, oral surgeons and podiatrists who do not have privileges to obtain patient histories and perform physicals may not admit patients without a physician co-admitter who is a Member. Obtaining the services of a physician co-admitter shall be the responsibility of the dentist, oral surgeon or podiatrist.

(a) The responsibilities of the physician co-admitter shall include:

(1) Obtaining and documenting medical history pertinent to the patient's general health;

(2) Performing a physical exam of the patient to determine the patient's condition prior to anesthesia; and

(3) Monitoring the patient's general health status while hospitalized.

(b) The responsibilities of the dentist, oral surgeon or podiatrist co-admitter shall include as appropriate to his/her practice:

(1) Providing a detailed dental or podiatric history justifying the Hospital admission;

(2) Providing a detailed description of the examination of the mouth or foot and a pre-operative diagnosis;

(3) Completing an operative report describing the finding(s) and the operative technique. Tissue shall be sent to the Hospital pathologist for examination in accordance with Hospital policy;

(4) Completing progress notes in the patient's record pertinent to the dental or podiatric medical condition;

(5) Providing a clinical resume or summary statement; and

(6) Obtaining coverage by a physician anesthesiologist.

5.4 Temporary Privileges for Non-Applicants and for Emergencies

5.4.1 Temporary Privileges to Non-Applicants for Medical Staff Membership.

(a) When an important patient care, treatment, and/or service need, which may include the need for proctoring and/or on-site education, mandates an urgent but non-emergent authorization to practice, temporary privileges may be granted to a practitioner by the Hospital President upon the recommendation of the Chair of the Department concerned, provided that the Hospital shall first verify the current licensure and competence of the practitioner. The Hospital President shall obtain such person's signed acknowledgment to be bound by the Hospital and Medical Staff Bylaws and Rules and Regulations that are then in force in all matters relating to temporary Clinical Privileges. Such privileges shall be of a limited time frame, not to exceed one hundred twenty (120) days and may not be renewed.

5.4.2 Termination of Temporary Clinical Privileges of Non-Applicants

(a) The Hospital President or his/her designee may at any time, upon the recommendation of the Medical Staff President and/or the department Chair responsible for the individual's supervision, terminate an individual's temporary privileges. Immediately upon the termination of Clinical Privileges, the Chair of the Medical Executive Committee or the appropriate department Chair shall have authority to arrange for alternative medical coverage for any hospitalized patient(s) of the suspended Member. The wishes of the

patient shall be considered in the selection of the alternative physician.

(b) The granting of any temporary admitting or Clinical Privileges is a courtesy on the part of the Hospital. Neither the granting, denial or termination of such privileges shall entitle the individual concerned to any of the procedural rights provided in these Bylaws with respect to hearings or appeals.

5.4.3 Care in an Emergency.

(a) Authorization. During an emergency, any qualified Practitioner , 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. 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.

(b) 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.

(c) 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.

5.5 Special Supervision and Reporting Requirements

Special requirements of supervision and reporting may be imposed by the appropriate department Chair on any person granted temporary Clinical Privileges and for privileges granted to non-members of the Medical Staff. The Hospital President or his/her designee shall immediately terminate temporary privileges upon notice of any failure by the individual to comply with such special conditions.

5.6 Clinical Privileges for Telemedicine Services

5.6.1 Practitioners who wish to provide telemedicine services for the purpose of prescribing, rendering a diagnosis, or otherwise providing clinical treatment to a Hospital patient, without clinical supervision or direction from a Medical Staff member, shall be required to apply for and be granted Clinical Privileges for such services. Note: Medical coverage services provided from a distant site to the Hospital by a Joint Commission accredited organization through a contractual arrangement are not considered telemedicine services under this section.

5.6.2 Credentialing of practitioners for privileges to perform telemedicine services to patients at the Hospital may be accomplished by:

(a) fully credentialing the practitioner providing telemedicine services as a member of the Active or Associate Staff according to the procedures set forth in Articles IV and V of these Bylaws;

(b) credentialing the practitioner providing telemedicine services in accordance with the procedures set forth in this Article V, using credentialing information provided by the site where the practitioner is providing the professional service (the "Distant Site"); or

(c) credentialing the practitioner based solely upon the credentialing information and decisions of the Distant Site if:

(1) the Distant Site is Joint Commission accredited;

(2) the practitioner is privileged at the Distant Site to provide those services to be provided at the Hospital; and

(3) the Hospital conducts an internal review of the practitioner's performance of these privileges at the Hospital and sends to the Distant Site information that is useful to the Distant Site's assessment of the practitioner's quality of care, treatment and services for use in privileging and performance improvement, including at a minimum: all adverse outcomes related to sentinel events (as defined by The Joint Commission) that are considered reviewable by The Joint Commission and result from the telemedicine services provided at the Hospital; and complaints about the practitioner from patients, Medical Staff members, or other staff at the Hospital.

(4) The privileges granted shall be subject to the approval of the Medical Executive Committee and the Board of Trustees

5.7 Temporary Disaster Privileges

5.7.1 Authority. If the Hospital's Emergency Operations Plan has been activated and the Hospital is unable to meet immediate patient needs, any Member of the medical staff or other Practitioner with Clinical Privileges, to the degree permitted by professional 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 licensed independent practitioners who are not Members of the Medical Staff by the Hospital President or Medical Staff President, or their designees, as provided in Hospital policy.[2]

5.7.2 Process.

(a) The process for granting temporary disaster privileges shall include the basic steps of photo identification where practitioners must at a minimum present a valid government-issued photo identification (e.g., driver's license or passport) and at least one (1) of the following:

(1) a photo ID card or badge from a health care organization that clearly identifies professional designation;

(2) a current license to practice;

(3) primary source verification of the license;

(4) identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advanced Registration of Voluntary Health Personnel (ESAR VHP), or other recognized state or federal organization or group;

(5) identification indicating that the individual has been granted authority by a government entity to render patient care, treatment, and services in disaster circumstances;

(6) confirmation by a licensed independent practitioner currently privileged by the Hospital or by a medical staff member with personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

(b) The Medical Staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, and/or medical record review of volunteer staff in accordance with legal and accreditation requirements.[3] Based on Hospital's oversight of each volunteer licensed independent practitioner the Hospital determines within 72 hours of the practitioner's arrival if granted disaster privileges should continue.

(c) Primary source verification of licensure for practitioners, who will provide care, treatment or services under the disaster privileges, begins as soon as the immediate situation is under control, or within 72 hours from the time the volunteer practitioner presents to the Hospital, whichever comes first. If primary source verification of a volunteer licensed independent

[2] EM.02.02.13 EP 2.
[3] EM.02.02.13; EP 5-6.

practitioner's licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the Hospital documents all of the following:

(1) Reason(s) it could not be performed within 72 hours of the practitioner's arrival;

(2) Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment, and services; and

(3) Evidence of the hospital's attempt to perform primary source verification as soon as possible.

If, due to extraordinary circumstances, primary source verification of licensure of the volunteer licensed independent practitioner cannot be completed within 72 hours of the practitioner's arrival, it is performed as soon as possible.

5.7.3 Termination. Once the immediate situation has passed and such determination has been made consistent with the Hospital's Emergency Operations Plan, all temporary disaster privileges will automatically terminate immediately. Any individual identified in the Hospital's Emergency Operations Plan or Policy with the authority to grant temporary disaster privileges shall also have the authority to terminate such disaster privileges. Such authority may be exercised in the sole discretion of the Hospital and will not give rise to any procedural rights of review under these Bylaws or otherwise.

ARTICLE VI
LEAVE OF ABSENCE/RESIGNATION

6.1 Leave of Absence

(a) The Board of Trustees may grant a leave of absence for a Member on recommendation of the Medical Executive Committee for an initial period of time not to exceed twelve (12) months. The Member should submit a written request for leave of absence one month in advance of the start date to the department Chair, who will forward his/her recommendation to the Medical Executive Committee. The Member must provide the reason for requesting the leave and the period of time requested. The Member shall be required to make appropriate arrangements for coverage of currently assigned emergency department call dates and to complete all outstanding medical records prior to the leave.

In an emergent medical situation, a request for leave of absence may be approved with an immediate effective date by the department Chair and shall be forwarded to the Medical Executive Committee for subsequent approval. In such emergent situation, the Member will not be required to arrange for coverage of Emergency Department assignments or to complete outstanding medical records. The Department Chair is responsible for making adjustments for emergency department assignments and for completion of medical records.

(b) While on leave of absence, the Member must apply for reappointment as required by the Medical Staff Bylaws and pay applicable fees. However, the Member's privileges shall be voluntarily restricted and shall be exempted from Medical Staff responsibilities until reinstatement and return from leave of absence.

(c) The Medical Executive Committee may extend a leave of absence based on a written request from the Member and a recommendation for approval by the Department Chair for an additional period of time provided such extension does not exceed a total of twenty-four (24) consecutive months. A request for an extension of medical leave shall be submitted at least thirty (30) days prior to the expiration of the original period of leave.

(d) Reinstatement from a medical leave of absence requires the Member to provide relevant clinical information concerning his/her recuperation to the department Chair. It must be sufficient in detail to determine the ability of the Member to perform all formerly granted privileges at an acceptable level of competence and proficiency and to determine the ability to provide continuous care to patients. A written statement from the Member's treating physician sufficient to support reinstatement is required.

At least thirty (30) days prior to the expiration of an approved period of medical leave of absence, the Member shall submit to the department Chair a written request for reinstatement or an extension of medical leave. The request must include a summary of activities during the leave and relevant health information. The Department Chair shall make a recommendation to the Credentials Committee for review and to the Medical Executive Committee for action. Failure by the Member to follow the procedure for reinstatement shall result in termination of Membership and privileges (not reportable to the Texas Medical Board or the National Practitioner Data Bank). In such event, the Member shall be required to reapply to the Medical Staff and will be processed as an initial applicant. The Department Chair may require a FPPE and evaluate the results before making a positive recommendation for reinstatement to the Credentials Committee and the Medical Executive Committee.

6.2 Resignation

When a Member intends to relocate his/her clinical practice beyond the Hospital's service area or to cease using the Hospital for patient care, notice of resignation shall be made in writing to the Department Chair at least thirty (30) days in advance when possible to the department to which the Member is assigned. The Chair shall forward the notice of resignation to the Credentials Committee and the Medical Executive Committee with a recommendation and an effective date. Resignations shall be effective upon approval by the Board of Trustees. All Medical Staff responsibilities will remain in effect until this approval, unless waived by the Department Chair and indicated in the recommendation. When all reasonable attempts have been made to obtain written notification of resignation without success, the member will be assumed to have resigned and the usual resignation process will be followed.

ARTICLE VII
OFFICERS OF THE MEDICAL STAFF

7.1 Medical Staff Officers

7.1.1 General.

(a) The Medical Staff shall elect officers to represent the Medical Staff for matters of mutual concern to the Hospital's administration and to the Board of Trustees. The officers of the Medical Staff, their qualifications, tenure and responsibilities are defined in this Article. The officers of the Medical Staff by virtue of their position shall serve on the Medical Executive Committee. The officers of the Medical Staff shall be the President, President-Elect, Immediate Past-President and Secretary. Officers must be members of the Active Staff who use the Hospital as their primary facility for patient care and who have participated in organized Medical Staff and Hospital activities. They must be in good standing at the time of nomination and election and must continue so during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

(a) Medical Staff officers shall have demonstrated leadership capabilities, indicate a willingness and ability to serve, attend continuing education relating to Medical Staff leadership functions, if requested, shall disclose any potential conflicts of interest related to the leadership position held, including but not limited to, ownership in competing health care facilities and leadership positions on other hospital medical staffs and shall not simultaneously hold office on another medical staff.

(b) Non-competition.

A Medical Staff officer may not serve on the governing board of, be an employee of, or serve as a medical staff officer of any hospital or other organization that is a) affiliated with a hospital other than a Texas Health Resources (THR) hospital, or b) affiliated with a health care system other than THR, during his/her term of office as a Medical Staff officer of the Hospital.

If, after assuming office, a Medical Staff officer becomes ineligible to serve as provided in this Subsection, the officer shall immediately notify the Hospital's President and resign from the office.

The process for filling that vacancy shall be as outlined in Section 7.5 below.

(d) A Medical Staff member who is actively practicing in the Hospital will not be considered ineligible for election to an officer's position solely because of his professional discipline, specialty, or practice as a hospital-based physician.

7.1.2 President - The President shall:

(a) act on behalf of the Medical Staff and the Board of Trustees, in coordination and cooperation with the Hospital President in matters of mutual concern involving the Hospital;

(b) serve as an ex officio member of the Board of Trustees, Chair of the Medical Executive Committee and as an ex officio member, without vote, of all Medical Staff committees;

(c) act on behalf of the Medical Staff and represent the views, policies, needs and grievances of the Medical Staff and communicate on the medical activities of the staff to the Board of Trustees and to the Hospital President;

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

(e) recommend to the Medical Executive Committee appointment of committee Chairs and members, in accordance with the provisions of these Bylaws, to all standing and special Medical Staff committees except the Medical Executive Committee;

(f) serve as the responsible Medical Staff Officer for monitoring the overall performance of the Medical Staff with regard to compliance with the Medical Staff Bylaws, Rules & Regulations, and the policies of the Medical Staff; and implement a precautionary suspension or restriction of privileges when indicated, and enforce the Medical Staff's compliance with these Bylaws when a professional review activity of a Member has been initiated or implemented;

(g) aid in coordinating the activities and concerns of the Hospital Administration, Nursing and other patient care personnel with those of the Medical Staff;

(h) provide day-to-day liaison on medical matters with the Hospital President and the Board of Trustees;

(i) receive and interpret the policies of the Board of Trustees to the Medical Staff and communicate to the Board of Trustees on the performance and maintenance of quality with respect to the delegated responsibility of the Medical Staff to provide medical care; and

(j) serve on such other committees as may be required and perform all other functions as may be assigned to the President by these Bylaws, the Medical Executive Committee, or the Board of Trustees.

7.1.3 President-Elect - The President-Elect shall:

(a) assume all the duties and have the authority of the President in the event of the President's temporary inability to perform due to illness, being out of the community or being unavailable for any other reason;

(b) be a member of the Medical Executive Committee and such other committees as may be required;

(c) automatically succeed the President when the President fails or is unable to serve for any reason;

(d) perform such duties as are assigned to him/her by the President.

7.1.4 Immediate Past President - The Immediate Past President shall:

(a) be a member of the Medical Executive Committee, the Board of Trustees and other committees as specified;

(b) provide advice to the officers regarding the performance of their assigned duties;

(c) perform such additional or special duties as shall be assigned to him/her by the President, the Medical Executive Committee or the Board of Trustees.

7.1.5 Secretary - The Secretary shall:

(a) be a member of the Medical Executive Committee and such other committees as specified;

(b) cause to be kept accurate and complete minutes of all Medical Executive Committee and Medical Staff meetings;

(c) perform such other duties as ordinarily pertain to his/her office;

(d) serve as the Chair of the Bylaws Committee.

7.1.6 Chain of Command.

Should both the President and the President-Elect be unavailable in an emergency, the authority and duties of the President will be temporarily assumed by the elected officers of the Medical Staff in the following order of succession: Past President, second year member at large, and first year member at large.

7.2 Election of Officers

7.2.1 The Medical Staff shall elect officers by written ballot and the results announced at the annual meeting of the Medical Staff from nominations from the Nominating Committee. Only members of the Active Staff shall be eligible to vote. A candidate must receive a majority of the votes cast. When there are three or more candidates for an officer position and no one candidate receives a majority of the votes, the two (2) candidates receiving the greatest number of votes shall be included in the next ballot until one candidate has obtained a majority vote.

7.2.2 Nominations for officers will not be received from the floor during the annual meeting.

7.3 Term of Office

7.3.1 Applicable to calendar year 2013:

Except as provided below, all officers shall serve a one (1) year term from the day they assume office and shall assume office on January 1 following the annual meeting. The Medical Executive Committee, by a two-thirds (2/3) majority vote at a duly called meeting at which a quorum is present, may approve a start date other than January 1 for any officer and may approve an officer term for other positions for a period longer than one (1) year not to exceed two (2) years.

7.3.2 Effective January 1, 2014:

(a) Except as provided in Subsection (b) below, the President and the Secretary shall serve a term of two (2) years from the day they assume office and shall assume office on January 1 following the annual meeting.

During the first year of a Medical Staff President's term, the Immediate Past President will serve a one-year term. There will not be a President-Elect during this first year.

During the second year of a Medical Staff President's term, the President-Elect will be elected and serve a one-year term. During this second year of the Medical Staff President's term, there will not be an Immediate Past President. At the end of the second year of the two-year term of the then Medical Staff President, the President-Elect of the Medical Staff shall automatically assume the office of the President.

(b) The Medical Executive Committee, by a two-thirds (2/3) majority vote at a duly called meeting at which a quorum is present, may approve a start date other than January 1 for any officer and may approve a term for the Immediate Past-President or President Elect for a period longer than one (1) year not to exceed two (2) years.

7.4 Removal of Officers

The Medical Executive Committee, by a two-thirds (2/3) majority vote of those present at a duly called meeting at which a quorum is present, or the Board of Trustees on its own initiative, may remove any Medical Staff officer for failure to comply with the Bylaws, Rules and Regulations, guidelines, and policies of the Medical Staff and/or the Hospital; failure to perform the duties of the position held; conduct detrimental to the interest of patients, the Hospital, the Board of Trustees, and/or the Medical Staff or an infirmity that renders the individual incapable of fulfilling the duties of his/her office. When initiated by the Medical Executive Committee, notice of the meeting at which such action takes place shall have been given in writing to such officer at least ten (10) calendar days prior to the date of such meeting. The officer shall be afforded the opportunity to speak on his/her own behalf before the Medical Executive Committee prior to the taking of any vote on his/her removal.

When the Board of Trustees is contemplating action to remove an elected officer on its own initiative, it will give written notice of the contemplated action to the officer, and it will refer the matter to a special combined committee composed of three (3) representatives from the Board of Trustees and three (3) Medical Staff representatives, appointed respectively by the Chair of the Board of Trustees and the highest ranking elected Medical Staff officer who is not the subject of the removal action. The Hospital President also sits with this special committee as a non-voting member.

The elected officer in question will be provided an opportunity to speak to the special combined committee before any vote on removal, and the special combined committee shall issue a written report on the issue of removal to the Board of Trustees. The Board of Trustees shall vote on the decision to remove the officer after receiving the special combined committee's report. The Board of Trustees' decision is the final decision.

7.5 Vacancies in Office

If there is a vacancy in the office of the President during the first year of the President's term, the Immediate Past-President shall serve as the Interim President until the vacancy is filled. A special election will be held for the Active Staff to select a new President. If there is a vacancy in the office of the President prior to the expiration of 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 another Active Staff member to serve out the remainder of the term.

ARTICLE VIII
COMMITTEES/MEETINGS OF THE MEDICAL STAFF

8.1 Standing Committees

In addition to the Medical Executive Committee, the Medical Staff shall establish standing committees to support the fulfillment of its broad purpose and responsibilities to the Board of Trustees. Standing committees of the Medical Staff, their responsibilities and composition are defined in this Article. Ad hoc committees may be appointed by the Medical Staff President or by a Department Chair as appropriate to fulfill any need not deemed to be the responsibility of a standing committee. Medical Staff committees defined in this Article shall be considered the standing committees of the Medical Staff. They are as follows:

Medical Executive Committee
Behavioral Event Review Committee
Bylaws Committee
Committee on Physician Health & Well-Being
Credentials Committee
Nominating Committee
Practitioner Performance Evaluation Committee

8.1.1 Standing committees shall have the responsibilities and function in accordance with this Article.

8.1.2 Standing Committees may form subcommittees to accomplish specific responsibilities and functions. The committee Chair shall appoint the subcommittee chair and members. The subcommittee shall report to the standing committee.

8.2 Provisions Common to All Committees

8.2.1 Each Medical Staff committee shall have a Chair who shall be a member of the Active Staff and shall be appointed by the Medical Staff President and ratified by the Medical Executive Committee. There is no limit on the number of terms a committee Chair may serve. Each committee may choose to elect a Vice-Chair.

8.2.2 Members of each Medical Staff committee shall be appointed from the Active, Associate and Affiliate Staff categories by the Medical Staff President in consultation with the committee Chair and ratified by the Medical Executive Committee. Members of the Emeritus Staff may be appointed as non-voting committee members based on justifiable need and recommendation of the committee Chair.

The Medical Staff President shall also appoint members from the Hospital staff to serve on Medical Staff committees, as appropriate and as recommended by the Hospital President or his designee.

Hospital employees shall serve ex officio without vote except as specified in this Article; however, if a committee member is also a Medical Staff Member, the committee member may serve with vote. In such case, the Hospital employee may serve with vote. Unless otherwise specified in this Article, Committee members shall be appointed for a one (1) year term beginning at the start of the Medical Staff year. There is no limit to the number of terms a committee member may serve.

Unless otherwise provided in this Article VIII, the Medical Staff President, Hospital President, and Chief Medical Officer shall be non-voting members of all Medical Staff committees listed in this Article VIII, subcommittees and ad hoc committees.

8.2.3 The Medical Staff President or his designee has the authority to appoint one (1) or more ad hoc members to a committee. In addition, unless otherwise provided in this Article, a committee chair may appoint one (1) or more ad hoc members to his/her committee on an as-needed basis. Medical Staff committees will be supported by Hospital administrative staff.

8.2.4 Notice of committee meetings shall be made on behalf of the Chair and sent at least seven (7) working days in advance of the meeting. The attendance of a committee member at any meeting shall constitute a waiver of that member's notice of the meeting unless the member is present for the purpose of objection to the adequacy of notice of the meeting.

8.2.5 At least one third (1/3) of the voting members of a committee but not less than two (2) voting members, as defined in these Bylaws, shall constitute a quorum.

8.2.6 A special meeting of any committee may be called by or at the request of the Chair, by the Medical Staff President, or by a petition signed by not less than one-fourth (1/4) of the voting members of the committee. In the event that it is necessary for a committee to act on a question without being able to meet, the voting members may be presented with the question, in person, by mail, by fax or by electronic means such as e-mail or text message, and their vote returned to the committee Chair in like manner. The results of such a vote shall be binding so long as the question is voted on by a majority of the committee members eligible to vote.

8.2.7 A committee Chair and/or any appointed committee member may be removed from serving on the committee for justifiable cause and the vacancy filled by the Medical Staff President at his/her discretion. Voluntary resignations from a committee Chair or member position shall be addressed to the Medical Staff President who may fill the vacancy.

8.2.8 Each Committee and any authorized subcommittee or ad hoc committee shall maintain confidential and privileged minutes and other records of each of its meetings. Minutes shall include a record of the attendance of members, the recommendations made and the votes taken on each matter. Committee members including the Chair shall maintain confidentiality of information, discussions, deliberations and decisions at committee meetings.

Minutes with reports and recommendations of each committee shall be deemed to have been signed when approved by the committee at its next regularly scheduled meeting. Minutes shall be transmitted to the Medical Executive Committee after each meeting or as otherwise provided in these Bylaws. To prevent delay in reporting to the Medical Executive Committee, drafts of minutes, so marked, may be submitted prior to final approval by the Committee. Subsequent changes to any draft should be noted in the minutes of the committee's next meeting and should be included in the report to the Medical Executive Committee.

8.2.9 Confidentiality of Committee Activities.

(a) Definition: Any standing committee of the Medical Staff, or subcommittee, ad hoc committee of a standing committee of the Medical Staff, or departmental committee permitted by the Bylaws_is a medical peer review committee. Pursuant to the Texas Medical Practice Act and other applicable state laws, a medical peer review committee is a committee of a health care entity or the medical staff of a health care entity, that (1) operates under written bylaws approved by the policy-making body or the governing board of the health care entity and (2) is authorized to evaluate the quality of medical and health care services or the competence of physicians, including evaluation of the performance of those functions specified by state law. A medical peer review committee's actions and deliberations are privileged and protected from discovery pursuant to state and federal laws.

(b) Confidentiality of Committee Activities: The Medical Staff committees provided in these Bylaws, including any subcommittees and ad hoc committees, are considered medical peer review committees and are entitled to the full protection of privileges as provided under state law. For purposes of these Bylaws, all activities, communications, records, and proceedings by and/or prepared at the direction of any of the committees of the Medical Staff are confidential and privileged from discovery to the fullest extent allowed by federal and state law.

This privilege cannot be waived unless in writing by the Chair or Vice Chair of a committee. Such activities or documents generated by Outside Agencies as defined in Section 8.2.10 below, shall constitute medical peer review committee activities and documents and shall be privileged and protected from discovery to the fullest extent allowed by federal and state law.

8.2.10 Delegation of Committee Activities.

In carrying out the medical peer review committee responsibilities described in this section, committee chairs may designate outside individuals, agencies and/or organizations ("Outside Agencies") as agents of the applicable medical peer review committee for the sole purpose of carrying out the medical peer review committee's responsibilities as described herein.

8.3 Medical Executive Committee

The Medical Executive Committee shall have broad responsibility for directing the professional activities of the Medical Staff, for representing and for acting on behalf of the Medical Staff in all matters and for monitoring compliance of the Medical Staff with the Bylaws, Rules and Regulations, guidelines, and policies of the Medical Staff and the Hospital. The Medical Executive Committee shall serve as the executive committee of the Medical Staff, and a majority of voting members shall be physicians.

8.3.1 The composition of the Medical Executive Committee shall be:

(a) All Department Chairs including Designated Department Chairs;

(b) All Vice-Chairs of departments having a Designated Department Chair, excluding the Vice-Chairs of the departments of Emergency Medicine, Pathology and Radiology and similar Hospital-based departments;

(c) Three (3) members of the attending staff of the Department of Internal Medicine representative of specialty divisions. Provided, however, for each attending staff member of the Internal Medicine Department who serves as an At-Large Member ("Internal Medicine

At-Large Member") pursuant to Subsection (h) below, during such two-year term of such Internal Medicine At-Large Member, a member of the attending staff of the Internal Medicine Department will not be appointed under this Subsection (c).

The members shall be selected by the Internal Medicine Department Chair and shall serve two (2) years. The members may succeed themselves.

(d) the Medical Staff President;

(e) the Medical Staff President-Elect;

(f) the Immediate Past President of the Medical Staff;

(g) the Secretary of the Medical Staff;

(h) two (2) At-Large Members elected by the Medical Staff. Nominations of At-Large Members shall be made by the Nominating Committee in the same manner as the Medical Staff officers. At-Large Members shall be from the Active Staff. The At-Large Members shall serve a term of two (2) years on a staggered basis. An At-Large Member may succeed himself, but shall not serve more than six (6) consecutive years [three (3) consecutive terms];

(i) Trauma medical director;

(j) the Credentials Committee Chair;

(k) the Practitioner Performance Evaluation Committee Chair;

(l) the Chief Medical Officer (non-voting);

(m) the Hospital President and/or his/her designee(s) (non-voting).

(n) The Board of Trustees may appoint a representative to serve on the Medical Executive Committee (non-voting);

8.3.2 If a Member holds two (2) or more of the positions that qualify for Medical Executive Committee membership, he/she shall serve in those capacities but with only one (1) vote. At the request of the Department Chair, the Vice-Chair may act as the departmental representative in the Chair's absence, with one (1) vote. No Member shall be excluded from membership on the Medical Executive Committee solely because of his/her professional discipline or specialty.

8.3.3 The Medical Staff President shall act as Chair of the Medical Executive Committee and shall preside over all Medical Executive Committee meetings. The Medical Staff President-Elect shall serve as Vice-Chair of the Medical Executive Committee, and in the absence of the Chair, shall preside over meetings of the Medical Executive Committee and fulfill other duties and responsibilities.

The Medical Staff President and President-Elect shall be voting members of the Medical Executive Committee.

8.3.4 The Medical Staff Secretary shall serve as Secretary of the Medical Executive Committee. He/she shall see that minutes of the Medical Executive Committee meetings are properly kept, attend to all correspondence, and perform such other duties as normally pertain to his/her office.

8.3.5 The Hospital President, or his/her designee, shall attend all meetings of the Medical Executive Committee and all of its committees, and advise as to administrative and fiscal aspects of those subjects under discussion. The elected leadership of the Medical Staff shall bring the recommendations of the Medical Executive Committee to the Board of Trustees. The Board of Trustees representative shall advise the Medical Executive Committee of Board of Trustees policy.

8.3.6 Responsibilities and Functions.

The Medical Executive Committee shall have broad responsibility for directing the professional medical activities of the Medical Staff. The Medical Executive Committee shall have the authority and responsibility for implementation of the Bylaws, Rules and Regulations and such other Medical Staff policies and procedures necessary to fulfill the objectives and responsibilities of the Medical Staff.

As set forth herein, in compliance with the provisions of the Bylaws of the Medical Staff. The duties of the Medical Executive Committee may include, but not be limited to the following:

(a) to represent and to act on behalf of the Medical Staff in all matters, without requirement of subsequent approval by the Medical Staff, between meetings of the Medical Staff, subject only to any limitations imposed by these Bylaws;

(b) to coordinate the activities and general policies of the various departments and sections;

(c) to receive and act upon committee reports and to make recommendations concerning them to the Hospital President and the Board of Trustees;

(d) to implement Medical Staff policies which are not the responsibility of the departments;

(e) to provide liaison among the Medical Staff, the Hospital President and the Board of Trustees;

(f) to recommend action to the Hospital President on matters of a medico-administrative and Hospital management nature;

(g) to see to it that the Medical Staff is kept abreast of The Joint Commission accreditation program and is informed of the Hospital's accreditation status;

(h) to oversee the enforcement of Hospital policies and procedures and Medical Staff Rules and Regulations in the best interest of patient care and of the Hospital on the part of all persons who hold appointment to the Medical Staff and Allied Health Staff;

(i) to refer situations involving questions of the clinical competence, patient care and treatment, case management or inappropriate behavior of any Members to the appropriate department or section for appropriate action in accordance with the corrective action procedures outlined in these Bylaws;

(j) to review the Bylaws Committee report regarding recommended changes in the Bylaws, Rules and Regulations, and associated documents and recommend such changes thereto as may be necessary or desirable;

(k) to make recommendations regarding the mechanism to review credentials and to delineate Clinical Privileges and appointment and reappointment application forms;

(l) to act on reports from the Credentials Committee concerning the credentials of all applicants and to make recommendations to the Board of Trustees for staff membership, assignment to staff departments and delineation of Clinical Privileges;

(m) to initiate and oversee the review of information available concerning the performance and clinical competence of Members and other practitioners with Clinical Privileges, and as a result of such reviews, make recommendations to the Board of Trustees for reappointments and renewal or changes in Clinical Privileges;

(n) to make recommendations to the Board of Trustees regarding the organization of quality management activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities;

(o) to take reasonable steps to promote professional and ethical conduct and competent clinical performance on the part of all Members, including the initiation of and/or participation in Medical Staff corrective actions or review measures when warranted;

(p) to report through its Chair at each Medical Staff general meeting;

(q) to make recommendations to the Board of Trustees regarding:

(1) the structure of the Medical Staff;

(2) the process used to review credentials and delineate privileges;

(3) the mechanism by which Medical Staff membership may be terminated; and

(4) the mechanism for hearing procedures;

(r) review and act on the reports of the Medical Staff committees, Medical Staff departments, quality and patient safety and other assigned activity groups and making recommendations to the Board of Trustees on the structure of the organized Medical Staff; and

(s) perform such other duties as are set forth in these Bylaws or as are delegated by the Medical Staff and/or Board of Trustees.

8.3.7 In any instance where a Medical Executive Committee member has a conflict of interest regarding any matter which comes before the Medical Executive Committee, e.g. a conflict of interest involving a Medical Staff Member, or in any instance where a Medical Executive Committee member brings a complaint against a Medical Staff Member, such Medical Executive Committee member may be asked and may answer any questions concerning the matter to be considered but shall not vote on the matter.

8.3.8 The Chair of the Medical Executive Committee, his/her representative and such members of his/her committee as may be necessary shall be available to meet with the Board of Trustees or its applicable committee on all recommendations that the Medical Executive Committee may make.

8.3.9 Meetings.

The Medical Executive Committee shall meet monthly, or as needed to transact pending business. Important Medical Executive Committee actions shall be reported to the Medical Staff as a part of its report at each general Medical Staff meeting. Medical Executive Committee recommendations shall be transmitted to the Board of Trustees with a copy to the Hospital President.

8.3.10 Removal of Members.

The procedures for removal of a Medical Executive Committee member who is a Medical Staff officer are set out in Section 7.4. Any other Medical Staff Member of the Medical Executive Committee may be removed for cause on two-thirds (2/3) vote of the Medical Executive Committee or for cause on two-thirds (2/3) vote of the Board of Trustees.

Only the Hospital President may remove the Chief Medical Officer as a Medical Executive Committee member, and only the Board of Trustees may remove the Hospital President as a Medical Executive Committee member.

8.4 Behavioral Event Review Committee

8.4.1 The Behavioral Event Review Committee membership shall consist of:

(a) the Immediate Past President of the Medical Staff or Medical Staff President-Elect,

(b) the Chief Medical Officer, and

(c) the two (2) Medical Staff Members-at-Large elected to serve on the Medical Executive Committee.

The Immediate Past President or the President-Elect shall be the committee chair.

The Director, Medical Staff Services, shall provide support to the Chair for the conduct of the validation of any issues brought to the committee, preparing information and reports for the Chair and for documentation of the committee's activities.

8.4.2 Responsibilities and functions.

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.

8.4.3 Meetings.

The Behavioral Event Review Committee will meet as needed at the call of the Chair in order to support timely screening and validation of disruptive behavioral reports and to determine appropriate action in consultation with the applicable department Chair.

8.5 Bylaws Committee

8.5.1 The Bylaws Committee shall consist of at least five (5) members and no more than eight (8)) members. The Bylaws Committee membership shall consist of:

(a) the Medical Staff President,

(b) the Medical Staff President-Elect,

(c) the Immediate Past-President of the Medical Staff,

(d) the Medical Staff Secretary;

(e) two (2) other Medical Staff Members at large - appointed by the Medical Staff President,

(f) the Chief Medical Officer (non-voting) and

(g) Medical Director, Medical Staff Services (non-voting).

The Medical Staff Secretary shall serve as the committee chair.

8.5.2 Responsibilities and Functions: The Bylaws Committee shall:

(a) Maintain the Medical Staff Bylaws and Rules and Regulations on an ongoing basis to reflect current Medical Staff organization and function and compliance with regulatory and accrediting requirements.

(b) Conduct an in-depth review of the Bylaws, Rules and Regulations and accompanying procedural manuals at least every three (3) years or more often as deemed necessary.

(c) Maintain current knowledge of federal and state laws and guidelines as they relate to Medical Staff issues and refer questions to legal counsel.

(d) Draft such revisions as are necessary for submission to the Medical Executive Committee for approval and for submission of a ballot to voting Medical Staff Members when required under these Bylaws.

8.5.3 Meetings: The Bylaws Committee shall meet annually and as needed to determine that the Bylaws meet current standards, requirements and Medical Staff practices.

8.6 Committee on Physician Health & Well-Being

8.6.1 The Committee on Physician Health & Well-Being membership shall consist of:

(a) the Chair,

(b) at least four (4) Medical Staff Members at large – appointed by the Medical Staff President,

(c) the Chair or Vice-Chair of the respective clinical department of which the subject Medical Staff Member is a member (ad hoc members) or such other ad hoc member who may be appointed by the Medical Staff President, and

(d) the Chief Medical Officer (non-voting).

8.6.2 Responsibilities and Functions: The Committee on Physician Health & Well-Being shall:

(a) Provide assistance and support to Medical Staff Members.
(b) Coordinate the evaluation of reports of suspected impairment of any Members and make recommendations to the Executive Committee including:

(1) Receive reports of suspected impairment concerning Medical Staff Members.

(2) Initiate a review of reports of suspected impairment.

(3) Make recommendations to the Executive Committee concerning a course of action to be taken with respect to an impaired Member or Member suspected of being impaired.

(c) The committee may provide consultation to Medical Staff leaders or other Medical Staff committees regarding a Member exhibiting a pattern of disruptive behavior.

8.6.3 Meetings: The Committee on Physician Health & Well-Being shall meet as needed at the request of the Chair or the Medical Staff President.

8.7 Credentials Committee

8.7.1 The Credentials Committee membership shall consist of:

(a) At least nine (9) members appointed from the Active, Associate, or Affiliate staff;

(b) The Chief Medical Officer (non-voting), and

(c) The Medical Director of Medical Staff Services (non-voting).

The Medical Staff President shall appoint the Chair and Vice Chair, and the Chair shall serve a three (3) year term.

8.7.2 Responsibilities and Functions: The Credentials Committee shall:

(a) Coordinate the credentialing and delineation of privileges process for Members and Advance Practice Professionals.

(b) Review the recommendations of the clinical department Chairs regarding appointment and/or reappointment of Medical Staff membership and/or delineation of Clinical Privileges.

(c) Review the recommendations for Clinical Privileges of Advance Practice Professionals of the Allied Health Committee, a subcommittee of the Credentials Committee.

(d) Make recommendations to the Medical Executive Committee regarding Medical Staff applications for appointment and/or reappointment including staff category, Clinical Privileges and department affiliation.

(e) Approve criteria and qualifications for granting privileges.

8.7.3 Meetings: The Credentials Committee shall meet monthly or more often as needed.

8.8 Nominating Committee

8.8.1 The Nominating Committee membership shall consist of:

(a) the Immediate Past President of the Medical Staff or the Medical Staff President- Elect,

(b) the Medical Staff Secretary,

(c) two (2) additional members appointed by the Medical Staff President,

(d) the Medical Staff President (non-voting),

(e) the Chief Medical Officer (non-voting) and

(f) Medical Director, Medical Staff Services (non-voting).

The Medical Staff President shall select the Nominating Committee Chair.

8.8.2 Responsibilities and Functions: The Nominating Committee shall:

(a) Solicit qualified and interested officer candidates by surveying Members of the Active Medical Staff.

(b) Nominate candidates meeting qualifications for election of the Medical Staff President-Elect, Secretary, and one At-Large Member of the Medical Staff.

(c) Review and document the qualifications and experience of the candidates nominated to hold office.

8.8.3 Meetings: The Nominating Committee shall meet as necessary prior to the above Medical Staff elections.

8.9 Practitioner Performance Evaluation Committee (PPEC)

8.9.1 The PPEC membership shall consist of:

(a) Nineteen (19) Members who are members of the Active Staff,

(b) the Immediate Past-President or the President-Elect of the Medical Staff (or his/her designee) (non-voting),

(c) the Chief Medical Officer or his/her designee (non-voting),

(d) the Chief Nursing Officer or his/her designee (non-voting),

(e) the Medical Director of Medical Staff Services or his/her designee (non-voting),

(f) the Director of Quality Improvement & Patient Safety (QIPS) or his/her designee (non-voting), and

(g) one (1) or more members of the QIPS support staff (non-voting).

8.9.2 Responsibilities and Functions: The PPEC shall:

Perform the duties described in the PPEC Charter including evaluation of Member performance.

8.10 Medical Staff Meetings

8.10.1 Annual Medical Staff Meeting.

An annual Medical Staff meeting shall be convened for the purpose of electing Medical Staff officers and may include reports of review and evaluation of the work completed during the preceding year. The meeting shall be scheduled at such time as to permit the Board of Trustees' ratification of elected officers prior to the commencement of the Medical Staff year on January 1 of the coming year.

8.10.2 Special Meetings of the Medical Staff.

Special meetings of the Medical Staff may be called at any time by the Board of Trustees, the Hospital President, the Medical Staff President, a majority of the Medical Executive Committee, or a petition signed by not less than one-fourth (1/4) of the voting staff.

Notice of special Medical Staff meetings shall be provided at least two (2) weeks prior to the date of the meeting unless waived by the Medical Staff President because of the urgency to hold the special meeting.

8.10.3 Voting In Lieu Of Meetings.

In the event it is necessary for the Medical Staff to act on a question without a Medical Staff meeting, the eligible voting Medical Staff may be presented with the question by mail, fax, e-mail or other electronic means of communication and their votes returned to the Medical Staff President in the manner prescribed in the question.

The results of such a vote shall be valid so long as the question is voted on by a majority of the Medical Staff eligible to vote. A majority of these voting shall determine the question, unless otherwise provided by these Bylaws.

8.10.4 Quorum Requirements.

The presence of twenty-five persons eligible to vote shall constitute a quorum for any regular or special Medical Staff meeting. This quorum is required for any action to be taken, and all actions taken shall be binding.

8.11 Agenda

Important actions of the Medical Executive Committee shall be included in reports to the Medical Staff at any regular meeting or any special meeting called for the purpose of receiving such reports.

ARTICLE IX.
MEDICAL PEER REVIEW AND CORRECTIVE ACTION

9.1 General

9.1.1 Medical Peer Review, as defined in Section 9.9 below and the Practitioner Performance Evaluation policy of the Medical Staff, is conducted on an ongoing basis, with primary responsibility placed on the Medical Executive Committee and the other Medical Staff committees for implementation of the Hospital's Quality, Risk, and Patient Safety Plan as it relates to the Medical Staff and others with Clinical Privileges.

Medical Peer Review activities shall be pursuant to written policies of the Medical Staff and the procedural safeguards herein, as applicable, to provide each Practitioner the rights to which he/she is entitled under state and federal law.

9.1.2 The Quality and Patient Safety Plan supports the Hospital's culture and is rooted in the organization's mission and values. The Plan enables the Hospital to provide integrated, organization-wide participation in performance improvement and provides the framework and requirements by which the Hospital improves the quality of care, outcomes and services, decreases risk, and improves patient safety.

In addition, the Hospital's FPPE and OPPE programs are intended to be implemented on a voluntary and collegial basis to the fullest extent possible. If necessary, changes cannot be implemented on a voluntary basis, matters may be referred to the Medical Executive Committee for corrective action as set forth below.

Information generated pursuant to professional review activities, specifically the ongoing implementation of the Quality, Risk, and Patient Safety Plan, Focused Professional Practice Evaluation (FPPE), and Ongoing Professional Practice Evaluation (OPPE) is also used in the reappointment and re-credentialing process.

9.1.3 In addition to evaluating the results of OPPE, the Practitioner Performance Evaluation Committee (PPEC) and Behavioral Event Review Committee (BERC) evaluate identified issues regarding the competence or professional conduct of Members or others with Clinical Privileges, with referral to the Medical Executive Committee if indicated.[4] Members may be requested to participate in performance improvement activities as described in Section 9.2.2 or be placed under FPPE in accordance with the Medical Staff *Peer Review* policy for the purpose of obtaining additional information or to modify practice.

[4] MS.09.01.01 EP 1.

Neither performance improvement activities nor FPPE entitle the Practitioner to Procedural Rights of Review under these Bylaws or otherwise.

9.2 Performance Improvement Activities

9.2.1 These Bylaws encourage the use of progressive steps by Medical Staff leaders and the Hospital including collegial and educational efforts, to address questions relating to a Practitioner's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the Practitioner to resolve questions that have been raised, to restore trust, to establish accountability, to rehabilitate the involved Practitioner to the extent appropriate, and to protect patient care and safety.

9.2.2 As part of the Medical Peer Review process, the PPEC, BERC, the Department Chair or his/her designee, Section Chief or his/her designee, Chief Medical Officer, and/or Medical Staff President may at any time, review a Member's practice and Hospital medical records of the Member's patients. If indicated, the PPEC, BERC, or above-referenced Medical Staff leaders may utilize additional collegial intervention efforts to implement practice changes of the Member 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 Member's compliance with them is not mandatory and are not a limitation or restriction of Clinical Privileges, they do not entitle the Member to Procedural Rights of Review.

9.2.3 All performance improvement activities by Medical Staff leaders and the Hospital are part of the Hospital's Peer Review process.

9.2.4 Also as part of the Peer Review process, the PPEC or other appropriate medical staff committee may request that a Practitioner enter into performance improvement programs on a voluntary basis in accordance with Medical Staff policies, which may or may not limit or restrict the exercise of Clinical Privileges or prerogatives of Medical Staff membership. A voluntary performance improvement program is not considered corrective action under these Bylaws.

9.2.5 If documentation of implementation of performance improvement activities is included in a Practitioner's file, the Practitioner will have an opportunity to review it and respond in writing. The response shall be maintained in the Practitioner's file along with the original documentation.

9.2.6 Collegial intervention efforts are encouraged but are not mandatory and shall be within the discretion of the appropriate Medical Staff leaders and Hospital management.

9.2.7 Special Attendance Requirements.

Whenever a suspected deviation from standard clinical or professional practice is identified, a Medical Staff leader may require the Practitioner to confer with the appropriate Medical Staff committee or the Board of Trustees, or a subcommittee thereof, or ad hoc committee appointed to consider the matter.

At least five (5) days prior to the conference date, special notice of the conference shall be given to the Practitioner, including the date, time, and place, a statement of the issue(s) involved, a statement that the Practitioner's attendance is mandatory, and a statement that the Practitioner is subject to automatic suspension of Clinical Privileges for failure to attend. If the Practitioner is unable to attend, the Practitioner must immediately arrange, with the chair of the committee or the Medical Staff leader an acceptable alternative date which date shall be within fourteen (14) days of the originally scheduled conference.

Whenever an educational program is recommended as a result of professional review activities, the Practitioner whose performance has prompted the program and a Medical Staff leader shall agree upon an acceptable program date within thirty (30) days of the recommendation. The Practitioner shall be given special notice that attendance is mandatory at least fourteen (14) days prior to the program. Failure of the Practitioner to attend shall be reported to the Medical Executive Committee for consideration for possible corrective action.

9.2.8 Procedures for addressing concerns regarding a Practitioner's health or conduct separate from the corrective action process are set out in written Medical Staff policies. Nothing in those policies

precludes initiation of corrective action pursuant to this Article based on health or conduct concerns when indicated.

9.3 Grounds for Corrective Action and Process for Requesting a Corrective Action

9.3.1. Criteria for initiation.

(a) Grounds for corrective action include but are not limited to the following:

(1) the clinical competence or clinical practice of any Practitioner, including the care, treatment or management of a patient or patients, is lower than the standards or aims of the Hospital or the Medical Staff or accepted professional standards;

(2) a known or suspected violation by any Practitioner of applicable ethical standards or the Bylaws, Rules or Regulations or Medical Staff or Hospital policies;

(3) conduct by any Practitioner that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff or which undermines the culture of safety, including the inability of the Practitioner to work harmoniously with others;

(4) a known or suspected impairment from substance abuse, physical or psychological disability.

(5) receipt of notice that a Practitioner is under investigation by his/her professional licensing board or that his license or other legal credential authorizing practice in Texas or any other state has been subject to any type of corrective or disciplinary action; or

(6) failure of the Practitioner to effect voluntary practice changes requested by the Medical Executive Committee or the PPEC or to comply with other actions imposed under Section 9.2.

(b) Any Practitioner, any Medical Staff committee, Medical Staff leader, the Hospital President, or the Board of Trustees who reasonably believes there is sufficient basis for possible corrective action against a Practitioner may request an investigation be initiated for purposes of possible corrective action.

Unless immediate action is required under Section 9.6, the request must be in writing, submitted to the Medical Staff President, and supported by reference to the specific activities or conduct alleged. The Medical Staff President shall promptly provide the written complaint or question to the Medical Executive Committee.

(c) The Medical Staff President shall request that the involved Practitioner's Department Chair review the request. When the request deals with health or behavioral issues, the Medical Staff President, at his/her option, may request the Committee on Physician Health & Well-Being or the Behavioral Event Review Committee to evaluate the matter, and in such case, will submit the request to the Chair of such committee.

The Department Chair or committee to which the request is referred shall have the authority to review relevant documents (e.g. Reliability Learning Tools reports, medical records) and interview any person or persons including the Practitioner under review, possible witnesses, Hospital employees, and other Practitioners.

(d) After the review of the request, the Department Chair or committee to which the request was referred shall provide a written report to the Medical Staff President who shall promptly inform the Hospital President. If the report concludes that no corrective action is necessary, the Medical Staff President, in consultation with the Chief Medical Officer, may dismiss the matter or may respond with any appropriate action that does not constitute a corrective action. Refer to Section 9.2.2 for examples.

Subject to the approval of the Medical Executive Committee under Subsection (e) below,

the Medical Staff President may also issue a letter of warning or reprimand, and the Practitioner may provide a written response. Both the Medical Staff President's correspondence to the Practitioner and the Practitioner's written response shall be placed in the Practitioner's quality file. Actions that are not defined as grounds for a hearing under Article X shall not entitle the Practitioner to the hearing and appellate review procedures of Article X of these Bylaws.

(e) The Medical Executive Committee shall review the request at its next regular meeting or a special called meeting and any action already taken by the Medical Staff President and decide whether to initiate an investigation for purposes of possible corrective action. If the Medical Executive Committee determines that the matter may be resolved without the necessity of initiating an investigation or taking corrective action, the Medical Executive Committee (or the Medical Staff President as its designee) may attempt to do so**.** The Medical Executive Committee may also approve any action taken by the Medical Staff President under Subsection (d) and dismiss the matter.

9.4 Procedures for an Investigation Authorized by the Medical Executive Committee

9.4.1 General; Investigation Defined; Automatic Termination of Privileges While Under an Investigation

(a) The Hospital President, in consultation with the Medical Staff President, shall be responsible for complying with any mandatory reporting requirements the Hospital has under Texas and federal law relating to Medical Staff membership or Clinical Privileges. Nothing in this section or the other provisions of the Bylaws shall prevent an individual Member or Board of Trustees member from making any other report to a state or federal government agency as permitted or required by law.

(b) Investigation Defined. An "Investigation" for purposes of mandatory reporting requirements is only:

(1) An investigation affirmatively initiated by the Medical Executive Committee following receipt of a request for a possible corrective action as set forth in Section 9.3.1 based on competence or professional conduct;

(2) That period of time following issuance of an Adverse Recommendation or Action based on competence or professional conduct in the course of appointment or reappointment of Clinical Privileges, or an Adverse Recommendation or Action taken pursuant to Section 9.5; or

(3) That period of time following issuance of a precautionary suspension under Section 9.6.

Note: FPPE for identified concerns is not considered an Investigation unless it is imposed specifically as a precursor to corrective action.

(c) Unless otherwise provided in the Bylaws, 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.

(d) Automatic Termination of Clinical Privileges While Under Investigation.

Unless required by these Bylaws or by law, an automatic termination or expiration of a Practitioner's Clinical Privileges while the Practitioner is under Investigation is not a surrender of Clinical Privileges while under Investigation subject to mandatory reporting (i.e. having to report for a surrender of privileges while under investigation). Examples include but are not limited to expiration of temporary Clinical Privileges, automatic termination pursuant to Section 9.8, and automatic termination pursuant to a contract for professional services. (Note: The National Practitioner Data Bank considers automatic expiration of Clinical Privileges at the end of an appointment period while the Practitioner is under an Investigation due to failure to reapply for privileges as a surrender of privileges.)

9.4.2 Initiation of Investigation.

(a) If the Medical Executive Committee decides to initiate an investigation for purposes of possible corrective action, the Medical Executive Committee's decision shall be documented in the minutes of the meeting. The Medical Executive Committee shall delegate the investigation to one of the following committees ("Investigating Committee"):

(1) Practitioner Performance Evaluation Committee;

(2) the Behavioral Event Review Committee;

(3) the Committee on Physician Health & Well-Being;

(4) an Ad Hoc Committee of the Medical Executive Committee.

(b) If the request for possible corrective action was made by the PPEC following review by the PPEC of the same issues that are the basis of the request, an investigation pursuant to this Section 9.4.1 shall not be required provided that the PPEC'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.

(c) The Investigating Committee shall have the authority to review relevant documents (e.g. SALT reports, medical records) and interview any person or persons including the Practitioner under review, possible witnesses, Hospital employees, and other Practitioners. It shall also have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed, subject to the approval of the Hospital President in consultation with the Medical Staff President.

(d) The Investigating Committee shall keep the Medical Staff President fully informed of all actions taken in connection with the investigation.

(e) The Medical Staff President, in turn, shall keep the appropriate Department Chair and the Hospital President informed of the investigation.

9.4.3 Notice to Affected Practitioner.

The Medical Staff President, on behalf of the Medical Executive Committee shall contact the affected Practitioner and shall send written notice to him/her, not later than the end of the fifth (5th) working day after the decision is made to initiate an investigation. The notice shall advise the Practitioner of initiation of an investigation for purposes of possible corrective action and provide a general statement of the matters being investigated.

If additional matters requiring investigation are discovered during the investigation, the investigation may be expanded with appropriate notice sent by the Medical Staff President, on behalf of the Medical Executive Committee, to the Practitioner in question.

9.4.4 Physical or Psychological Exam.

The Investigating Committee may require the Practitioner to have a physical and/or psychological exam. In such case, the matter may be referred to the Committee on Physician Health & Well-Being or the Behavioral Event Review Committee. The Practitioner shall authorize the release of the relevant information from the exam to the individual designated by the Medical Staff for further disclosure to the relevant committees for purposes of this professional review activity.

The Chair of this committee shall provide the results of any exam to the Investigating Committee.

9.4.5 Meeting with the Practitioner.

The Investigating Committee shall afford the Practitioner an opportunity to meet with the committee as a part of its investigation. Prior to the interview, if any, the Practitioner shall be provided with a general listing of the medical records or events that are the subject of the investigation. 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.

This meeting is not a hearing, and none of the procedural rules for hearings shall apply. Neither the Practitioner nor the Investigating Committee shall have the right to be represented by legal counsel at this meeting.

9.4.6 Completion of Investigation and Report of Findings.

(a) Completion of Investigation.

The Investigating Committee shall complete the investigation and issue a written report within a reasonable time, not to exceed sixty (60) days unless an extension is granted by the Medical Staff President for good cause.

(b) Report of Findings to the Medical Executive Committee.

The Investigating Committee shall forward a written report containing its findings, conclusions, and recommendations to the Medical Executive Committee with a copy to the Department Chair. At all times the Medical Executive Committee shall retain authority and shall have discretion to take whatever action may be warranted by the circumstances without regard to the status of the investigation including, without limitation, precautionary suspension, restriction of privileges, or termination of the investigation.

9.5 Procedures Following an Investigation

9.5.1 Medical Executive Committee Recommendations/Action.

At its next regular meeting or a special called meeting, the Medical Executive Committee shall review the report from the Investigating Committee. 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.

On receipt of all information it deems necessary, 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 actions that may be taken by the Medical Executive Committee include, but are not limited to, the following:

(a) determine no corrective action be taken and, if the Medical Executive Committee determines there was not credible evidence for the complaint in the first instance, remove the request for corrective action from the Practitioner's file;

(b) defer action for a reasonable time when circumstances warrant;

(c) refer the matter to the Department Chair to issue a letter of guidance or counsel or to recommend additional training or education or some other collegial intervention (not considered corrective action);

(d) recommend issuance of a letter of warning or reprimand;

(e) recommend additional training or education, to be completed prior to or concurrent with the exercise of Clinical Privileges;

(f) recommend the imposition of conditions, limitations, or restrictions on continued appointment or the exercise of privileges (e.g. requirements of co-admissions, mandatory consultation, monitoring, proctoring);

(g) recommend change of membership category;

(h) recommend suspension, or revocation of Clinical Privileges;

(i) recommend revocation of Medical Staff membership; or

(j) make any other recommendations the Medical Executive Committee deems necessary or appropriate.

In the event the Medical Executive Committee concludes it is necessary to take immediate action to suspend or restrict a Practitioner's privileges prior to a final action by the Board of Trustees, the Medical Executive Committee may impose a precautionary suspension or restriction of privileges in accordance with section 9.6.1.

9.5.2 Notice to the Practitioner.

(a) Within seven (7) calendar days following the Medical Executive Committee's decision, the Hospital President shall provide the Practitioner with special notice of the recommendation.

(b) If the Medical Executive Committee recommends an action that is an Adverse Recommendation or Action, the notice to the Practitioner shall also inform the Practitioner of his procedural rights of review as provided by Article X.

(c) A recommendation by the Medical Executive Committee not to take corrective action (see Section 9.5.1[a]), to refer the matter to the Department Chair (see Section 9.5.1[c]), or for corrective action that is not an Adverse Recommendation or Action shall be forwarded to the Board of Trustees for a final decision.

9.6 Precautionary Suspension or Restriction of Privileges

This section applies when it may be necessary to take immediate action to suspend or restrict a Practitioner's privileges.

9.6.1 Grounds for Precautionary Suspension or Restriction of Privileges.

(a) Any incumbent in the positions listed below has the authority to issue a precautionary suspension or restriction of all or any portion of a Practitioner's Clinical Privileges:

- the Medical Staff President;
- the President-Elect or the Immediate Past President;
- the Credentials Committee Chair;
- the Chair of Surgical Services;
- the applicable Department Chair or Vice-Chair;
- the Hospital President.

If time permits, the incumbent will confer with the Chief Medical Officer. This action may be taken when there is a reasonable belief that failure to take such action may result in imminent danger to the health of any patient or other person.

(b) A precautionary suspension or restriction pursuant to this Section shall be only as necessary to address the imminent danger.

9.6.2 Care of Patients.

If necessary, the President, the Chief Medical Officer, or the applicable Department Chair shall assist in securing alternative coverage by another Practitioner of any of the Practitioner's patients who are hospitalized at the time of the precautionary action.

9.6.3 Status of a Precautionary Suspension or Restriction.

A precautionary suspension or restriction of privileges is an interim step in the Peer Review process and is not a complete corrective action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension. However, a precautionary suspension or restriction of privileges that lasts longer than thirty (30) calendar days has the same meaning and

effect as a summary suspension as that term is defined and described in the National Practitioner Data Bank (NPDB) Guidebook, as it may be amended from time to time.

9.6.4 When Effective; Notice to the Practitioner.

(a) A precautionary suspension or restriction of privileges shall become effective immediately upon imposition. The Hospital President and the Medical Staff President shall be notified immediately. The precautionary suspension or restriction of privileges shall remain in effect unless it is modified by the Medical Executive Committee or Board of Trustees.

(b) The person imposing the precautionary suspension or restriction shall verbally notify the Practitioner of the action and the reasons for the action as soon as possible, followed by special notice by the Hospital President as promptly as possible following the suspension or restriction.

9.6.5 Procedure Following Precautionary Suspension or Restriction.

(a) Within ten (10) days of imposition of a precautionary suspension or restriction of privileges, the Medical Executive Committee shall review, the matter resulting in a suspension or restriction.

Prior to, or as part of this review, the Practitioner shall be given an opportunity to meet with the Medical Executive Committee. The Practitioner may propose ways other than suspension or restriction of privileges to protect patients or other persons.

(b) After considering the matter resulting in the precautionary suspension or restriction 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 9.4 above on an expedited basis to the extent possible, if an investigation has not already begun. The Medical Executive Committee shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).

(c) If the Medical Executive Committee recommends termination of the precautionary suspension or restriction, the action shall be terminated effective immediately, subject to a final decision by the Board of Trustees.

(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 (5) days of the decision.

(2) If the Board of Trustees determines that precautionary suspension or restriction is still indicated, the action shall be immediately reinstated, and the Hospital President shall notify the Practitioner as provided in Section 9.6.4. In its recommendation, the Board of Trustees shall indicate if the recommendation is pending an investigation pursuant to Section 9.4 on an expedited basis if not already begun, or if no further investigation is needed.

(d) If the Medical Executive Committee's recommendation to affirm or modify the precautionary suspension or restriction without initiation of or further investigation under Section 9.4 (or the Board of Trustees' reinstatement of the action as provided in subsection (c)(2) above) is an Adverse Recommendation or Action, the Practitioner shall be entitled to the procedural rights of review under Article X and all further procedures shall be as set forth in that Article.

(e) If the precautionary suspension or restriction remains in place and the Medical Executive Committee recommends initiation of or further investigation under Section 9.4 which results in an Adverse Recommendation or Action, the Practitioner shall be entitled to the procedural rights of review under Article X and all further procedures shall be as set forth in that Article. The Practitioner shall be entitled to only one hearing concerning the precautionary suspension or restriction and the results of the investigation.

(f) If the Medical Executive Committee recommends termination of the precautionary suspension or restriction, it may also recommend to the Board of Trustees that the action be rescinded. Consideration of rescission of a precautionary 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. If a precautionary suspension is rescinded by final decision of the Board of Trustees, while the Practitioner's files will retain a record of the actions taken, the precautionary 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.

(g) All Practitioners have a duty to cooperate with the Hospital President, the department Chair, the Medical Executive Committee, and the Hospital President in enforcing a precautionary suspension or restriction of privileges.

9.7 <u>Voluntary Agreement</u>

9.7.1 Whenever the activities or professional conduct of any Practitioner are of such concern that, in the assessment of the Medical Staff President or the Chief Medical Officer, further evaluation of the activities or professional conduct is necessary, the Hospital President 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 Peer Review activities.

9.7.2 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 (3) 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.

9.8 <u>Automatic Action</u>

In the following instances, a Practitioner's Clinical Privileges shall be automatically relinquished, suspended, or restricted. An automatic relinquishment, suspension, or restriction under this section is not a corrective action and is not an Adverse Recommendation or Action and shall not entitle the Practitioner to any procedural rights of review under Article X of these Bylaws. Automatic relinquishment, suspension, or restriction shall take effect immediately.

The occurrence of automatic action does not prevent the imposition of corrective action for the same or related grounds pursuant to the procedures in Sections 9.3 - 9.6. Except for Section 9.8.5, the Hospital President shall provide the Practitioner with special notice of the imposition of automatic action. An automatic suspension lasting ninety (90) days shall become an automatic termination of Medical Staff membership and privileges, except as otherwise stated below.

If a Practitioner believes an error has been made and that there is no basis for the automatic action, he must notify the Hospital President within seven (7) days of notice of the automatic action 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.

9.8.1 <u>Licensure</u>.

(a) <u>Revocation or Suspension</u>. Whenever a Practitioner's license or other legal credential authorizing the Practitioner's practice in Texas is revoked or suspended, Medical Staff membership and Clinical Privileges shall be automatically revoked or suspended as of the date such action became effective.

(b) <u>Restriction</u>. Whenever a Practitioner's license or other legal credential authorizing the Practitioner's practice in Texas is limited or restricted by the applicable licensing or certifying authority, any Clinical Privileges the Practitioner has been granted at the Hospital that are within the scope of such limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such licensing or certifying authority's action became

effective and throughout its duration.

(c) Probation. If a Practitioner is placed on probation by the applicable licensing or certifying authority, his or her membership status and Clinical Privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action became effective and throughout its duration.

9.8.2 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 Medical Staff Services has not received documentation from the appropriate governmental agency of registration at the end of the ninety (90) days, all of the Practitioner's Clinical Privileges and Medical Staff membership shall automatically terminate.

9.8.3 Professional Liability Insurance.

Failure to maintain professional liability insurance in amounts and of a type required by the Board of Trustees shall result in automatic suspension of a Practitioner's Clinical Privileges, and if within thirty (30) calendar days after the automatic suspension, the Practitioner does not provide evidence of required professional liability insurance, including coverage for gap, the Practitioner's Medical Staff membership shall automatically terminate.

Each Practitioner shall submit evidence of coverage annually (or more often for policy periods of less than twelve (12) months). Any Practitioner who cancels or reduces or otherwise loses his or her insurance shall notify the Hospital immediately upon receipt of notice of such cancellation, loss or reduction. Such Practitioner shall not exercise any clinical privilege in the Hospital during the period he or she is uninsured or inadequately insured.

9.8.4 Medicare Fraud and Abuse; Involuntary Exclusion from a Federal or State Health Care Program

Any Practitioner who is convicted of a crime pursuant to the Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. 100-93 (the "Anti-Kickback Statute," codified at 42 U.S.C. § 1320a–7b) or becomes involuntarily excluded from a Federal or State Health Care Program will be automatically terminated from the Medical Staff. "Federal or State Health Care Program" includes the Medicare program, the Medicaid program, and TRICARE and any other federal or state health care program.

9.8.5 Failure to Complete Medical Records.

Using the procedures in the Rules and Regulations, a Member's admitting privileges, except for emergency admissions, shall be suspended for Delinquency in completion of medical records ("Medical Record Suspension"). "Delinquency" is defined as one (1) or more medical records that are incomplete fourteen (14) 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 remains on automatic suspension for more than 90 consecutive days.
If a Member has six (6) automatic Medical Record Suspensions in a rolling twelve-month period, the Member shall be required to attend a formal meeting of the Medical Executive Committee. Following the Member's meeting with the Medical Executive Committee, if the Medical Staff Member has a seventh (7th) Medical Record Suspension in a rolling twelve-month period, the Member's membership and Clinical Privileges shall be automatically terminated.

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.

9.8.6 Failure to Satisfy Special Appearance, Provide Requested Information, or Undergo an Exam Requirement.

A Practitioner who fails without good cause to appear at a meeting, provide requested health information, or undergo a requested health evaluation or examination for which the Practitioner received special notice in accordance with Section 9.2.6 automatically shall be suspended from

exercising all or such portion of Clinical Privileges as may be specified in the meeting until the meeting occurs or the matter is resolved by subsequent action of the Medical Executive Committee or Board of Trustees.

9.8.7 Termination of Privileges Pursuant to a Contract.

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 X if their Medical Staff membership, status, or privileges are restricted, terminated, or modified pursuant to the terms of a contract with the Hospital.

If, however, the Medical Staff status, membership, or privileges of a Practitioner under contract are modified, restricted, or terminated 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 Article X. In the event of a conflict between the contract and these Bylaws, the terms of the contract shall control.

9.8.8 Criminal Conviction.

Conviction of guilty or a *nolo contendere* plea by a Practitioner for a felony shall cause all of the Practitioner's Clinical Privileges and Medical Staff membership to automatically terminate.

9.8.9 Misrepresentation or Misstatement in, or Omission from the Application

Any material misrepresentation or misstatement in, or omission from the application, whether intentional or not, shall cause automatic and immediate rejection of the application resulting in termination of appointment and Clinical Privileges. In the event that an appointment has been granted prior to the discovery of such material misrepresentation, misstatement or omission, such discovery shall result in automatic dismissal from the Medical Staff and termination of Clinical Privileges, if any;

9.8.10 See also Section 2.1.2(e) regarding Automatic Loss of Eligibility for Reappointment.

9.9 Medical Peer Review

9.9.1 Medical Peer Review Committee Status.

The Medical Executive Committee, the Medical Staff Departments, and all Medical Staff and Department 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, 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.

9.9.2 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 Recommendation or Action, including but not limited to corrective action, and affording procedural rights of review as provided in the Medical Staff Bylaws;

(c) Any evaluation of the merits of a complaint relating to Practitioners or others with 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 Performance Improvement 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;

(g) "Medical peer review" as defined in the Texas Medical Practice Act; and

(h) "professional review activity" as defined by the federal Health Care Quality Improvement Act.

9.9.3 Agents.

(a) 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 committees and the Medical Staff as applicable when performing the authorized functions and responsibilities of the committees and Medical Staff.

(b) Practitioners, whether or not members of the Staff, who are requested by the Medical Executive Committee, a Department, or a committee (whether standing, special or ad hoc) or a task force thereof or of the Medical Staff, or the Board of Trustees to review the patient care, treatment, or services of another Practitioner and/or who do so as an authorized function of the requesting Medical Executive Committee, Medical Staff Department, committee or task force, Medical Staff, or the Board of Trustees, shall be considered agents thereof when performing such review in good faith.

(c) Any good faith action by an agent or member of the Medical Executive Committee, a Department, a committee or task force thereof or of the Medical Staff, or the Board of Trustees when performing such functions and responsibilities shall be considered an action taken on behalf of the Medical Executive Committee, Medical Staff Department, committee or task force, Medical Staff, or the Board of Trustees 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 the Medical Staff and Department officers, the Chief Medical Officer and other Practitioners serving in medical staff leadership and/or administrative positions, and the Hospital President.

ARTICLE X
HEARING AND APPEAL PROCEDURES

10.1 General

A hearing and appellate review shall be in substantial compliance with the procedural safeguards herein to provide the Practitioner the rights to which he or she is entitled under state and federal law.

10.2 Right to Hearing and Appellate Review

10.2.1 Grounds for Hearing.

A Practitioner is entitled to request a hearing whenever the Medical Executive Committee makes one of the following recommendations or takes one of the following actions (hereinafter, "Adverse Recommendation or Action"):

(a) denial of initial appointment to the Medical Staff;

(b) denial of reappointment to the Medical Staff;

(c) revocation of appointment to the Medical Staff;

(d) denial of requested Clinical Privileges (excluding temporary privileges);

(e) limitation on Clinical Privileges;

(f) a precautionary suspension or restriction of Clinical Privileges but only as provided in Section 9.6.5, or any other suspension of Clinical Privileges (excluding temporary privileges);

(g) any revocation of Clinical Privileges;

(h) an observation or proctor requirement if the observer's or proctor's approval is required for the Practitioner to exercise Clinical Privileges;

(i) a mandatory concurring consultation or supervision requirement (i.e. the consultant or supervisor must concur with or approve the course of treatment before the Practitioner may exercise a Clinical Privilege);

(j) an education, training, or counseling requirement that must be satisfied prior to exercising Clinical Privileges; or

(k) any other restriction or limitation on Clinical Privileges that is based upon professional competence or conduct, if such action is reportable to the National Practitioner Data Bank.

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

These rights also apply if the Board of Trustees makes one of the above recommendations or actions following a recommendation or action by the Medical Executive Committee that does not entitle the Practitioner to a hearing.

10.2.2 Actions Not Grounds For a Hearing.

The recommendations or actions that do not constitute grounds for a hearing and appeal include but are not limited to the following and any others so specified elsewhere in these Bylaws. They shall take effect without hearing or appeal, provided that the Practitioner shall be entitled to submit a written explanation which shall be placed in his/her file:

(a) A voluntary agreement pursuant to Section 9.7 or any automatic action taken pursuant to these Bylaws including an automatic action taken pursuant to Section 9.8;

(b) Issuance of a letter of guidance, warning or reprimand, placement on probation (that is not accompanied by a limitation or restriction of Clinical Privileges), or any recommendation or action voluntarily accepted by the Practitioner;

(c) Imposition of an observation, proctoring, supervision, or consultation requirement that the Practitioner must comply with (i.e. observation of the Practitioner's performance by a peer in order to provide information to a medical staff peer review 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;

(d) Imposition of any conditions or other requirements including but not limited to proctoring or mandatory consultation in the course of a focused professional practice evaluation in connection with an initial grant of Clinical Privileges;

(e) Retrospective chart review, conducting an investigation into any matter or the appointment of an ad hoc investigation committee, or a requirement to appear for a special meeting under the provisions of these Bylaws;

(f) Denial of a request for a leave of absence, or for an extension of a leave;

(g) Failure to process an application because it is incomplete or untimely, or failure to expedite an application;

(h) Failure to process an application for membership and/or privileges due to a significant or material misrepresentation, misstatement or omission, whether intentional or not, or because the Practitioner does not meet the eligibility criteria for the privilege or membership;

(i) Failure to process an application for membership and/or privileges or to continue to exercise certain privileges because a relevant specialty is closed as approved by the Board of Trustees or covered under an exclusive provider agreement;

(j) Failure to grant, termination or limitation of temporary privileges;

(k) Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;

(l) Failure to grant a requested change in assigned staff category;

(m) Failure to consider a request for appointment, reappointment, or privileges within five (5) years of a final Adverse Recommendation or Action regarding such request;

(n) Removal or limitation of emergency department call obligation;

(o) Any requirement to complete an educational assessment or to complete a health and/or psychiatric/psychological assessment in accordance with these bylaws;

(p) Any requirement equally imposed on all similarly situated Practitioners; and

(q) Grant of conditional appointment or reappointment for a duration of less than 24 months.

10.2.3 Practitioners Under Contract

A Practitioner who is subject to a contract, or whose group is subject to a contract, with the Hospital or pursuant to a contract to deliver professional services to patients of the Hospital, is not entitled to the procedural rights specified in this Article X if his or her Medical Staff membership, status, or privileges is restricted, terminated, or modified pursuant to the terms of the contract with the Hospital.

10.3 Notice of Adverse Action; Rights of the Practitioner

10.3.1 Notice of Adverse Recommendation or Action.

The Hospital President shall give the Practitioner special notice of an Adverse Recommendation or Action, as defined under Section 10.2.1, within seven (7) days of the recommendation or action. The notice shall include:

(a) the nature and reasons for the Adverse Recommendation or Action;

(b) a listing of the specific or representative patient records and other documents (if any) that were relied on as the basis of the Adverse Recommendation or Action by the Medical Executive Committee or Board of Trustees, whichever initiated the Adverse Recommendation or Action;

(c) an explanation of the Practitioner’s right to request a hearing by special notice under these procedures, to be submitted to the Hospital President, within thirty (30) days of receipt of the notice and a statement that failure to do so waives any further procedural rights of review; and

(d) a summary of the Practitioner’s rights during the hearing as outlined below under Section 10.3.2 and a copy of Article X of these Bylaws.

10.3.2 Rights of the Practitioner.

The Practitioner shall have the following rights:

(a) a hearing before a Hearing Committee as outlined in Section 10.8;

(b) to be present at the hearing, which right may be forfeited if the Practitioner fails without good cause to appear, and to be represented by an attorney or other person of his or her choice;

(c) to have a record made of the proceeding by a court reporter retained by the Hospital, copies of which may be obtained by the Practitioner from the court reporter upon payment of any reasonable charges associated with its preparation;

(d) to call and examine witnesses on any matter relevant to the issue of the hearing, to challenge any witness, and to rebut any evidence;

(e) to present evidence determined to be relevant by the presiding officer, regardless of its admissibility in a court of law;

(f) to submit a written statement at the close of the hearing or on a later date set by the presiding officer;

(g) to receive the written report of the Hearing Committee including a statement of the basis of the Hearing Committee's recommendation; and

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

10.4 Request for Hearing; Waiver of Right to a Hearing

10.4.1 The Practitioner must request a hearing in writing to the Hospital President within thirty (30) days of the date of receipt of notice of the Adverse Recommendation or Action sent to the Practitioner. The request must be sent by special notice. Prior to or in conjunction with requesting a hearing, the Practitioner may request mediation in accordance with the procedure set forth in these Bylaws.

10.4.2 A Practitioner's failure to request a hearing in the manner and within the time required shall be deemed a waiver of his or her right to a hearing, any rights to appeal any Adverse Recommendation or Action that would have been raised at a hearing, and any other procedural rights of review under these Bylaws, or otherwise. The Adverse Recommendation or Action shall become effective immediately subject to approval by the Board of Trustees. The Hospital President shall provide the Practitioner with special notice of the final decision by the Board of Trustees within twenty (20) days of the decision.

10.5 Scheduling; Notices; Failure to Set Hearing Date

10.5.1 Notice and Scheduling.

(a) Notice.

Following receipt of a timely request for a hearing, the Hospital President or his or her designee shall schedule the hearing as provided below and provide special notice to the Practitioner of:

(1) the place, time and date of the hearing, which shall not be less than thirty (30) days from the notice date. Reasonable attempts shall be made to schedule the hearing as soon as practical if the Practitioner is subject to suspension or restriction of privileges and the Practitioner requests in writing that a hearing be scheduled sooner;

(2) the list of documents and witnesses, if any, expected to testify in presenting the basis for the Adverse Recommendation or Action, which list of documents and

witnesses may be supplemented until fourteen (14) days prior to the hearing, unless the parties agree to later supplements; and

(3) the requirement that, at least fourteen (14) 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 his or her challenge of the Adverse Recommendation or Action.

(b) Scheduling.

The Practitioner may waive in writing his or her right to the above thirty (30) day requirement. In such case, the hearing shall be held as soon as arrangements may reasonably be made.

10.5.2 Rescheduling the Hearing.

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.

10.5.3 Failure To Set Hearing Date.

Regardless of a 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 ninety (90) days from the date of the Hospital's initial proposal for a hearing date, the Practitioner shall be deemed to have waived his or her right to a hearing and to have accepted the Adverse Recommendation or Action, unless both parties agree to a delayed hearing date.

In the case of waiver based upon a failure to proceed with a hearing in a timely manner with regard to an Adverse Recommendation or Action by the Medical Executive Committee, the Adverse Recommendation or Action shall become effective pending final decision by the Board of Trustees.

The Board of Trustees shall consider the Medical Executive Committee's recommendation at its next regular meeting, and if the Board of Trustees is in accord with the recommendation, its decision shall be final.

In the case of waiver based upon a failure to proceed with a hearing in a timely manner with regard to an Adverse Recommendation or Action taken by the Board of Trustees, the Adverse Recommendation or Action shall become effective as the Board of Trustees' final decision.

10.6 Witnesses and Access to Documents

10.6.1 The Practitioner shall, upon written request to the Hospital President or his or her designee, be given an opportunity to review (or receive copies upon payment of the Hospital's reasonable copying costs) the patient records and other documents listed in the notice of hearing that are being relied on in issuing the Adverse Recommendation or Action.

The Practitioner is not entitled to access any other documents such as committee minutes, another Practitioner's records or files, or to any rights of discovery in preparation for the hearing except as specifically provided in these Bylaws.

10.6.2 At least fourteen (14) days prior to the start of the hearing, the Medical Executive Committee or the Board of Trustees, whichever took the Adverse Recommendation or Action, and the Practitioner must each provide the other with a list or index of the documents intended to be presented during the hearing and with a copy of the documents unless they have been previously provided.

Either party with objections to documents being produced at the hearing must send notice of such objection to the other party by special notice at least seven (7) days prior to the start of the hearing. The objections shall be addressed if possible, at a pre-hearing conference by the presiding officer and, if not, at the start of the hearing.

10.6.3 If additional documents need to be presented or are requested during the hearing and their need could not have been reasonably anticipated so as to comply with the section above, they may be

utilized in the hearing subject to the requirements of these Bylaws including Sections 10.7, 10.10.5, and 10.10.6 below and provided the other party is given advance notice and an opportunity to review and object to them.

10.6.4 Each party is responsible for arranging for the attendance of their respective witnesses at the hearing.

10.6.5 Any party presenting an individual as an expert witness must provide a written report by the expert to the other party at least 14 days in advance of the hearing.

10.7 Supplemental Witness Lists and/or Supplemental Documents; Request for Additional Preparation Time

Either party may supplement the list of witnesses or documents on special notice to the other party, provided that the parties may mutually agree to later supplements; 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.

10.8 Hearing Committee and Presiding Officer

10.8.1 The hearing must be conducted before an ad hoc medical peer review committee ("Hearing Committee") of at least three (3) Medical Staff Members.

10.8.2 The members of the Hearing Committee must be able to be impartial and objective as to the Practitioner and may not:

(a) have been involved in requesting the corrective action against the Practitioner or participated in the investigation or issuance of the Adverse Recommendation or Action;

(b) have a conflict of interest; or

(c) be a direct economic competitor of the Practitioner.

Knowledge of the matter does not preclude a person from serving on the Hearing Committee.

10.8.3 Appointment of Presiding Officer.

(a) The Hospital President shall appoint an outside presiding officer for the hearing to preside over the hearing and serve as counsel to the Hearing Committee, and the presiding officer shall be an attorney. The presiding officer may not have provided legal advice to the Hospital with regard to the Adverse Recommendation or Action.

The Hospital President shall give special notice to the Practitioner of the name of the presiding officer. An outside presiding officer may not have provided legal advice with regard to the Adverse Recommendation or Action.

(b) The presiding officer may be present during the deliberations (and assist the Hearing Committee with the preparation of the report) if requested by the Hearing Committee but may not vote. The presiding officer shall have the authority to implement procedures to maintain order and decorum and to assure that the hearing is conducted in accordance with this Article X. 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.

(c) The presiding officer may conduct a pre-hearing conference to address objections to the documents produced, the proceedings, or other matters to the extent they can be addressed in advance.

10.8.4 Objections.

At least thirty (30) days prior to the date of the hearing, the Hospital President shall give the Practitioner special notice of the names of the Hearing Committee members and their specialties or subspecialties. The Practitioner must file his or her objections to any Hearing Committee member or members, if any, with a specific statement of the reason for the objections, by special notice to the Hospital President within fourteen (14) days of receipt of such notice.

The Hospital President shall forward any objections made by the Practitioner to the presiding officer who may make decisions in his or her sole discretion regarding the objections and replacement of such Hearing Committee member or members. Failure to file objections as required above shall constitute the Practitioner's acceptance of the impartiality and objectivity of the Hearing Committee members and waiver of any further right to object. The decision of the presiding officer is final. If there is no outside presiding officer, the Hospital President shall rule on the objections.

The Practitioner must file any objection to the presiding officer by special notice to the Hospital President within fourteen (14) calendar days of receipt of such notice. The Hospital President shall then make a decision on the objection in his or her sole discretion.

10.9 Representation; Practitioner Testimony

10.9.1 Medical Executive Committee Representation; Board of Trustees Representation.

The Medical Executive Committee, when its action has prompted the hearing, shall appoint one or more of its members (e.g. the applicable Department Chair) or some other Medical Staff Member, or Members, to represent it at the hearing, to present the facts in support of its Adverse Recommendation or Action, and to examine witnesses. When the hearing is prompted by action of the Board of Trustees, the Chair of the Board of Trustees shall appoint one or more of its members and/or one or more Members of the Medical Staff to represent it at the hearing, to present the facts in support of its Adverse Recommendation or Action, and to examine witnesses.

It shall be the obligation of such representative(s) to present evidence in support of the Adverse Recommendation or Action. The Hospital President shall appoint legal counsel to assist the representative(s). The representative of the Medical Executive Committee or Board of Trustees shall have the same rights as the Practitioner as set forth in Section 10.3.2.

10.9.2 Practitioner Testimony.

If the Practitioner does not testify in his or her own behalf, he or she may be called and examined by the representative(s) of the Medical Executive Committee or Board of Trustees and the Hearing Committee.

10.10 Procedures for Conducting the Hearing

10.10.1 Record of the Hearing.

A verbatim record of the hearing shall be kept by a court reporter and retained by the Hospital.

The cost of attendance of the reporter shall be the responsibility of the Hospital, and the cost of obtaining a copy of the transcript shall be the responsibility of the requesting party.

10.10.2 Failure to Appear.

The personal presence of the Practitioner for whom the hearing has been scheduled is required. Failure of the involved Practitioner to be present during the hearing, without good cause, or submit or respond to questioning shall constitute a waiver of the Practitioner's right to a hearing and any further procedural rights of review under these Bylaws, or otherwise.

10.10.3 Contact with Hearing Committee Members.

All parties in the hearing are prohibited from any contact with the Hearing Committee members regarding the merits of the matter at all times during the hearing or any subsequent appeal, except

as part of the formal hearing process. Failure to comply shall be grounds for corrective action and may result in further action against the Practitioner who is the subject of the hearing. 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.

10.10.4 Waiver of Time Frames; Postponement.

The Practitioner may waive the time frames specified for the hearing in this Article X. The waiver shall be in writing and submitted to the Hospital President.

Once the hearing is convened, postponement of a hearing beyond the time set forth in this Article shall be made only with the approval of the presiding officer, in consultation with the Hearing Committee. A Practitioner's request for postponement of the hearing shall be in writing and submitted to the presiding officer. Granting of such postponements shall only be for good cause shown and in the sole discretion of the presiding officer.

10.10.5 Presiding Officer's Role.

The presiding officer appointed herein shall have the authority to implement procedures to maintain order and decorum, to minimize duplicative or irrelevant evidence, and to see that the hearing is conducted in accord with these Bylaws. The presiding officer shall be entitled to determine the order of the proceedings and shall make all rulings on matters including the admissibility of evidence and hearing procedural issues that arise before, during or following the hearing up until issuance of the Hearing Committee's report.

The presiding officer shall conduct a pre-hearing conference to address any objections to the documents produced as required by these Bylaws, the proceedings, or other matters to the extent they can be addressed in advance.

10.10.6 Rules of Evidence; Burden of Proof to Challenge an Adverse Action or Recommendation.

The hearing need not be conducted strictly according to the Texas rules of evidence relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule that might make such evidence inadmissible in a civil or criminal action. The presiding officer may, at his/her discretion, require that evidence be taken under oath or affirmation, administered by a court reporter. The Hearing Committee and presiding officer may question any party or witness.

To challenge an Adverse Recommendation or Action, the Practitioner must provide evidence to the Hearing Committee sufficient for the Hearing Committee to find that the recommendation or action either lacked sufficient factual basis or that it was arbitrary, unreasonable, or capricious.

10.10.7 Recess.

The Hearing Committee may, at its sole discretion and without notice to the parties, recess the hearing for the convenience of the participants, or for the purpose of requesting that the parties obtain new or additional evidence or present additional witnesses.

10.10.8 Majority Presence.

At least a majority of the members of the Hearing Committee must be present to conduct the hearing. No member may vote by proxy. If a member is absent during some of the proceedings, he or she may not participate in deliberations until he or she has certified for the record that he or she has read the transcript for any portions of the hearing during which absent.

10.10.9 Submission of Written Statements.

The Practitioner and the representative(s) of the Medical Executive Committee or Board of Trustees shall have the right to submit to the Hearing Committee a written statement on any matter(s) pertinent to the Adverse Recommendation or Action during the hearing and at the end of the hearing by the time and date designated by the presiding officer. Upon conclusion of the presentation of oral and

written evidence and the submission of any written statements, the hearing shall be closed and no further evidence shall be admitted.

10.10.10 Deliberation.

Within fifteen (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. The Hearing Committee shall be limited to consideration of the evidence presented in the hearing and may not solicit information from third parties. If the Hearing Committee requests additional information from a party, that request shall be in writing and communicated to both parties.

Each party shall be provided with a copy of any requests and responses and permitted to submit any comments to the Hearing Committee on the response, and a copy shall be provided to the other party. The Hearing Committee may also reopen the hearing if necessary on special notice to the parties.

10.10.11 Adjournment and Report.

(a) By majority vote, the Hearing Committee shall make findings as to the basis of the Adverse Recommendation or Action and shall recommend that the Adverse Recommendation or Action be affirmed, modified, or reversed, to include a statement of the basis for the recommendation. If the Hearing Committee recommends modification of the Adverse Recommendation or Action, it shall also recommend the type of modification. Upon completing the deliberations and reaching a recommendation, the hearing shall be adjourned. Within fourteen (14) 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.

(b) The written report of the Hearing Committee shall be forwarded to the Hospital President, who shall send a copy of the written report in a timely manner by special notice to the Practitioner and to the Medical Executive Committee or Board of Trustees, whichever initiated the Adverse Recommendation or Action.

10.10.12 Hospital Representatives.

Representatives of the Hospital may be present at all times during the hearing but not deliberations.

10.11 Consideration by the MEC or Board of Trustees; Notice to Practitioner

10.11.1 Medical Executive Committee Recommendation; Board of Trustees.

(a) Within thirty (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 to review the report to consider the recommendation of the Hearing Committee. The Medical Executive Committee/Board of Trustees, which ever initiated the Adverse Recommendation or Action, shall review the report and issue a written recommendation to affirm, modify, or reverse the Adverse Recommendation or Action, to include the basis of the recommendation.

(b) If the recommendation under Subsection (a) above was by the Medical Executive Committee and it remains an Adverse Recommendation or Action, the special notice shall include a statement of the Practitioner's right to appellate review and the procedures for filing an appeal as set forth below.

(c) If the recommendation under Subsection (a) above was by the Medical Executive Committee and it is not an Adverse Recommendation or Action, it shall be forwarded to the Board of Trustees. Within thirty (30) days of receipt, the Board of Trustees shall consider the Medical Executive Committee's recommendation and the Hearing Committee and issue its decision to include a statement of the basis of the decision.

(1) If the Board of Trustees' decision is an Adverse Recommendation or Action, the Hospital President shall send a copy of the Board's written recommendation to the

Practitioner, to include a statement of the Practitioner's right to appellate review and the procedures for filing an appeal as set forth below.

(2) If the Board of Trustees' decision is not an Adverse Recommendation or Action, it shall be the final decision and the Hospital President shall provide the Practitioner special notice of the final decision within twenty (20) days of the decision.

(d) If the recommendation under Subsection (a) above was by the Board of Trustees and it remains an Adverse Recommendation or Action, the special notice shall include a statement of the Practitioner's right to appellate review and the procedures for filing an appeal as set forth below. The Hospital President shall also notify the Medical Executive Committee of the recommendation.

(e) If the recommendation under Subsection (a) above was by the Board of Trustees and it 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 twenty (20) days of the decision, with a copy to the Medical Executive Committee.

10.11.2 Notice to Practitioner.

(a) If the Medical Executive Committee initiated the Adverse Action or Recommendation, within five (5) days of the Medical Executive Committee's decision, the Hospital President shall send a written report of its recommendation to the Practitioner by special notice.

(b) If the decision of the Medical Executive Committee is an Adverse Recommendation or Action as defined in Section 10.2.1, the notice shall advise the Practitioner of the right to appeal as set out below.

If the Board of Trustees initiated the Adverse Action or Recommendation, once the Board of Trustees' makes its decision, the decision will be final and the Practitioner will have no right of appeal.

10.12 Board of Trustees Action Following Medical Executive Committee Recommendation

10.12.1 Right to Appeal.

If the Practitioner disagrees with the findings and/or recommendation of the Medical Executive Committee, the Practitioner may appeal the recommendation to the Board of Trustees by filing a written statement to this effect with the Hospital President by special notice within twenty (20) days of receipt of the Medical Executive Committee's recommendation.

The written statement must list all elements of the Medical Executive Committee's report with which the Practitioner disagrees, citing the specific basis for the disagreement, with reference to the grounds for appeal under Section 10.12.3 below. The statement must also list all procedural objections to the issuance of the Adverse Recommendation or Action and the hearing, if any.

10.12.2 Waiver.

Failure of the Practitioner to submit a written statement in appeal within the required fifteen (15) days shall be deemed a waiver of the Practitioner's right to appeal under these Bylaws, or otherwise.

10.12.3 Grounds for Appeal.

The written request for an appeal under Section 10.12.1 shall include an identification of the grounds for appeal, and a clear and concise statement of the facts in support of the appeal. The grounds for appeal shall be limited to:

(a) the decision was made arbitrarily, capriciously, or with prejudice;

(b) the decision was not made in the reasonable belief that it would further quality health care;

(c) there was not a reasonable effort to obtain the facts of the matter;

(d) there was not a reasonable belief that the decision was warranted by the known facts; or

(e) there was not substantial compliance with the procedures required by these Bylaws so as to deny the Practitioner a fair hearing.

10.12.4 Rebuttal Statements.

If the Practitioner submits a written statement in appeal as required herein, the Hospital President shall provide that written statement to the Medical Executive Committee representative (or to the Board of Trustees representative when the hearing was prompted by the Board of Trustees) within three (3) days of receipt and notify that party of the opportunity to submit a written rebuttal to any items in the written statement.

A rebuttal statement must be in writing and delivered to the Hospital President within ten (10) days of receipt of the written statement being rebutted. The Hospital President shall provide a copy of the rebuttal statement to the Member in a timely manner and prior to any oral statements under Section 10.12.5.

10.12.5 Personal Appearance and Oral Statement.

The Board of Trustees, in its sole discretion, may permit the Practitioner and the Medical Executive Committee or Board representative to appear before the Board of Trustees at its next regular meeting or a meeting specially called by the Board of Trustees, and make an oral statement in addition to the written and rebuttal statements. The Board of Trustees may appoint a special committee of the board ("Board Committee") to hear the oral argument and review the matter.

If the parties make oral statements, they shall also be required to answer questions by the Board of Trustees or Board Committee. The parties may be accompanied by counsel, and counsel may make the oral statement unless otherwise provided by the Board of Trustees or Board Committee. The Board of Trustees or Board Committee may limit the time for the oral statements and presentation of witnesses is not permitted.

10.12.6 Appellate Review by the Board of Trustees.

Upon receipt of any written statements and rebuttals and following oral statements if any, or in the case of waiver of appeal rights by the Practitioner, the Board of Trustees shall review the matter. If a Board Committee was appointed under Section 10.12.5, the Board Committee shall, within fourteen (14) days after the adjourned date of the committee's meeting, make a written report to the Board of Trustees.

The appellate review shall be limited to the grounds for appeal stated in Section 10.12.3.

No new evidence may be presented, and no discussion of evidence shall be considered except in the Board's sole discretion and only upon a showing that it was not available at the time of the hearing. New or additional matters not raised during the hearing or in the Hearing Committee report, nor otherwise reflected in the record, shall not be introduced during the appellate review.

10.13 Final Decision by the Board of Trustees; Notice to Parties

10.13.1 Final Decision by the Board of Trustees.

The Board of Trustees shall issue a final decision and, except as provided below, the decision shall be effective as of the date of the Board of Trustees meeting. The decision shall be in writing and include a statement of the basis of the decision. The Board of Trustees may, prior to making a final decision, refer the matter back to the Hearing Committee or the Medical Executive Committee for specific action. If so, the referral shall state actions to be taken and the reasons therefore and set a time limit for the action. The referral may include a directive for an additional hearing or continuation of the original hearing.

10.13.2 Notice to Parties.

The Hospital President shall provide the Practitioner with special notice of the Board of Trustees' final decision within five (5) days of the decision. The notice shall include the findings on the grounds for appellate review. The Hospital President shall also notify the Medical Executive Committee of the decision.

10.14 Mediation

10.14.1 Right to Mediation.

A Practitioner who requests and is entitled to mediation pursuant to section 241.101(d) of the Texas Health & Safety Code based on:

(a) being subject to an Adverse Recommendation or Action as defined in Section 10.2.1; or

(b) an allegation that the Credentials Committee has not acted on a complete application for appointment or reappointment within ninety (90) days of its receipt.

The Practitioner shall be provided with an opportunity for mediation as set forth in these Bylaws.

The Practitioner requesting and entitled to statutory mediation shall be referred to as an "Eligible Practitioner" for purposes of this section.

10.14.2 Request for Mediation.

The Eligible Practitioner must submit a request for mediation pursuant to section 241.101(d) of the Texas Health & Safety Code by special notice to the Hospital President within fourteen (14) days of:

(a) receipt of the notice of an Adverse Recommendation or Action as defined in Section 10.2.1; or

(b) the ninetieth (90th) day from the Credentials Committee's receipt of a complete application.

10.14.3 Scheduling and Terms.

(a) The mediation should be scheduled within twenty (20) days of the Eligible Practitioner's request and completed within seventy-five (75) days of the of the Practitioner's request and, in the case of an Adverse Recommendation or Action, shall be conducted before a hearing is scheduled and completed. Submission of a request for mediation temporarily suspends any hearing time lines in these Bylaws. If the Eligible Practitioner has waived his or her hearing rights as provided herein but desires to participate in mediation, mediation must be scheduled before the Adverse Recommendation or Action is submitted to the Board of Trustees for a final decision.

(b) 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 the parties mutually agree in writing to use a mediator not meeting

such requirements.

(c) 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 the Hospital President.

(d) The Hospital President shall determine the appropriate representative(s) of the Hospital at mediation. Attorneys for the parties may attend and participate in the mediation.

10.14.4 Mediation Agreements.

(a) 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.

(b) Any 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 Practitioner will be deemed to have waived all his remaining rights including, if applicable, the right to a hearing, under the Medical Staff Bylaws.

(c) If the Medical Executive Committee or 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. The Eligible Practitioner will retain any applicable procedural rights provided by the Bylaws but has no right to further mediation.

(d) Any time lines contained in the Medical Staff Bylaws and/or this Plan 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.

(e) 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.

10.14.5 Notice of Mediation Not Required.

Nothing in the Bylaws requires the Hospital to notify an Eligible Practitioner of his or her right under section 241.101(d) of the Texas Health & Safety Code to request mediation.

10.15 Limitations and Legal Requirements

10.15.1 Single Proceeding.

A Practitioner shall be entitled to only one (1) hearing, appeal, and mediation on any Adverse Recommendation or Action.

10.15.2 Reporting of Action.

Any mandatory reporting of a final professional review action on behalf of the Medical Staff, the Hospital, or the Board of Trustees, or their medical peer review committees/medical committees/professional review bodies, as such terms are defined by law, shall be done by the Hospital President or his or her designee. Nothing in this section or the other provisions of these Bylaws shall prevent an individual Member of the

Medical Staff or member of the Board of Trustees from making any other report to state or federal agencies as permitted or required by law.

10.15.3 Extension of Time Periods.

Any time periods within which action by a committee is to be taken are intended as guidelines and not to create a right of a Practitioner to have an action taken within the time period. Time periods for committee action may be extended by the Hospital President for good cause. A Practitioner who objects to an extension may file a written request with the Medical Executive Committee, which shall verify the existence of good cause.

ARTICLE XI
CONFIDENTIALITY, IMMUNITY, RELEASES, AND GENERAL PROVISIONS

11.1 Special Definitions

For purposes of this Article only, the following definitions shall apply:

(a) Information means proceedings, minutes, interviews, records, reports, forms, memoranda, statements, investigations, examinations, hearings, meetings, recommendations, findings, evaluations, opinions, conclusions, actions, data and other disclosures or communications, in whatever form.

(b) Good Faith means having an honest purpose or intent and being free from intention to defraud.

(c) Malice means the dissemination of a known falsehood or of information with a reckless disregard for whether or not it is true or false.

(d) Representative means the members of the Board of Trustees or the Texas Health Resources Board of Trustees, any Medical Staff Committee members, any director or committee of the Hospital; the Hospital President or his designees; registered nurses and other employees of the Hospital or Texas Health Resources; the Medical Staff, and any member, officer, clinical unit or committee thereof; internal or external legal counsel; and any individual authorized by any of the foregoing to perform specific information gathering, analysis, use or disseminating functions.

(e) Third Parties means both individuals and organizations providing information to any representative.

11.2 Authorization and Conditions

By submitting an application for Medical Staff appointment or reappointment or by applying for or exercising Clinical Privileges or providing specified patient care services at the Hospital, an applicant:

(a) authorizes representatives of the Hospital to solicit, provide and act upon information bearing on his professional ability, utilization practices and other qualifications;

(b) agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article; and

(c) acknowledges that the provisions of this Article are express conditions to his application for, or acceptance of, Medical Staff appointment and the continuation of such appointment and to his application for and exercise of Clinical Privileges or provision of specified patient services at the Hospital.

11.3 Confidentiality of Information

Information submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of:

(a) reviewing, evaluating, monitoring or improving the quality and efficiency of health care provided;

(b) reducing morbidity and mortality;

(c) evaluating current clinical competence and qualifications for Medical Staff appointment or Clinical Privileges;

(d) contributing to teaching or clinical research;

(e) determining that health care services were indicated or were performed in compliance with the applicable standard of care;

shall, to the fullest extent permitted by law, be confidential. Said information shall not be disseminated to anyone other than a representative of the Hospital or to other health care facilities or organizations of health professionals engaged in an official, authorized activity for which the information is needed nor be used in any way except as provided herein or except as otherwise required by law.

Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's record. It is expressly acknowledged by each Member that violation of the confidentiality provided herein is grounds for immediate and permanent revocation of Medical Staff membership and Clinical Privileges or specified services.

11.4 Immunity from Liability

No representative shall be liable to a Member for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of his duties as a representative, and no representative or third party shall be liable to a practitioner for damages or other relief by reason of providing information, opinion, counsel or services to a representative or to any healthcare
facility or organization of health professional concerning the Member if such representative or third-party acts:

(a) in good faith and without malice;

(b) in the reasonable belief that the decision, opinion, action, statement, recommendation, information, opinion, counsel or services were in furtherance of quality or efficient health care services and were warranted by the facts known;

(c) after a reasonable effort to obtain the facts of the matter; and

(d) in accordance with any applicable procedures specified in the Medical Staff Bylaws or other relevant manuals or policies, and state and federal law.

11.5 Activities and Information Covered

The confidentiality and immunity provided by this Article applies to all information or disclosures performed or made in connection with this Hospital or any other health care facility's or organization's activities concerning, but not limited to:

(a) applications for appointment, Clinical Privileges or specified services;

(b) periodic reappraisals for reappointment, Clinical Privileges or specified services;

(c) corrective or disciplinary actions;

(d) hearings and appellate reviews;

(e) quality management program activities;

(f) utilization review and management activities;

(g) claims reviews;

(h) risk management and liability prevention activities;

(i) other Hospital, committee, department or Medical Staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

11.6 Information

The information referred to in this Article may relate to a Member's professional licensure or certification, education, training, clinical ability, judgment, utilization practices, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect the quality, efficiency or appropriateness of patient care provided at the Hospital.

11.7 Releases

Each applicant or Member shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under relevant Texas law. Execution of such releases is not a prerequisite to the effectiveness of this Article.

11.8 Cumulative Effect and Severability

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information and immunities from liability are in addition to other protections provided by relevant Texas and federal law and not in limitation thereof. A finding by a court of law or administrative agency with proper jurisdiction that all or any portion of any such provision is not enforceable shall not affect the legality or enforceability of the remainder of such provision or any other provision.

ARTICLE XII
MISCELLANEOUS PROVISIONS

12.1 Bylaws

12.1.1 General.

The Medical Staff is responsible for adopting and amending the Bylaws, and this responsibility cannot be delegated. Except as provided in 12.1.4, any proposed new or amended Bylaws shall be presented to the Bylaws Committee and the Medical Executive Committee for review, approved by the Medical Staff, and sent to the Board of Trustees for final action as described below. These Bylaws shall be reviewed periodically for compliance with legal and accreditation requirements

12.1.2 Initiating New or Amended Bylaws.

Any new Bylaws or amendments to the Bylaws may be initiated: In writing upon petition signed by at least twenty percent (20%) of the voting Members (i.e. the Active Medical Staff), upon recommendation of the Bylaws Committee or the Medical Executive Committee.

When initiated by the Medical Staff, any proposed new or amended Bylaws shall be submitted in writing along with the signed petition to the Medical Staff President who shall forward the proposed amendment to the Bylaws Committee for review and comment within fourteen (14) days of receipt. After the Bylaws Committee's review, the proposal will then be sent to the Medical Executive Committee for review and comment.

12.1.3 Approval and Adoption.

(a) Voting by the Medical Staff.

The Medical Executive Committee shall choose one of the following two (2) methods for presenting proposed new or amended Bylaws to the Medical Staff:

(1) At any regular or special meeting of the Medical Staff, provided that the proposed changes have been circulated in writing or otherwise made available to the Medical Staff at least fourteen (14) calendar days prior to the meeting. Adoption of the proposed changes requires a majority vote of the Active Medical Staff present at the meeting. For purposes of this subsection, there is no quorum requirement; or

(2) By submitting the proposed Bylaws or Bylaws amendment(s) to the voting Members (i.e. the Active Staff) for vote by ballot in accordance with Section 12.4 of these Bylaws. Adoption of the proposed changes will require a majority of votes cast.

12.1.4 Technical and Editorial Amendments.

The Medical Executive Committee shall have the power to adopt such amendments to these Bylaws as are in its judgment, technical and editorial changes or clarifications and/or revisions to comply with reorganization or renumbering, or amendments necessary because of punctuation, spelling or other errors of grammar or expression, inaccurate cross references, or to reflect changes in committee names.

The action to amend may be taken by motion acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such amendments shall be communicated and in writing to the Medical Staff and to the Board of Trustees.

12.1.5 No Unilateral Amendment.

Except as provided in Section 12.1.3 above, neither the Medical Executive Committee, nor the Medical Staff, nor the Board of Trustees may unilaterally amend these Bylaws.

12.1.6 Adoption; Effective Date.

These Bylaws and all amendments to these Bylaws shall be effective upon the date approved by the Board of Trustees unless otherwise stated in the Bylaw provision or amendment approved by the Board of Trustees and shall apply to all pending matters to the extent practical, unless the Board of Trustees directs otherwise. Any Bylaws amendments and/or new Bylaws shall be distributed to the Medical Staff.

These Bylaws shall replace and supersede all previous Bylaws and be binding upon the Board of Trustees, the Medical Staff, the Hospital, and all outside persons including applicants for Membership. Notice of the revised text shall be distributed to Members.

12.2 Rules and Regulations

12.2.1 General.

The Medical Staff, using the procedures below and with the approval of the Board of Trustees, shall adopt such Rules and Regulations and Medical Staff policies as may be necessary to implement more specifically the general principles found in these Bylaws and to regulate the conduct of Medical Staff organizational activities.

Rules and Regulations shall set standards of practice that are to be required of each individual exercising Clinical Privileges in the Hospital and shall act as an aid to evaluating performance under, and compliance with, these standards. Rules and Regulations shall have the same force and effect as the Bylaws.

12.2.2 Adoption and Amendment.

(a) Rules and Regulations may be amended, repealed or adopted by one (1) of the following two (2) ways:

(1) By the affirmative vote of two-thirds (2/3) of the Medical Executive Committee (MEC) present at a regular or special meeting of the MEC at which a quorum is present.

When initiated by the MEC, at least fourteen (14) calendar days prior to the MEC meeting and vote, the MEC shall notify the Medical Staff of the proposal. The notice shall advise the Medical Staff of the opportunity and procedures to submit written comments on the proposal to the MEC for the MEC's consideration prior to voting on the proposal. The procedures for management of a conflict between the

Medical Staff and the MEC on the approved change are set out below in Section12.6.2 below.

Or -

(2) The Medical Staff may propose a new or amended Rule and Regulation upon written petition signed by at least twenty percent (20%) of the Active Staff. The proposed change shall then be submitted to the Medical Staff President who shall then refer the proposed change to the Bylaws Committee for review and comment for review and comment within fourteen (14) days of receipt. Within fourteen (14) days after the Bylaws Committee's review, the proposal will be sent to the Medical Executive Committee for review and comment at a regular or special called meeting.

The proposed change along with the Bylaws Committee's and Medical Executive Committee's comments shall then be submitted to the Medical Staff for vote upon providing at least fourteen (14) days' notice of the meeting or may be submitted to the voting members of the Medical Staff (i.e. the Active Staff) by mail ballot in accordance with Section 12.4 of these Bylaws.

Adoption or amendment shall require a majority vote of the Active Staff Members present at the Medical Staff meeting. For purposes of this subsection, there is no quorum requirement for the Medical Staff meeting when voting on the proposal.

(3) In cases of a documented need for an urgent amendment of the Rules and Regulations to comply with a law or regulation, 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 12.2.2(a)(1) above. In such case, the Medical Staff Members shall be notified of the amendment within ten (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 ten (10) days of the notice. The procedures for invoking the conflict management process are set out in Section 12.6.2 below. If the conflict management process is not invoked, no further action is required.

12.3 <u>Medical Staff Policies</u>

12.3.1 Adoption or amendment of a Medical Staff policy may be accomplished by one of the following two methods:

(a) By the affirmative vote of a majority of the Medical Executive Committee present at a regular or specially called meeting of the Medical Executive Committee at which a quorum is present. Medical Staff policies shall then be submitted to the Board of Trustees for approval. Any Medical Staff policy adopted by the Medical Executive Committee shall be communicated to the Medical Staff following adoption.

(b) The Medical Staff may propose a Medical Staff policy or policy amendment upon written petition signed by at least twenty percent (*20%*) of the Active Staff. The proposed policy or amendment shall then be filed with the Medical Staff Services to be forwarded to the Medical Staff President. The Medical Staff policy or amendment shall be then presented at its next regular or specially called meeting of the Medical Executive Committee for review and comment.

The proposed policy or amendment along with the Medical Executive Committee's comments shall then be submitted to the voting members of the Medical Staff (i.e. the Active Staff) for a vote upon providing at least fourteen (14) days' notice of a Medical Staff meeting or by mail ballot in accordance with Section 12.4. Adoption or amendment shall require a two-thirds (2/3) vote of the Active Staff Members casting a vote. For purposes of this subsection, there is no quorum requirement for the Medical Staff meeting when voting on the policy or amendment.

12.3.2 Whether adopted or amended by the Medical Staff or the Medical Executive Committee, any Medical Staff policy or amendment becomes effective only when approved by the Board of Trustees. If approved, within fourteen (14) calendar days of the Board of Trustees' approval, the Medical Staff Services shall send each Member notice of the adopted policy.

12.3.3 Any new and amended Medical Staff policy shall become effective once approved by the Board of Trustees. Once approved, the Medical Staff policy will be upheld by the Board of Trustees.

12.3.4 The conflict management procedures in Section 12.6.2 govern any conflicts between the Medical Staff and the Medical Executive Committee regarding adoption or amendment of a Medical Staff policy.

12.4 Ballots for Voting

At the direction of the Medical Staff President, a question which requires a vote of the voting members of the Medical Staff (i.e. the Active Staff) including but not limited to election of officers or adoption of new or amended (or repeal of) Medical Staff Bylaws, Rules & Regulations, or policies may be communicated to the Medical Staff by mail, fax, e-mail or other electronic means of communication.

The voting membership of the Medical Staff (i.e. the Active Staff) may cast votes on any such question by mail, fax transmission or e-mail. Ballots shall be returned to the Medical Staff Services by mail, fax transmission, or e-mail. The voting Member is responsible for seeing that his/her vote is received in the Medical Staff Services either via certified return receipt mail; fax confirmation from the transmitting fax machine; or electronic verification (e.g., "read receipt").

Approval by ballot requires a majority of votes received and a minimum of twenty-five (25) ballots returned. Ballots received within fourteen (14) days of being mailed/transmitted shall be counted.

12.5 Conflicts of Interest

12.5.1 In any instance where a Medical Staff committee member has or reasonably could be perceived to have a bias or a conflict of interest in any matter involving another Member or applicant that comes before such committee, or in any instance where a committee member requests an investigation of another Member or applicant, that committee member shall not participate in the discussion or voting on the matter and shall absent himself from the meeting during that time. A committee member shall disclose any such conflict or bias to the committee. However, the committee member may be asked and may answer any questions concerning the matter before leaving. The committee Chair routinely may inquire, prior to committee discussion of the matter, as to whether any member has any bias or conflict of interest. Any committee member with knowledge of the matter may call to the committee Chair's attention the existence of a bias or potential conflict of interest on the part of another committee member.

12.5.2 When performing a function outlined in the Bylaws, the Rules and Regulations, or Medical Staff or Hospital policies, if any Member has or reasonably could be perceived as having a conflict of interest or bias, the Member with a conflict shall not participate in the final discussion or voting on the matter, and may be excused from any meeting during that time. However, the Member may provide relevant information and may answer any questions concerning the matter before leaving.

12.5.3 A department Chair has a duty to delegate to a Vice Chair or other department member, review of applications for appointment, reappointment or Clinical Privileges or questions that may arise if the Chair has a conflict of interest with the person under review or could be reasonably perceived to have a bias or conflict of interest.

12.6 Conflict Resolution

12.6.1 Resolution of Conflict between the Board of Trustees and the Medical Executive Committee.

In the event the Board of Trustees makes a decision contrary to a recommendation by the Medical Executive Committee, the matter may (at the request of the Medical Executive Committee) be submitted to a Joint Conference Committee composed of the officers of the Medical Staff and an equal number of members of the Board of Trustees for review and recommendation to the Board of Trustees.

In addition, the Hospital President and the Chief Medical Officer shall serve as non-voting members of the committee. 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, the legal obligations of the Board of Trustees, and the safety and quality of patient care delivered at the Hospital. The committee will submit its recommendation to the Board of Trustees within thirty (30) days of making its decision. The Chair of the Board of Trustees or the President of the Medical Staff may call for a Joint Conference Committee meeting at any time to clarify any issue or provide information directly to the Board of Trustees or Medical Staff leaders.

A member elected by the committee shall serve as Chair, with a member from the Medical Executive Committee serving in even years and a member of the Board of Trustees serving in odd years. Approval of committee decisions or actions to be taken require a majority vote of the committee members present. A quorum shall be the attendance of least two (2) voting members from the Board of Trustees and two (2) voting members from the Medical Executive Committee. Approval by the committee of any decision or recommendation regarding the issue under review shall require a majority vote of the committee members present.

The committee shall report to the Medical Executive Committee and the Board of Trustees. If the committee cannot resolve a conflict referred to it in a manner agreeable to the parties, the Board of Trustees shall proceed with a final decision on the issue that gave rise to the conflict.

12.6.2 Resolution of Conflict between the Medical Staff and Medical Executive Committee regarding Adoption of a Rule and Regulation or Medical Staff Policy

In the event of a conflict between Members of the Medical Staff and the Medical Executive Committee regarding the adoption of any Rule & Regulation or Medical Staff policy, or any amendment thereto, upon a petition signed by twenty percent (20%) of the members of the Active Staff entitled to vote, the matter shall be submitted to the following conflict resolution process:

(a) A Conflict Resolution Committee shall be formed consisting of up to five (5) representatives of the Active Staff designated by the Active Staff members submitting the petition and an equal number of representatives of the Medical Executive Committee appointed by the Medical Staff President. The Hospital President or designee and the Chief Medical Officer or designee shall be an ex-officio non-voting member of any Conflict Resolution Committee.

(b) The Conflict Resolution Committee shall gather information regarding the conflict, meet to discuss the disputed matter, and work in good faith to resolve the differences between the parties in a manner consistent with protecting safety and quality. Within fourteen (14) calendar days of conclusion of the meeting, the Committee will consider the proposed Rule and Regulation, medical staff policy, or amendment, take a vote on the issue 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.

(c) Any recommendation which is approved by a majority of the Conflict Resolution Committee members present shall be submitted back to the Medical Executive Committee for consideration and approval.

(d) The Conflict Resolution Committee shall report to the Medical Executive Committee and the Board of Trustees. If the committee cannot resolve a conflict referred to it in a manner agreeable to the parties, the Board of Trustees shall proceed with a final decision on the issue that gave rise to the conflict.

12.7 Conflicts between/among Bylaws, Rules & Regulations, Medical Staff Policies

12.7.1 Medical Staff policies & procedures, the Medical Staff Bylaws and the Medical Staff Rules & Regulations shall not conflict with the Hospital's Bylaws adopted by the Board of Trustees.

12.7.2 In the event it is determined any Medical Staff Rules & Regulations, or Medical Staff policies or procedures of the Medical Staff is in conflict with any statement contained in these Bylaws, these Bylaws shall prevail and steps shall be initiated to revise the conflicting document.

Rules and Regulations and Medical Staff policies shall have the same force and effect as the Bylaws. Rules and Regulations and any policies shall be reviewed periodically for compliance with legal and accreditation requirements and current Medical Staff practice. In the event of any conflict between the Bylaws and the Rules and Regulations or the Bylaws and a policy, the Bylaws shall prevail.

12.8 Notices

Any notices to the Medical Staff required by this Article XII shall be deemed effective when sent by mail, fax transmission, or other electronic means using the contact information currently on file in the Medical Staff Services at the time of the notice.

12.9 Organized Health Care Arrangement

Texas Health Presbyterian Hospital Dallas (the "Hospital") participates in an Organized Health Care Arrangement (OHCA) under the Health Information Portability and Accountability Act of 1996 (HIPPA) and in accordance with the Texas Health Resources Organized Health Care Arrangement policy ("OCHA Policy"). The activities of the Medical Staff are intended to be included under this policy, and as such, the Medical Staff acknowledges its participation with the Hospital in an Organized Health Care Arrangement. Each Member agrees to abide by the terms of the Hospital's *Joint Notice of Privacy Practices*, 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 of the Medical Staff solely in their office setting. The Notice required by the statute and the OCHA policy will be administered by Hospital personnel for all Hospital-based episodes of care, including inpatient and outpatient treatment.

DEFINITIONS

Adverse Recommendation or Action: Any action or recommendation listed in Article X which entitles an applicant or Member to certain procedural rights of review.

Advanced Practice Professional ("APP"): An individual, other than a Member, who meets the criteria established by and is in a discipline approved by the Board of Trustees for APP status and who the Board of Trustees may grant Clinical Privileges or Scope of Service as set forth in Hospital policy. APPs are not eligible for Medical Staff membership and either:

a. Function in a support role under the delegation, direction, and/or supervision of a Member; or

b. Are permitted by the APP's license and Hospital policy and approved by the Board of Trustees to have a sponsoring Member and provide services in the Hospital without delegation, direction and/or supervision of a Member.

Allied Health Professional ("AHP"): An individual, other than a Member or Advanced Practice Professional, who is not employed by the Hospital and is in a discipline approved by the Board of Trustees for AHP status and who may be granted authorization under a written Scope of Service to provide patient care services under the supervision of a Member of the Medical Staff pursuant to Hospital policy.

Board of Trustees: The governing body of Texas Health Presbyterian Hospital Dallas, which has the ultimate responsibility and authority for the operation of Texas Health Presbyterian Hospital Dallas.

Bylaws: These Medical Staff Bylaws of Texas Health Presbyterian Hospital Dallas.

Chief Medical Officer: The Chief Medical Officer of Texas Health Presbyterian Hospital Dallas or his/her designee.

Clinical Privileges: Permission granted to a member of the Medical Staff to provide specific medical, dental, or surgical treatment or procedures, including access to Hospital equipment, facilities and personnel, within well-defined limits, based on the Member's license, experience, competence, ability and judgment, as more specifically described in Article V of these Bylaws.

Continuous Professional Liability Insurance Coverage: Current malpractice coverage that includes the requirement for supplemental coverage (tail coverage or prior acts' coverage) if a Member changes insurance carriers. The supplemental coverage requirement does not apply to those Members who maintain occurrence coverage.

Dentist: An individual who has and maintains a current and unrestricted license to practice dentistry in Texas.

Focused Professional Performance Evaluation ("FPPE"): Focused professional practice evaluation of a Practitioner as defined in the FPPE policy of the Medical Staff.

Hospital: Texas Health Presbyterian Hospital Dallas.

Hospital President: The President of Texas Health Presbyterian Hospital Dallas or his/her designee.

Investigation: Investigation for purposes of mandatory reporting as described in Section 9.4.1.

Joint Commission: The Joint Commission.

Medical Executive Committee ("MEC"): The governing committee of the Medical Staff as defined by these Bylaws.

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

Medical Staff: All Practitioners who have been granted Medical Staff membership and privileges in accordance with these Bylaws. This term does not apply to members of the Allied Health (Advance Practice Professional) staff or residents engaged in graduate medical education training programs at the Hospital.

Medical Staff President: The President of Texas Health Presbyterian Hospital Dallas Medical Staff or his/her designee.

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 physician, dentist, oral surgeon, or podiatrist, 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.[5]

Member in Good Standing: A Member whose Medical Staff membership and/or Clinical Privileges are not currently subject to any limitation or restriction, or automatic action (excluding any automatic suspension for failure to complete medical records) and who is not currently subject to corrective action or under investigation for purposes of possible corrective action pursuant to Article IX. 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 of appointment from the Medical Staff.

National Practitioner Data Bank: The national clearinghouse established pursuant to the Health Care Quality Improvement Act of 1986, Pub. L. No. 99-499, for obtaining and reporting information with respect to Adverse Actions or malpractice claims against Physicians or other practitioners.

Ongoing Professional Performance Evaluation ("OPPE"): Ongoing professional practice evaluation of a Member as defined in the OPPE policy of the Medical Staff.

Oral surgeon: A person, licensed by the Texas State Board of Dental Examiners, who has successfully completed an accredited postgraduate program in oral surgery.

Patient Contacts: Patient care activities in the Hospital carried out by the Member and defined as:

- The admission of a patient either as an inpatient, outpatient, or observation status;
- Holding primary responsibility for an inpatient or outpatient;
- 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;
- 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) (e.g., endoscopy, surgery, delivery); and
- Interpretation of any diagnostic test.

A Patient Contact does not include referrals for outpatient treatment or diagnostic procedures, e.g. a referral for lab or imaging services.

Multiple Patient Contacts by a Member during a single inpatient admission or outpatient stay will constitute a single Patient Contact by that Member for purposes of this definition.

Physician: A person with an M.D. or D.O. degree who has and maintains a current and unrestricted license to practice medicine in the State of Texas.

Podiatrist: A person with a D.P.M. degree who has and maintains a current and unrestricted license to practice podiatric medicine in the State of Texas.

[5] 42 U.S.C. Sec. 11101-11151

Practitioner: A Member of the Medical Staff or an individual applying for Medical Staff Membership. The term Practitioner does not include an AHP/APP.

Procedural Rights of Review: The hearing and appeal rights afforded to a Member as detailed by Article X of the Bylaws.

Rules and Regulations: The Rules and Regulations of the Medical Staff adopted pursuant to these Bylaws.

Special Notice: Written notice sent by certified mail, return receipt requested, or by personal delivery. Special notice is effective on receipt (or refusal of receipt). Special notice to a Practitioner shall be effective if delivered to the Practitioner's office or administrative staff or if delivered to an individual at the Practitioner's home address, using the addresses currently on file with Medical Staff Services.

The above terms may or may not be capitalized in the Bylaws.

Miscellaneous:

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

Whenever a personal pronoun is used herein, it shall be interpreted to refer to persons of either gender.

Bylaw Amendments:

Bylaws Committee	**September 27, 2021**
Medical Executive Committee	**October 13, 2021**
Medical Staff	**October 22, 2021**
Board of Trustees	**November 17, 2021**
Effective	**November 17, 2021**

Texas Health Texas Health Presbyterian Hospital Dallas
Rules & Regulations of the Medical Staff

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TEXAS HEALTH PRESBYTERIAN HOSPITAL DALLAS
MEDICAL STAFF RULES & REGULATIONS

PURPOSE

Generally, these Rules and Regulations are intended to establish guidelines for the conduct of and processes relating to Medical Staff Members, Advanced Practice Professionals, and Allied Health Professionals who have applied for or been granted Medical Staff appointment, Clinical Privileges, or authorization under a Scope of Service by the Board of Trustees. Nothing in these Rules and Regulations is intended or shall be deemed to exercise control, supervision or direction over the provision of medical services in the Hospital by Members who have been granted Medical Staff appointment and/or Clinical Privileges by the Board of Trustees and/or temporary privileges as provided in these Rules and Regulations. These Rules and Regulations are intended to establish guidelines for the provision of professional services in the Hospital.

CHAPTER 1
ADMISSIONS AND DISCHARGES

1.1 Admissions

Patients shall be admitted to Texas Health Presbyterian Hospital Dallas for inpatient, outpatient, observation or other services only on the orders of a Member who has been granted admitting privileges. Patients should be seen as soon as possible following admission. Patients admitted to an intensive care unit must be seen by the physician writing the order as soon as possible, which is generally expected to be within two (2) hours of admission. Patients admitted to an intermediate level of care (step-down unit) must be seen by the physician writing the order as soon as possible, which is generally expected to be within four (4) hours of admission. Patients transferred from another facility must be admitted to a physician Member who must acknowledge responsibility for the patient by signing a Memorandum of Transfer following the arrival of the patient.

1.2 Unassigned Patients

Patients appearing at the Emergency Department, or applying for admission who have no attending physician, shall be assigned by the Emergency Department physician to a Member in the department to which the patient's illness indicates assignment in accordance with the respective department's emergency department call policy.

1.3 Provisional Diagnosis

Except for emergency admissions, no patient shall be admitted to the Hospital without a provisional diagnosis. The provisional diagnosis for emergency admissions shall be provided as soon as possible following the patient's admission.

1.4 Short Term Admission

Admission for forty-eight (48) hours or less shall be considered a short -term admission, and it is acceptable to use a standard short form medical report for such patients.

1.5 Daily Patient Care

All patients shall be seen at least daily by the physician responsible for directing the patient’s care or his/her designee unless exempted based upon a policy developed by the applicable department and approved by the Medical Executive Committee. An appropriate progress note shall be included in the Medical Record.

1.6 Discharge

A patient shall be discharged from the Hospital by order of the patient's attending physician or his/her designee. The attending physician responsible for directing the patient’s care or his/her designee should be an active participant in the discharge planning process with Hospital staff in order to provide adequately for patient needs post Hospital stay. Where a co-admission requirement exists, a co-discharge shall be required.

A patient transferred to another facility shall be personally examined and evaluated to determine medical need by the physician authorizing the transfer. The physician 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 for conditions of Memorandum of Transfer per Hospital policy.

CHAPTER 2
DIAGNOSTIC AND THERAPEUTIC ORDERS

2.1 Patient Orders

2.1.1 All orders shall be given and signed by one of the following licensed practitioners:

a. Practitioners with Clinical Privileges.

1) a Medical Staff Member,
2) a Resident in an approved training program,
3) a physician assistant or advanced practice nurse ("Advanced Practice Professional" or "APP") who are authorized to provide patient care at the Hospital.

b. Outside Practitioners.

Orders for the outpatient services listed below may also be given by the following Outside Practitioners:

1) Texas licensed physicians, dentists, and podiatrists who are not members of the Medical Staff, or

2) Texas licensed APPs who are not authorized to provide patient care at the Hospital,

and such Outside Practitioner:

i) is responsible for the patient's care;
ii) must not be on the exclusion list of the federal or state Office of the Inspector General; and
iii) is acting within his/her scope of practice and licensure under Texas law.

c. Outpatient services which Outside Practitioners may order:

1) Phlebotomy for laboratory services;
2) Rehabilitation services (physical therapy, occupational therapy, speech therapy, and cardiac rehab);
3) Imaging;
4) Sleep medicine studies;
5) Patient education and counseling services.

Emergency Department (ED) physicians have privileges to write bridge orders to admit patients and initiate treatment. Such orders are effective at the time the ED physician enters the orders.

2.1.2 Handwritten orders shall be legible. Use of the Member's or APP's ID number in addition to his/her signature should be encouraged.

2.1.3 When ordering a test that requires clinical interpretation, enough relevant information should be provided with the order to inform and guide the interpreting Medical Staff Member concerning what the ordering practitioner is looking to determine.

2.2 Verbal Orders

Verbal orders shall be given by a Member, by Residents in an approved graduate medical education training program or by Physician Assistants or Advance Practice Nurses approved for Advanced Practice Professional status. Verbal orders must be communicated personally to licensed, certified or registered personnel as it

pertains to their licensure or defined scope of service. Verbal orders for application of restraints and for Do Not Resuscitate (DNR) Orders must be signed within 24 hours of the order being given. The date and time must be recorded when signing verbal restraint or DNR orders.

No verbal orders are permitted for Medical Staff consultation or administration of chemotherapy. All other verbal orders must be completed within the time frame for completion of medical records as specified in Section 5.9 of these Rules and Regulations.

Verbal orders may be received and transcribed by a:

Medical Staff Member;
registered professional nurse;
licensed practical nurse;
pharmacist, who may transcribe verbal orders pertaining to his/her area of expertise;
physical therapist, who may transcribe verbal orders pertaining to physical therapy regimens;
respiratory therapist, who may transcribe verbal orders pertaining to respiratory therapy treatments;
registered dietitian, who may transcribe verbal orders pertaining to dietary orders;
medical technologist who may transcribe verbal orders pertaining to laboratory tests; or
licensed social worker who may transcribe verbal orders pertaining to social services.

The individual receiving the verbal order from the Medical Staff Member shall read back the order to the Medical Staff Member to assure accuracy. Verbal orders shall be signed by the individual receiving them and the full name and hospital ID number of the Medical Staff Member who dictated the orders shall be written by the side of the individual's signature. Verbal orders must also include date and time the order was received. The Member, Resident or Allied Health Professional shall sign the verbal order. Members of the Resident Staff may also give orders for any patients under the direction of members of the Medical Staff who have not been specifically exempted as teaching or service patients. Nothing in this or any other section shall prohibit the any Medical Staff Member involved in the patient's care from giving orders for a patient who is a teaching service patient

2.3 Consultation

The attending physician is primarily responsible for requesting a consultation from a Member as appropriate, and as required by the bylaws, the Medical Staff, or the Hospital policies. Judgment as to the correct diagnosis treatment or the severity of illness generally rests with the physician responsible for directing the course of the patient's treatment. Any Member of the Medical Staff who has been granted appropriate Clinical Privileges at the Hospital may be called as a consultant regardless of his/her staff category assignment.

Consultation should be performed within twenty-four (24) hours or less depending on the nature and severity of the patient's condition.

2.4 Pre-Printed and Standing Orders

Medical Staff Members may develop standardized admission orders for patients with common provisional diagnoses. However, such orders shall be made specific for each individual patient before being implemented for that patient.

Standing orders may be developed for special care areas or for life-threatening situations. All standing orders shall be developed in cooperation with Nursing Service, other services, and Administration as appropriate, and must be approved by the appropriate Process Improvement Committee and the Medical Executive Committee. The MEC shall provide for periodic and regular review in conjunction with the medical staff, nursing, and pharmacy leadership.[6]

2.5 Transfer Orders

When a patient goes to surgery or is transferred to another service or another level of service, all orders must be re-entered in the electronic health record including resuscitation orders, medications, etc. , all previous orders, except Do Not Resuscitate orders, are automatically canceled. Previous medication orders may be resumed in the EHR

[6] CoP 482.24(c)(3)

Investigational Drugs and devices shall be handled in strict compliance with FDA regulations. Physicians, dentists, oral surgeons and podiatrists shall obtain approval for the use of investigational drugs and devices 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. Drugs administered to patients in the Hospital must be obtained from the Hospital Pharmacy.

2.6 Drug Standards

Drugs used shall, as a minimum standard, meet the requirements of the U.S. 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 and Therapeutics Committee. Patients may continue medications prescribed prior to Hospitalization as long as their physician has been so notified and gives an order to that effect consistent with Pharmacy and Therapeutics Committee policy and all such medication is noted in the medical record. All such drugs should be identified by a Hospital pharmacist.

Investigational Drugs and devices shall be handled in strict compliance with FDA regulations. Physicians, dentists, oral surgeons and podiatrists shall obtain approval for the use of investigational drugs and devices through the Texas Health Resource's Institutional Review Board. Such drugs shall be dispensed from the Hospital Pharmacy upon the authority of the investigator authorized to conduct the study. Drugs administered to patients in the Hospital must be obtained from the Hospital Pharmacy.

2.7 Admission Laboratory Procedures

There are no requirements for routine laboratory work on admission to the Hospital. Laboratory results, if done in a licensed laboratory (State license) and within seven (7) days of the admission may at the discretion of the attending physician and/or anesthesiologist, be incorporated into the patient record.

2.8 Progress Notes

Pertinent progress notes shall be entered in the record at the time of observation, sufficient to permit continuity of care and transferability. All patients shall be seen daily and as soon after admission as is deemed appropriate. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with a specific order as well as with results of tests and treatments. The practitioner responsible for directing the patient's care or his/her designee should see each hospitalized patient daily and document the patient's progress in the medical record for appropriate management of the patient's medical condition.

When a Resident, Physician Assistant or Advanced Practice Nurse performs a procedure normally thought of as care that would be given by a physician, the documentation in the progress notes must be countersigned by a physician.

CHAPTER 3
SPECIAL TREATMENT PROCEDURES

3.1 Restraints

Only a physician may order the use of restraints. Guidelines and specific procedures for the use of restraints are defined in Hospital policy, which is available from the nursing/departmental supervisor on all patient care units and all patient procedural areas The Department of Neurology & Psychiatry maintains a separate policy for restraints incorporating different regulatory requirements governing the use of restraints in this special patient population.

3.2 Seclusion

Seclusion, which is defined as placement of a patient alone in a room, may only be employed on the psychiatry inpatient unit by physician order according to the provisions of the restraint/seclusion policy approved for the Department of Neurology & Psychiatry.

3.3 Electro-Convulsive Therapy/Treatment

The policies governing the use of electro-convulsive and other forms of convulsive therapy are available online. Electro-convulsive therapy/treatment is restricted to appropriately credentialed physicians in the Department of Psychiatry with privileges to perform these procedures.

CHAPTER 4
SURGICAL PROCEDURES

4.1 Consent Required

It is the responsibility of each Member to obtain the informed consent from the patient or his/her legal representative, except in emergencies, prior to the commencement of a procedure or patient transfer to another facility. The Member shall document the risks, benefits and alternatives to treatment in accordance with Hospital policy. Patient permission should be obtained for any vendor or outside party to be present in the procedure or in the operating room in accordance with Hospital policy.

4.2 Assistant Required

The operating surgeon shall have a qualified assistant surgeon during all procedures as determined by departmental policy. Each policy shall be submitted to and approved by the Medical Executive Committee.

4.3 Specimens

All specimens removed during a surgical or other invasive procedure shall be sent to the Hospital laboratories for examination unless exempted under established criteria for surgical specimens that do not require examination by Pathology. Such exemption shall be approved by the Medical Executive Committee.

4.4 Anesthesia Care

An Anesthesiologist, physician member of the Medical Staff, or Certified Registered Nurse Anesthetist will maintain a complete anesthesia record. See Chapter 5, Medical Recordkeeping.

4.5 Follow-up Care

The follow-up care of the patient throughout the immediate postoperative period is the responsibility of the operating surgeon or his/her qualified designee.

CHAPTER 5
MEDICAL RECORDKEEPING

5.1 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 medical records at the patient's request shall require consent for release of these records in accordance with Hospital policy.

5.2 Medical Records Information

5.2.1 It is the responsibility of the attending Practitioner to prepare a complete and accurate medical record for each patient.

The medical record shall include identification data, complaint, history of present illness, past medical history, family history, system review, physical examination, diagnostic and therapeutic orders, special and procedural reports (such as consultation, clinical laboratory, x-ray reports, and others), clinical observations, provisional diagnosis, medical or surgical treatment, operative reports, progress notes, final diagnosis, condition on discharge, discharge summary, follow-up or autopsy report when available. [7]

5.2.2 No medical record shall be filed until it is complete, except on order of the Clinical Information

[7] Medicare Conditions of Participation (CoP) 42 CFR Sec. 482.24(c); CMS State Operations Manual (SOM) A-0449.

Committee. It is the function of the Medical Executive Committee to promulgate specific rules and regulations to the extent of suspension 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.

5.3 History and Physical Examination

5.3.1 Admission; Readmission within 30 Days.

A history and physical examination (H&P) must be in the electronic health record, on all patients undergoing surgery or other procedure requiring anesthesia no more than thirty (30) days prior to admission and no later than twenty-four (24) hours following admission.

The H&P also must be in the electronic health record before any surgery or procedure requiring anesthesia is performed unless the surgeon documents in the medical record that any delay to record the H&P would be a hazard to the patient. [8]

For emergency admissions, a brief description of the patient's condition should be immediately entered in the record pending completion of the H&P.

5.3.2 If an H&P has been performed within the thirty (30) days prior to admission, the H&P report or a legible copy of the report may be used provided the H&P is updated and the following are noted in the electronic health record or on the H&P within twenty-four (24) hours after admission but prior to surgery or any procedure requiring anesthesia:[9]

a. the H&P was reviewed;
b. the patient was examined;
c. any changes in the patient's condition since the time the H&P was performed that might be significant for the planned course of treatment;
d. If there are no changes, the statement "nothing has changed" or "no changes" will be documented and the H&P re-dated and signed.

Any H&P performed over thirty (30) days prior to admission will not be accepted.

5.3.3 The H&P (including any updated H&Ps) must be completed by a physician or Advanced Practice Professional with appropriate Clinical Privileges. An H&P completed by a physician who is not a Medical Staff Member may be used and included in the patient's medical record provided it is signed by the admitting physician and/or updated in the electronic health record.

5.3.4 Content. The H&P must meet Hospital guidelines as to content and timeliness and shall contain at least the following information regardless of format, e.g. recorded in a transcribed report, entered in CareConnect, or included in a doctor's office record:

- date of assessment;
- chief complaint;
- details of present illness;
- past medical history including previous surgery;
- social history;
- family history;
- review of systems;
- physical examination to include at least three distinct organ systems;
- vital signs;
- current medications and allergies;
- diagnosis/clinical impression/conclusions;
- plan of treatment/course of actions;
- physician signature.

[8] CoP 42 CFR Sec. 482.24(c)(4); CMS SOM A-0458.
[9] CoP 42 CFR Sec. 482.24(c)(4); CMS SOM A-0461

5.3.5 Outpatients and observation patients. An H&P shall be obtained for outpatients prior to an outpatient invasive procedure requiring anesthesia or within 24 hours after admission for patients admitted for observation.

5.3.6 Abbreviated, tailored content for H&Ps. The Medical Executive Committee may approve abbreviated or tailored content for an H&P for use prior to an outpatient procedure when requested by a clinical department. Any request for an abbreviated or tailored H&P must be submitted to the Clinical Information Committee for approval and referral to the Medical Executive Committee.

5.3.7 An adequate admission note shall be written upon admission.

5.3.8 Refer to Hospital policy for other requirements relating to H&Ps, e.g. specific patient types, signature of H&Ps.

5.4 Consultations as History and Physical

Consultations may be used as a history and physical exam if they are recorded or dictated within twenty-four (24) hours after the patient's admission and if they are adequate in content.

5.5. Care of Surgical Patients

Except in an emergency, it is the responsibility of the Member performing the surgery to see that the patient's medical history and physical exam, any indicated diagnostic tests, and a preoperative diagnosis are completed and recorded in the patient's medical record prior to surgery or other procedure requiring anesthesia services. In the case of an emergency, any required information not recorded prior to surgery shall be recorded in the medical record as soon as possible following the surgery.

5.5.1 Pre-anesthesia, pre-sedation evaluations.[10]

Any patient for whom general or regional anesthesia or monitored anesthesia care is planned must have a pre-anesthesia evaluation completed within forty-eight (48) hours prior to surgery or other procedure requiring anesthesia. An anesthesiologist, other Medical Staff Member, or CRNA with privileges to administer the anesthesia must perform the evaluation.

A pre-sedation evaluation is required for moderate and deep sedation but is not required to be completed within forty-eight (48) hours or any other time period.) [11]

The pre-anesthesia evaluation for general, regional, and monitored anesthesia should include at a minimum:

a. Review of the medical history, including anesthesia, drug and allergy history, interview, if possible given the patient's condition, and examination of the patient;

b. Interview and examine the patient, if possible given the patient's condition;

c. Notation of anesthesia risk, e.g. ASA classification of risk;

d. Identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure, e.g. difficult airway, ongoing infection, limited intravascular access;

e. Additional pre-anesthesia data or information, if applicable prior to administration of anesthesia, e.g. stress tests, additional specialist consultation; and

f. Development of the plan for the patient's anesthesia care including the type of medications for induction, maintenance, and post-operative care and discussion with the patient or patient's representative of the risks and benefits of the delivery of anesthesia.

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[10] 42 CFR 482.52(b)(1); CMS SOM A-1003.

[11] TJC PC .03.01.03; RC.02.01.01.

5.5.2 Anesthesia report. [12] There must be an intraoperative anesthesia record or report for each patient who receives general, regional, or monitored anesthesia. The report should include the following:

a. Names of Practitioner(s) who administered anesthesia, and as applicable, the name and profession of the supervising anesthesiologist or operating practitioner;

b. Name, dosage, route, and time of administration of drugs and anesthesia agents;

c. Technique(s) used and patient position(s), including the insertion/use of any intravascular or airway devices;

d. Name and amounts of IV fluids, including blood or blood products if applicable;

e. Vital signs as well as oxygenation and ventilation parameters; and

f. Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.

5.5.3 Post-anesthesia evaluation. [13]

a. A post-anesthesia evaluation shall be completed and documented by an anesthesiologist, other Medical Staff Member, or CRNA with privileges to administer anesthesia.

For inpatients, a post anesthesia evaluation must be completed and documented within forty-eight (48) hours following surgery or other procedure requiring anesthesia. For outpatients, the post anesthesia evaluation shall be performed prior to discharge and as close to discharge as feasible.

b. The post-anesthesia evaluation should include the following:

- respiratory function, including respiratory rate, airway patency, and oxygen saturation level;
- cardiovascular function, including pulse rate and blood pressure;
- mental status;
- temperature;
- pain;
- nausea and vomiting; and
- postoperative hydration.

5.5.4 Operative Reports.

The primary surgeon shall enter or dictate an operative report after the surgery or other high-risk procedure upon completion of the procedure and before the patient is transferred to the next level of care. However, if the Member who performed the procedure goes with the patient to the next level of care, the report may be entered while in the new unit or level of care.[14] In such case, the Member should include in the note that he/she traveled with the patient to the next level of care."

When an operative note is dictated, the Member shall enter an immediate post-operative note in the electronic health record following the procedure. (See Section 5.5.5 below for additional information.)

Operative reports shall provide sufficient information about the surgical procedure and the patient's condition to facilitate care in the immediate post-operative period.

[12] 42 CFR 284.52(b)(2); CMS SOM A-1004.
[13] 42 CFR Sec. 482.52(b)(3); CMS SOM A-1005, DSHS 25 TAC 133.41(a)(2)(C).
[14] TJC RC.02.01.03

Operative reports should contain the following information at a minimum: [15]

- date and time of surgery;
- name of the primary surgeon, anesthesiologist and any assistants or other practitioners (even when performing those tasks under supervision);
  - pre-operative diagnosis;
  - type of anesthesia or analgesia used;
  - the specific technical procedure(s) performed and description of the procedure[16];
  - any prosthesis, material, graft, transplant, or device inserted into the patient;
  - description of anatomical findings;
  - specimens removed;
  - a description of the techniques, findings, and tissues removed or altered[17];
  - any complications, untoward or unanticipated events or conditions, and the management of such events;
  - any estimated blood loss;
  - post operative diagnosis;
  - physician signature.

5.5.5 Post-Operative progress note. [18]

When a full operative report cannot be entered immediately after the procedure, a post-operative progress note should be entered in the electronic health record before the patient is moved to the next level of care.

Post-operative notes shall contain the following information at a minimum:

- name of the primary surgeon and his/her assistants;
- preoperative diagnosis;
  - post-operative diagnosis;
  - surgical findings;
  - procedure(s) performed;
  - technical procedures;
  - specimens removed;
  - estimated blood loss; and
  - operating Practitioner's signature.

The medical record should also contain the following post-operative information:

- the patient's vital signs and level of consciousness;
- any medications, IV fluids;
- any administered blood, blood products, and blood components.

5.6 Consultations

5.6.1 Reports of all consultations on the patient must be promptly filed in the patient's medical record.

5.6.2 If the report is not immediately available, a brief consultation note shall be promptly documented in the medical record and contain, at a minimum, pertinent information for anyone required to attend the patient. [19]

5.7 Readmission within 30 days

If the patient is re-admitted within thirty (30) days for the same or related problem, an interval history and physical examination may be used provided that the original information is available.

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[15] 42 CFR Sec. 482.51(b)(6); CMS SOM A-0959

[16] JC RC 02.01.03 EP 6

[17] DSHS, 25 TAC Sec. 133.41(w)(2)(F).

[18] JC RC 02.01.03 EP7.

[19] CoP 42 CFR Sec. 484.24(c)(4)(iii); CMS SOM A-0464.

5.8 Access to Records

Access to all medical records of all patients shall be accorded to staff physicians in good standing and who have a medical need to know or fulfill a staff responsibility, preserving the confidentiality of personal information concerning individual records of the patient. Subject to the discretion of the Hospital President, former members of the Medical Staff shall be permitted access to the medical records of their patients concerning all periods during which they attended the patients in the Hospital.

5.9 Symbols and Abbreviations

The Hospital uses abbreviations and symbols from Stedman's Medical Dictionary and The Joint Commission "Do Not Use" List of Abbreviations as a reference guide.

5.10 Authentication and Correction

5.10.1 All entries in the patient's medical record including orders and verbal orders shall be dated, timed, and authenticated by the ordering Medical Staff Member/APP or other Member or APP responsible for the patient's care. [20] Electronic signatures are considered an appropriate form of authentication.

5.10.2 Histories and Physicals and discharge summaries performed by medical residents must be countersigned by the attending or supervising physician.

5.10.3 Members may sign medical records for their Member partners as long as the signing Member has been involved in the care of the patient whose record is being signed.

5.10.4 Any change or addition in a medical record shall be clearly marked as an addendum or change, and signed, dated and timed by the Practitioner.

5.10.5 Use of electronic signatures are allowed as specified in these Rules & Regulations and Hospital policy. The use of signature stamps is not permitted.

5.11 Completion of Medical Records and Hospital Required Clinical Information

5.11.1 The medical record of a discharged patient shall be completed within 14 days following discharge. The failure to complete a medical record within 14 days after discharge shall result in automatic suspension of the Member's admission privileges except for emergency admissions. Suspension of privileges shall be in accordance with the Medical Staff Bylaws, Section 5.11.2 below, and any policy approved by the Medical Executive Committee to implement these rules.

The above rule shall also apply when the Hospital requests clinical information post discharge to comply with mandatory reporting requirements placed on the Hospital for accreditation purposes, and/or to comply with state and/or federal law and regulations.

5.11.2 Failure to Complete Medical Records or to Provide Hospital Required Clinical Information.

A Member who has one or more incomplete medical records or fails to respond to the Hospital's request for information under Section 5.11.1 will be advised of this after seven (7) days. If records remain incomplete after fourteen (14) days, they shall be delinquent and all admission privileges except for emergency admissions will be automatically suspended. A Medical Staff Member with a medical records suspension for more than thirty (30) days may be required to meet with the Clinical Information Committee or other appropriate Medical Staff committee in accordance with Section 9.2.7 of the Medical Staff Bylaws.

The Member must complete all incomplete records for the suspension to be lifted.

Automatic suspensions for incomplete medical records will be reported to the Medical Executive Committee. Exceptions for enforcement of this Rule & Regulation shall be allowed only on the written

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[20] CoP §482.24(c)(1); SOM A-0450.

approval of the Department Chair or his/her designee in those situations patient care could be adversely affected.

The Practitioner's Clinical Privileges shall be automatically terminated along with Medical Staff membership if the Practitioner remains on automatic suspension for more than 90 consecutive days.

5.11.3 Progressive interventions.

a. One to three Medical Record Suspensions in a Rolling Twelve-Month Period.

Notification will be sent to the Member for each of the suspension(s).

The appropriate Department Chair will be notified upon suspension. Following a third (3rd) medical record suspension in a rolling twelve (12) month period, the Member shall be required to meet with the Clinical Information Committee using the procedures in Section 9.2.7 of the Medical Staff Bylaws.

b. Four medical record suspensions in a Twelve-Month Period.

Following a fourth (4th) medical record suspension in a rolling twelve (12) month period, the Department Chair will be notified, and a letter of reprimand will be sent to the Member in question. The Member will be advised that inquiring facilities will be notified of the Member's repeated failure to complete his/her assigned medical records, e.g. when a Member applies for privileges at another facility. This information will be made available to the Credentials Committee at the time of reappointment.

c. Six Medical Record Suspensions in a Twelve-Month Period.

Following a sixth (6th) medical record suspension in a rolling twelve (12) month period, the Member will be required to attend a formal meeting with the Medical Executive Committee using the procedures in Section 9.2.7 of the Medical Staff Bylaws. Failure to meet with the Medical Executive Committee may result in a recommendation to the Medical Executive Committee that his/her name is being referred to the appropriate licensing agency.

d. Seven or more Medical Record Suspensions in a Twelve-Month Period.

Following the Member's meeting with the Medical Executive Committee, if the Member has a seventh (7th) medical record suspension within a rolling twelve (12) month period, the Member's membership and Clinical Privileges will be automatically terminated.

5.12 Discharge Summary; Final Diagnosis

5.12.1 Discharge summary. [21]

a. All medical records (both inpatient and outpatient) must include a discharge summary and must be entered into the electronic health record within twenty-one (21) days. The discharge summary (or a short-stay summary for patients hospitalized less than 48-hours) shall be dictated or created and entered in the electronic health record.

A Member or Advanced Practice Professional responsible for the patient's care during the hospital stay or outpatient visit shall enter the discharge summary. A Member who delegates authority to an APP to prepare the discharge summary must co-authenticate and date the discharge summary.

b. The discharge summary should provide information to other caregivers and facilitate continuity of care including the following:

1) the reason for the hospitalization;
2) the outcome of the hospitalization (e.g. the treatment, procedure, or surgery);
3) the disposition of the case;

[21] CoP §482.24(c)(4)(vii); SOM A-0468

4) final diagnosis;
5) the patient's condition at discharge; and
6) provisions for follow-up care, if applicable.

5.12.2 The Medical Staff Member shall include a final diagnosis in the electronic health record.

5.13 Notifications

5.13.1 Health Information Management will contact the Medical Staff Member with the incomplete medical record(s) regarding medical record deficiencies and suspensions by one of the following methods:

a. Electronic notification: In-basket electronic health record message;
b. Fax transmission;
c. Phone call; or
d. Notice by regular mail.

5.13.2 It is the responsibility of the Member to notify the Medical Staff Services and Health Information Management of any changes in contact information.

5.14 Coding Queries

The Hospital may send a coding query to a Member to clarify documentation in the medical record. The Member must respond to the coding query within seven (7) days after receiving the query in the Member's in-basket in the electronic health record.

It is the expectation that the Member respond to the query by either documenting a progress note in the electronic health record clarifying the documentation or declining the query and stating the reason for declining.

CHAPTER 6
SUPERVISION OF RESIDENT STAFF

6.1 Teaching Programs

Consistent with the sponsorship of an Accreditation Council on Graduate Medical Education approved residency training program and Affiliation Agreement for residency training programs, it is necessary and desirable to conduct medical education programs within the Hospital. The Medical Education Committee shall develop guidelines for inclusion of patients in teaching programs and for supervision of medical care within the Hospital's Medical Education Program. Such guidelines shall be submitted to the Medical Executive Committee of the Medical Staff for approval.

Pelvic Surgery Fellowship. The Pelvic Surgery Fellowship is a non-accredited fellowship generally for one year. The selected visiting physician ("Fellow") is only eligible for clinical privileges as necessary to carry out the duties and the functions of the pelvic surgery fellowship so long as the Fellow continues in that role. At the end of the fellowship, the clinical privileges automatically terminate.

6.2 Supervision Requirements for Teaching Service Patients

Attending Staff, who are faculty in an approved residency program, shall supervise the care of all teaching service patients in a manner that is consistent with the ACGME requirements for the applicable residency program. Supervision shall be structured to provide trainees with progressively increasing responsibility commensurate with their level of education, ability and experience. The patient's immediate care shall be performed by the resident whenever possible. Attending Staff are expected to be available to assist residents in the care of the patient at all times. Attending Staff with supervisory responsibilities for teaching service patients must countersign history and physical examinations and discharge summaries documented by the resident staff for teaching service patients.

Teaching service patients shall be assigned to the department or section concerned in the treatment of the disease which necessitated the admission. Participation in teaching programs is one criterion upon which continued good standing on the Medical Staff is based. In those departments and services conducting Graduate Medical Education programs, records may be kept indicating the degree and kind of participation in educational activities by each member of the practicing staff.

6.3 Supervision Requirements for Private Patients

All private patients will be eligible for the teaching services, but private patients shall be treated by their own private physicians, who shall continue as the primary physician and provide supervision to the Resident. A physician may exempt a patient from the teaching service when he/she believes it is in the patient's best interest or welfare. This may include the number or proportion of admissions to teaching services.

6.4 Patient Orders

Members of the Resident Staff may also give orders for any patients who have not been specifically exempted as teaching or service patients under the direction of members of the Medical Staff. Nothing in this or any other section shall prohibit the physician, dentist, oral surgeon and/or podiatrist involved in the patient's care from giving orders for a patient who is a teaching service patient.

CHAPTER 7
GENERAL

7.1 Identification Badges

Members and credentialed Advanced Practice and Allied Health Professionals under the supervision of Members shall wear identification badges issued by the Hospital for security and identification purposes when providing services in the Hospital.

7.2 Continuous Physician Coverage

A physician who anticipates being unavailable must provide for coverage by another physician whose Hospital privileges permit him/her to treat the patient(s) whom he/she may be covering and who will be responsible for care of the patient(s) during his/her absence. The name of the physician who will be responsible for the patient(s) in the attending physician’s absence will be listed with the physician’s telephone exchange. In case of failure to name such an alternate, the following

(a) Chair of the Department or in his/her absence, the Vice-Chair;

(b) the President of the Medical Staff or his/her designee; or

(c) the Hospital President or his/her designee

will have the authority to call a qualified consenting Member to care for the patient in such an event.

7.3 Response to Pages and Telephone Calls

Members and Advanced Practice and Allied Health professionals under the supervision of Members are expected to respond to pages and/or telephone calls from patient care areas of the Hospital as quickly as possible but within thirty (30) minutes of receiving the message from the paging service or other voice recording on Member’s phone number provided to staff. Pages designated as “Stat” should be returned in five (5) minutes.

7.4 Response to Requests of the Emergency Department

Refer to Trauma policy for Trauma response guidelines.

The physician who is providing on-call services ("On-Call Physician") must evaluate every patient with a medical emergency condition that is requested of the On-Call Physician by the Emergency Department ("ED") for observation, consultation or admission services. The medical emergency is deemed by the Emergency Department Physician. The On-Call Physician is expected to respond to the call from the ED within thirty (30) minutes. "Respond" is defined as presenting oneself to the ED or telephoning the ED and speaking to the ED physician. If the On-Call Physician does not respond within the appropriate amount of time as judged by the ED physician caring for the patient, the ED physician will call the On-Call Physician's designated alternate to provide the needed service, if any. If the designated alternate is unavailable or is not identified, the department chair for such clinical service will be requested to resolve the issue. The ED will submit an occurrence report to the On-Call Physician's clinical service department chairman and the Hospital's Chief Medical Officer noting the failure to timely respond.

If the ED physician request that the On-Call Physician come to the ED to examine/treat a patient, the On-Call Physician must do so within thirty (30) minutes, even if the On-Call Physician does not agree with the ED physician's assessment. If a mutually agreeable plan for care can be achieved over the phone, it is permissible to manage the patient using the ED physician as a proxy, but otherwise, the ED physician's judgement prevails.

If an On-Call Physician is contacted regarding a request from another facility to evaluate the circumstances around a requested transfer to the Hospital, the On-Call Physician must respond within thirty (30) minutes to discuss and evaluate the clinical information provided by the transferring facility. The Hospital will determine whether it has the capacity to accept a transfer and the On-Call Physician will inform the Hospital whether he/she has the requisite clinical expertise to appropriately support the transfer. The On-Call Physician is required to accept or consult the transfer of a patient with an emergency medical condition at another hospital's emergency department if the On-Call Physician has the capability to care for the patient.

On-Call Physicians who provide call coverage to multiple facilities simultaneously are responsible for ensuring the availability of backup coverage should conflicting clinical responsibilities impede his/her ability to respond in a timely manner. Back up coverage must be by a physician with similar qualifications and clinical privileges at the Hospital.

Any failure by an On-Call Physician to not comply with this Section 7.4 may be grounds for corrective action by the Medical Staff or separate action by the Hospital.

7.5 Disaster Plans

Each Member shall comply with the Emergency Preparedness Plan approved by the Medical Executive Committee and the Board of Trustees. Such internal and external disaster plans shall be formulated by the Emergency Preparedness Committee.

7.6 Utilization Review

Patients with extended hospitalization should have the reasons documented by the physician responsible for directing the overall care of the patient in the progress notes. Discharge planning should be initiated as soon as the need for such services is determined.

7.7 Death of Hospitalized Patient

In the event of the death of a hospitalized patient, the patient will be pronounced dead within a reasonable time by the physician responsible for directing the overall care of the patient, his/her physician designee, or a registered nurse caring for the patient, when the criteria defined under state law regarding pronouncement have been met. For procedures regarding the release of a deceased patient's body, refer to Administrative Policy Section III, Procedure 16A, *Release of Bodies to Funeral Home from the Morgue* and Administrative Policy Section III, Procedure 16B, *Release of Bodies to Funeral Homes from the Floor*.

7.8 Qualified Medical Personnel for Conducting Medical Screening Examinations

A "Qualified Medical Personnel" who may conduct a medical screening examination in the Emergency Department ("ED") is a person who provides medical coverage services in the ED and who is either a Member of the Medical Staff ("Member") or member of the Advance Practice Professional Staff.

With respect to psychiatric assessments in the Emergency Department or a behavioral health unit, "Qualified Medical Personnel" means either a member of the medical staff of Hospital or any of the following licensed behavioral health providers who have been granted Clinical Privileges: Psychologists (Ph.D., PsyD), Registered Nurses, Master's prepared Social Workers (LCSW, LMSW), Licensed Professional Counselor (LPC, LPC Intern), and Licensed Marriage and Family Therapist (LMFT, LMFTA). Each Psychologist, Registered Nurse, Social Worker, Licensed Professional Counselor, or Licensed Marriage and Family Therapist who serves as Qualified Medical Personnel shall have received training on what constitutes an appropriate psychiatric assessment.

In the Labor & Delivery Department, Qualified Medical Personnel may be either a Member with obstetrical privileges, Certified Nurse Midwife or a registered nurse in the Labor & Delivery Department who has received training on what constitutes an appropriate medical screening exam.

A physician shall perform medical screening exam of an obstetrical patient if: 1) the patient is being considered for transfer to another facility; 2) the RN, based upon the assessment findings, asks for a physician to evaluate the patient during admission or prior to discharge; or 3) the patient asks to be examined by a physician.

CHAPTER 8
AUTOPSIES

8.1 Autopsies

Each Member shall be encouraged to request autopsies when appropriate. Autopsies are usually performed by a hospital-based Pathologist, or his/her Member designee, and shall not be done without proper written consent. Attendance at autopsies is encouraged and the Pathology Department will notify the attending physician of the time of the autopsy and post notices of scheduled autopsies whenever possible. The procedure for requesting an autopsy is defined in Administrative Policy Section III, Procedure 8, *Procedure for Autopsy Authorization*.

CHAPTER 9
ORGANIZED HEALTH CARE ARRANGEMENT

9.1 Organized Health Care Arrangement

The Board of Trustees of Texas Health Presbyterian Hospital Dallas has adopted a policy to act as an Organized Health Care Arrangement (OHCA) under the Health Information Portability and Privacy Act of 1996 (HIPPA) and in accordance with the Texas Health Resources Organized Health Care Arrangement Policy. The Medical Staff of Texas Health Presbyterian Hospital Dallas acknowledges its participation with Texas Health Presbyterian Hospital Dallas in an Organized Health Care Arrangement with respect to jointly managed patients. Each Member agrees to abide by the terms of the Hospital's *Joint Notice of Privacy Practices*, 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 of the Medical Staff solely in their office setting. The Notice required by the statute and the policy will be administered by Hospital personnel for all Hospital-based episodes of care, including inpatient and outpatient treatment.

MEDICAL STAFF RULES & REGULATIONS:

Bylaws Committee	**September 27, 2021**
Medical Executive Committee	**October 13, 2021**
Medical Staff	**October 22, 2021**
Board of Trustees	**November 17, 2021**
Effective	**November 17, 2021**