TEXAS HEALTH PRESBYTERIAN HOSPITAL PLANO
MEDICAL STAFF

2021

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DEFINITIONS

The following definitions may or may not be capitalized in the Bylaws and related manuals.

ADMINISTRATION means the Hospital President appointed by the Board of Trustees to be responsible for the overall executive supervision and coordination of the Hospital. The President may, consistent with his responsibilities under the Bylaws of the Hospital, designate a representative to perform his responsibilities under the Medical Staff Bylaws.

ADVERSE RECOMMENDATION OR ACTION means a recommendation or action as defined in Article 8.1-1 of the Bylaws which entitles the Practitioner to procedural rights of review.

ALLIED HEALTH PROFESSIONAL or **AHP** means an individual, other than a licensed Physician, oral / maxillofacial surgeon, Dentist or Podiatrist, who is qualified by academic and clinical training and by prior and continuing experience and current competence in a discipline which the Board of Trustees has determined to allow to practice in the Hospital and who either:

(a) is licensed by the state and permitted by the Hospital to provide services in the Hospital without the direction or immediate supervision of a Physician (i.e., “independent AHP”); or
(b) functions in a medical support role to and under the direction and supervision of a Practitioner (i.e., “Practitioner-directed AHP”).

AHPs are not members of the Hospital's Medical Staff and are not entitled to the same rights, privileges and prerogatives of Practitioners. Except as provided by Hospital policy, AHPs are not Hospital employees.

AS SOON AS PRACTICAL means within a reasonable period of time depending upon the circumstances involved, as determined by the Hospital in its sole discretion.

BOARD OF TRUSTEES means the decision-making body of Texas Health Presbyterian Hospital Plano. Except as provided herein and as appropriate to the context and consistent with the Bylaws of the Hospital and delegations of authority made by the Board of Trustees, it may also mean any committee of the Board of Trustees or any individual authorized by the Board of Trustees to act on its behalf on certain matters.

CAMPUS means any facility owned, leased, or operated by Texas Health Resources System that is a part of the Hospital.

CLINICAL PRIVILEGES or **PRIVILEGES** means the permission granted pursuant to the Bylaws and related manuals to a Practitioner or AHP to render specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services at the Hospital.

DAYS means calendar days unless the term “working days” is used.

DENTIST means an individual with a DDS degree or its equivalent, who is licensed in Texas to practice dentistry and whose practice is in the area of general dentistry or a specialty thereof.

EX-OFFICIO means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means with voting rights.

FOCUSED PROFESSIONAL PERFORMANCE EVALUATION (FPPE) means a process to evaluate the competency and/or professional performance of a Member when questions arise concerning a Member’s ability to provide safe, quality patient care. FPPE may also be implemented to evaluate a Member’s competence to perform initially requested privileges.

HOSPITAL means Texas Health Presbyterian Hospital Plano.

HOSPITAL PRESIDENT means the chief executive officer of the Hospital appointed by the Board of Trustees responsible for day-to-day operations of the Hospital and includes his or her designee.

INVESTIGATION means an investigation as defined in Article 7.3.

MANUAL OR MANUALS mean the Credentials Manual, Hearing & Appellate Review Plan, Rules and Regulations, Organization & Functions Manual, and any other ancillary governance documents to the Bylaws adopted as provided in Article 14.3.

MEDICAL BOARD means the executive committee of the Medical Staff established under Article 11.1 of the Medical Staff Bylaws.

MEDICAL PEER REVIEW means the activities defined in Article 3.2 of the Organization and Functions Manual.

MEDICAL STAFF or **STAFF** is the organizational component of the Hospital that includes all Practitioners as that term is defined below, who are appointed to the Medical Staff and are privileged to attend Patients or to provide other diagnostic, therapeutic, teaching or research services at the Hospital.

MEDICAL STAFF BYLAWS or BYLAWS means the Bylaws of the Medical Staff. Related manuals means any one or more of the following documents as appropriate to the context:

(a) Medical Staff Hearing and Appellate Review Plan
(b) Medical Staff Credentials Manual
(c) Medical Staff Rules & Regulations
(d) Medical Staff Organization & Functions Manual

MEDICAL STAFF MEMBER IN GOOD STANDING means a Practitioner who has been appointed to the Medical Staff and who is not subject to corrective action or any limitation or restriction of voting, office-holding or other prerogatives under these Medical Staff Bylaws and the related manuals or any other policies of the Medical Staff or the Hospital.

MEDICAL STAFF OFFICE means the Hospital Department assigned to assist the Medical Staff leaders and their committees in carrying out the functions and responsibilities set out in the Bylaws and Manuals. When doing so, the staff of the Medical Staff Office act as agents of the Medical Staff committees.

MEDICAL STAFF PRESIDENT means that member of the Active Staff elected pursuant to these Medical Staff Bylaws and related manuals to be the principal elected officer of the Medical Staff for purposes of managing the Medical Staff's activities in fulfilling the responsibilities delegated to it by the Board of Trustees. In his absence, it includes his designee or other person acting on his behalf as provided in these Bylaws.

MEDICAL STAFF YEAR means the 12-month period from January 1 to December 31.

ONGOING PROFESSIONAL PERFORMANCE EVALUATION (OPPE) means a defined process evaluation of the competency and professional performance of each Member on an ongoing basis in order to identify professional practice trends that impact on quality of care and Patient safety. Data gathered during the process is factored into decisions regarding a Member's privileges at intervals prior to and at the end of the two (2) year reappointment cycle.

ORAL / MAXILLOFACIAL SURGEON means an individual with a DDS or equivalent degree who is licensed to practice dentistry in Texas and who has successfully completed an approved postgraduate program in oral surgery.

PATIENT means inpatients or outpatients of the Hospital.

PATIENT CONTACT means the admission and/or having primary responsibility for a Patient admitted as an inpatient or outpatient to the Hospital, or the performance of a diagnostic service or clinical procedure on a Patient admitted to the Hospital at the request of the Practitioner who admitted or has primary responsibility for the Patient. Consultation for the purpose of evaluating or providing an opinion on the Patient's condition where a Patient visit is conducted and/or a report is dictated by the consulting Practitioner and included in the medical record shall also constitute a Patient contact. Consultation without a Patient visit or a report by the consulting Practitioner in the medical record shall not constitute a Patient contact.

PHYSICIAN means an individual with an M.D. or D.O. degree who is licensed in Texas to practice medicine.

PODIATRIST means an individual with a DPM degree who is licensed in Texas to practice podiatry.

PRACTITIONER means, unless otherwise expressly provided, any Physician, Oral/Maxillofacial Surgeon, Dentist or Podiatrist who is either

(a) applying for appointment to the Medical Staff and for clinical privileges: or
(b) currently holds appointment to the Medical Staff and has specific delineated clinical privileges; or
(c) is applying for or is exercising temporary, emergency or disaster privileges pursuant to the applicable section of the Bylaws and/or Credentials Manual.

PREROGATIVE means a participatory right granted, by virtue of Staff category or otherwise, to a Staff member and exercisable subject to the ultimate authority of the Board of Trustees and to the conditions imposed in these Bylaws, related manuals, and other bylaws, policies, procedures, rules, regulations, guidelines and requirements of the Hospital and its Medical Staff.

QUORUM means: (a) Medical Board – the presence of at least fifty-one present (51%) of the voting members of the Medical Board shall constitute a Quorum.
(b) All other meetings – members present, and voting shall constitute a Quorum.

SPECIAL NOTICE means notification sent by certified or registered mail, return receipt requested, or by personal delivery service with signed acknowledgement of receipt. Delivery shall be on the date actually received or the date delivery is refused.

WORKING DAYS means Monday through Friday, 10:00 a.m. to 5:00 p.m.

CONSTRUCTION OF TERMS AND HEADINGS

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

TEXAS HEALTH PRESBYTERIAN HOSPITAL PLANO
MEDICAL STAFF BYLAWS

ARTICLE I. GENERAL

1.1 RIGHTS OF MEDICAL STAFF MEMBERS

1.1-1 AUDIENCE WITH THE MEDICAL BOARD - In the event a Practitioner is unable to resolve a clinical or medical staff issue with his/her Department Chair, that Practitioner may, upon written notice to the Medical Staff President, meet with the Medical Board to discuss the issue. This does not constitute a hearing and none of the procedural rules for hearings shall apply.

1.1-2 RECALL ELECTION - Any Practitioner has the right to initiate a recall election of a Medical Staff officer and/or Department Chair. A petition for such recall must be presented, signed by at least 25% of the members of the Active Staff eligible to vote for the officer in question. The process for recall shall be as outlined in Section 9.7 of these Bylaws.

1.1-3 SCHEDULE MEDICAL STAFF MEETING - Any Practitioner may initiate the scheduling of a Medical Staff meeting. Upon presentation of a petition signed by 25% members of the Active Staff, the Medical Board will schedule a special staff meeting for the purpose addressed by the petitioners in the petition. No business other than that in the petition may be transacted.

1.1-4 REQUEST DEPARTMENT MEETING – Upon presentation of a petition signed by 51% of the Active Staff members belonging to a Department, that group may request a Department meeting when they believe that the Department has not acted appropriately.

1.1-5 HEARING AND APPEAL - Any Practitioner has a right to a hearing / appeal pursuant to theses Bylaws and the Hearing and Appellate Review Plan for reasons as outlined in Section 7.1.

1.2 PROCEDURES FOR APPOINTMENT

The basic steps of the process for appointment are outlined below and in further detail in the Credentials Manual.

1.2-1 REQUEST FOR AND FILING OF APPLICATION

A request for an application shall be submitted to the Medical Staff Office. If the applicant meets the basic membership requirements, as set out in the Bylaws and the Credentials Manual, the Medical Staff Office will then forward an application to the requesting Practitioner.

1.2-2 DEPARTMENT CHAIRMAN EVALUATION

After receipt and review of a complete application and verification of all required information, the Medical Staff Office will forward the complete application to the Department Chair for review. The Department Chair will review the application and make a recommendation to the Credentials Committee.

1.2-3 CREDENTIALS COMMITTEE EVALUATION

The Credentials Committee shall review the recommendations of the Department Chair, supporting documentation and relevant information available to it. The Credentials Committee shall prepare its written report and recommendations and transmit it to the Medical Board. In the event an application is withdrawn before the Credentials

Committee review or after the review but before the Medical Board review, the application shall be not be presented to the Medical Board.

1.2-4 MEDICAL BOARD ACTION

At its next regular meeting after receipt of a recommendation from the Credentials Committee, the Medical Board shall consider the application and issue a recommendation.

1.2-5 BOARD OF TRUSTEES ACTION

Except in the case of an Adverse Recommendation or Action which shall be governed by the Medical Staff Hearing and Appellate Review Plan, at its next regular meeting after receipt of a recommendation from the Medical Board, the Board of Trustees shall review the recommendation and issue a decision.

1.3 PROVISIONAL STATUS ADVANCEMENT

Procedures for provisional status advancement are outlined below.

1.3-1 REQUIREMENTS FOR PROVISIONAL STATUS

The Provisional Status period is applicable to all members initially appointed to the Medical Staff, other than Active Community Affiliate, regardless of category. The status of new appointees to active, courtesy or consulting categories of the Medical Staff shall be provisional for a minimum of two years, during which time the appointee shall be subject to focused professional practice evaluation (FPPE) as set forth in written policy.

Except as provided below in the next sentence, reappointments to provisional status for any Practitioner may not exceed one year and the Practitioner shall not advance from provisional status until an FPPE is completed. Practitioners who do not have at least five Patient Contact may obtain / maintain Courtesy Staff status by providing documentation from an Active Staff member attesting to the fact:

(1) that the Courtesy staff member participates in a formalized cross-coverage arrangement with the Active staff member; or

(2) that Courtesy staff member's only activity at this Hospital is to provide surgical assistance to the Active Staff member.

Under this exception, if the cross-coverage arrangement ceases or if the Courtesy staff member assisting in the OR begins to admit and operate independently of the primary surgeon or if the Active staff member elects to terminate his medical staff membership at the Hospital, the membership and privileges of the Courtesy staff member will automatically terminate.

In the event a Member appointed to the Active-Ambulatory category does not have five or more Patient Contacts after two (2) years in provisional status, the Member may be reappointed for an additional year to provisional status. At the end of the additional year, the Member's privileges shall automatically terminate if the Member does not have five or more Patient Contacts. For all other Practitioners except those described above, the Practitioner's privileges shall automatically terminate if the Practitioner does not have five or more Patient Contacts at the end of the second year in provisional status. For Practitioners described in Section 3.7-1(b), the Practitioner may stay provisional until a FPPE is completed, regardless of the length of time and, if reappointed, such reappointment shall be for two years.

Duties of provisional active members of the Medical Staff shall be the same as active members of the Medical Staff with the following exceptions. They may not hold elective office or chair committees. They may be members of any committee except executive, utilization, joint conference, and credentials committees. Physicians having contractual agreement with the Hospital may serve Ex-Officio upon these committees, however.

Provisional appointees to the active staff may attend but shall not have any voting privileges, either on Medical Staff matters or departmental matters.

1.3-2 PROVISIONAL ADVANCEMENT

(a) Within sixty (60) days of the end of the Provisional Status period, information will be collected regarding the Practitioner's activity since the date of his initial appointment and/or granting of temporary privileges and forwarded to the Department Chair for his review and recommendation.

(b) The report and recommendation of the Department Chair will be forwarded to the Credentials Committee, Medical Board and Board of Trustees.

(c) The final decision of the Board of Trustees will be communicated to the Practitioner in writing.

1.4 REAPPOINTMENT

The basic steps of the process for reappointment are outlined below and in further detail in the Credentials Manual.

1.4-1 DETERMINATION OF ELIGIBILITY FOR REAPPOINTMENT

Prior to the expiration of the term of appointment, the Practitioner who has had verified Patient contacts during the past twenty-four months will be provided with a reappointment application.

1.4-2 SUBMISSION OF APPLICATION FOR REAPPOINTMENT

At least ninety (90) days prior to the expiration of the term of appointment, the Practitioner shall furnish to the Medical Staff Office, a complete electronic application for reappointment and any requests for changes in Department or Medical Staff category assignments.

1.4-3 DEPARTMENT EVALUATION

The Chair of each Department in which the Practitioner requests or has exercised privileges shall review the reappointment application and issue a recommendation.

1.4-4 CREDENTIALS COMMITTEE EVALUATION

The Credentials Committee shall review the reappointment application, the recommendation(s) of the Department Chair and make a recommendation to the Medical Board for reappointment or non-reappointment.

1.4-5 MEDICAL BOARD EVALUATION

The Medical Board shall review the reappointment application and its supporting information. The Medical Board shall prepare a written report regarding its recommendation for reappointment or non-reappointment,

1.4-7 BOARD OF TRUSTEES ACTION

Except in the case of an Adverse Recommendation or Action which shall be governed by the Medical Staff Hearing and Appellate Review Plan, at its next regular meeting after receipt of a recommendation from the Medical Board, the Board of Trustees shall review the recommendation and issue a decision.

1.5 STAFF DUES

Subject to the approval of the Board of Trustees, the Medical Board shall have the power to set the amount and time of payment of dues for each category of membership and the amount of the processing fee for initial applications and reappointment and to determine the manner of expenditure of funds received. The processing fees will be determined by the Hospital and will be paid to the Hospital.

1.6 MEDICAL STAFF FUNCTIONS

Provision shall be made in these Bylaws or by resolution of the Medical Board, approved by the Board of Trustees, either through assignment to the Departments, to staff committees, to Medical Staff officers or officials, or to interdisciplinary Hospital committees for the effective performance of the staff functions as specified in this section and described in the current Organization and Functions Policy Manual and of such other Medical Staff functions as the Medical Board or the Board of Trustees shall reasonably require. These functions may include the following:

1.6-1 Monitor, evaluate, and improve care provided in and develop clinical policy for patient care areas in the Hospital;

1.6-2 Conduct or coordinate quality appropriateness, and improvement activities, including invasive procedures, blood usage, drug usage reviews, medical record, and other Medical Peer Reviews.

1.6-3 Conduct or coordinate utilization review activities;

1.6-4 Conduct or coordinate credentials investigations for staff membership and grants of clinical privileges and specified services;

1.6-5 Provide continuing education opportunities responsive to quality assessment/improvement activities, new state-of-the-art developments, and other perceived needs;

1.6-6 Develop and maintain surveillance over drug utilization policies and practices;

1.6-7 Monitor the Hospital's infection control program;

1.6-8 Participate in the development of the Hospital's disaster plan, for Hospital growth and development and for the provision of services required to meet the needs of the community;

1.6-9 Direct staff organizational activities, including staff bylaws, review and revision, staff officer and committee nominations, liaison with the Board of Trustees and Hospital administration, and review and maintenance of Hospital accreditation;

1.6-10 Coordinate the care provided by Practitioners with the care provided by Patient Care Services and with the activities of other Hospital patient care and administrative services; and

1.6-11 Engage in other functions reasonably requested by the Medical Board and the Board of Trustees.

1.7 TERM OF APPOINTMENT

Appointments to the Medical Staff and grants of clinical privileges shall not exceed 24 months and may be for a shorter period as recommended by the Medical Board and approved by the Board of Trustees. A conditional reappointment of membership and/or clinical privileges for a period of less than 24 months may be granted at any time, including when there is a question or concern about the Practitioner's clinical competence or professional behavior, or a situation where there is an Investigation or hearing pending at the time of reappointment.

ARTICLE II. QUALIFICATIONS FOR APPOINTMENT

2.1 GENERAL

Appointment to the Medical Staff and granting of clinical privileges is a privilege granted by the Board of Trustees upon recommendation by the Medical Board, that shall be extended only to

competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated policies of the Medical Staff, the Hospital, and the Board of Trustees. Each applicant has the burden of producing adequate information to establish their qualifications and competence.

Only Practitioners who can document their background, experience, training, judgment, character, demonstrated current clinical competence, physical and mental capabilities, adherence to the ethics of their profession, and ability to work professionally and cooperatively with others shall be qualified for appointment to the Medical Staff. The general competencies that must be documented are in the areas of: patient care; medical/clinical knowledge; practice-based learning and improvement; interpersonal and communication skills; professionalism; and systems-based practice.

No applicant may be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of licensure to practice in this or any other state, or of membership in any professional organization, or of having privileges at another Hospital. Persons applying to the Medical Staff must meet the following eligibility criteria to be considered.

No aspect of Medical Staff appointment or particular clinical privileges shall be denied on the basis of: age; sex; race; creed; color; national origin; a disability unrelated to the ability to fulfill patient care and required Staff obligations; or, any other criterion unrelated to the delivery of quality patient care in an efficient manner in the Hospital facilities, to professional qualifications, or to the Hospital's purposes, needs and capabilities.

2.2 MEMBERSHIP QUALIFICATIONS

2.2-1 LICENSURE

Must hold a current valid, unrestricted license issued by the State of Texas to practice medicine, dentistry, or podiatry and have never had a license to practice revoked or suspended by any state licensing agency.

2.2-2 CONTROLLED SUBSTANCE REGISTRATION

Must hold, if applicable to his practice, a current, valid Drug Enforcement Administration (DEA) controlled substances registrations and have never had the federal or another state-controlled substances registration revoked or suspended.

2.2-3 PROFESSIONAL EDUCATION AND TRAINING

Documentation of training and experience must include the following:

For Physicians:

(a) Must be a graduate of a school/college of medicine or osteopathy that was fully accredited throughout the period of the Practitioner's attendance, or a graduate of a foreign medical school and holds a certificate from the Educational Commission for Foreign Medical Graduates that is valid indefinitely, or have a Fifth Pathway certificate and have passed the Foreign Medical Graduate Examination in the Medical Sciences; and, either

(b) satisfactory completion of an approved residency, or

(c) certification by the specialty board appropriate to the Physician’s area of practice at the Hospital is required for all applicants within the time period required by the applicable board or five (5) years of completing residency training or fellowship, whichever is the lesser of the two.

For Oral/Maxillofacial Surgeons: (a) Graduate of an approved fully accredited school of dentistry, (b) satisfactory completion of an approved postgraduate training program in oral surgery, and (c) certification by the specialty board appropriate to the Practitioner's area of practice at the Hospital is required for all applicants within the time period required by the applicable board or five (5) years of completing residency training or fellowship, whichever is the lesser of the two.

For Dentists: (a) Graduate of an approved fully accredited school of dentistry, (b) satisfactory completion of at least one year in an approved postgraduate training program, and (c) certification by the specialty board appropriate to the Practitioner's area of practice at the Hospital is required for all applicants within the time period required by the applicable board or five (5) years of completing residency training or fellowship, whichever is the lesser of the two.

For Podiatrists: (a) Graduate of an approved fully accredited school of podiatry, (b) certification by the specialty board appropriate to the Practitioner's area of practice at the Hospital is required for all applicants within the time period required by the applicable board or five (5) years of completing residency training or fellowship, whichever is the lesser of the two, and (c) (1) certification by the American Board of Podiatric Surgery, or (2) satisfactory completion of at least one year in an approved podiatric surgical residency.

Certification by the appropriate specialty board must be continuously maintained by the applicable Practitioner as a requirement for ongoing membership on the Medical Staff. In the event that board certification lapses, the member may apply through the Credentials Committee for a waiver, to the extent that an unforeseen hardship or other extenuating circumstances was a cause of the lapse. Failure to make a timely application for re-certification or failure of a re-certification examination or its equivalent should not be considered to constitute a hardship or an extenuating circumstance. A waiver may be approved only if: (a) the member commits in writing his intent to become recertified within the next available cycle of re-certification by his or her respective specialty board; (b) is otherwise in good standing as a member of the Medical Staff; and (c) has a satisfactory quality record as evidenced in Medical Peer Review records and fulfillment of all other requirements appropriate to the member's membership level. Approval of the Credentials Committee, Medical Board and the Board of Trustees is required.

At the time of reappointment, Practitioners' education and training will be evaluated based on the requirements in effect at the time of the Practitioner's initial appointment to the Medical Staff provided appointment is continuous. Practitioners who are members of the Medical Staff prior to January 1, 2008, and who have never been board certified shall not be required to comply with the board certification requirements in this Section 2.2-3 as long as they continuously remain members of the Medical Staff. If membership expires or terminates for any reason, on request for reinstatement or submission of an application for initial appointment, the Practitioner must satisfy all qualifications of appointment, including the board certification requirements regardless of the length of time of the gap in membership.

2.2-4 CLINICAL PERFORMANCE AND COMPETENCE

The Practitioner must have prior and current clinical practice experience, clinical results and utilization practice patterns, documenting a continuing ability to provide patient care services at an acceptable level of quality and efficiency.

2.2-5 MAINTENANCE OF APPROPRIATE WORKING ENVIRONMENT

The care of Patients requires an integrated and smoothly functioning team composed of the Medical Staff, Allied Health Professional staff, clinical and support staff. Members of the Medical Staff must behave in a professional and cooperative manner, contributing

to setting and maintaining an atmosphere for safe, collegial, high quality care, and demonstrate their commitment to these objectives. Each member of the Medical Staff is required to follow the values of Respect, Integrity, Compassion and Excellence upon which the Hospital's Code of Conduct is based. Distribution of the Code of Conduct and the Staff policy on appropriate Practitioner conduct will occur when the initial application for staff membership is made and each reappointment thereafter. Disruptive or inappropriate behavior will be addressed in accordance with the applicable Medical Staff Bylaws and the related manual, policies, procedures, and rules and regulations, including referral to the Professional Activities Committee or other applicable Medical Staff committees.

2.2-6 PROFESSIONAL AND ETHICAL CONDUCT

To adhere to generally recognized standards of medical and professional ethics applicable to the member. Specifically, but without limitation, this includes refraining from: delegating to a Practitioner or Allied Health Professional patient care responsibilities that are beyond the scope of said Practitioner's or AHP's license to practice or other known qualifications; failing to reveal to the Patient the identity of the Practitioners involved in providing him services; failing to seek appropriate consultation when medically indicated; failing to provide or arrange for appropriate and timely medical coverage and care for Patients for whom he is responsible; and failing to obtain informed patient consent to treatments.

2.2-7 DISABILITY FREE/UNDER CONTROL

(a) **Impairment**: To be free of or have under adequate control any impairment that interferes with, or presents a reasonable probability of interfering with, the Practitioner's ability to satisfy any of the general qualifications, perform the essential functions of staff membership, and exercise all or any of the clinical privileges requested or granted safely and competently.

(b) **Provide Documentation**: To provide documentation of necessary health status and ability on request, including submitting to examination, evaluation or testing in accordance with written staff policy and cooperating with the Health and Rehabilitation Committee.

2.2-8 VERBAL AND WRITTEN COMMUNICATION SKILLS

Ability to read and understand the English language, to communicate orally and in writing in the English language in an intelligible manner, and to prepare medical record entries and other required documentation in a timely, accurate and legible manner.

2.2-9 PROFESSIONAL LIABILITY INSURANCE

Must carry professional liability insurance coverage issued by a recognized company licensed to do business in the state of Texas and of a type and in an amount equal to or greater than the limits established by the Board of Trustees.

2.2-10 PROXIMITY TO THE HOSPITAL

Office is located within 30 miles of the Hospital, in order to provide continuing care to his Patients and to assure availability within a reasonable time period when the Patient's condition requires his prompt attention.

2.2-11 COVERAGE REQUIREMENTS

Demonstrate written arrangements for alternative medical coverage for Patients for whom he is responsible with an appropriately privileged Staff member should the Practitioner be unavailable. Consulting Category may be exempted from the coverage requirements if providing specialized service and/or backup coverage is not readily available.

2.3 WAIVER

Except as otherwise provided herein and using the procedures below, the Board of Trustees may

waive any basic qualification or Staff category specific requirement when in its discretion such waiver will serve the best interests of patient care in the Hospital and the community it serves. Waiver of a category specific requirement for a minimum or maximum number of Patient Contacts may be granted only if the Practitioner makes a satisfactory showing of unusual circumstances unlikely to occur again in his practice that were the basis of the failure to satisfy the requirement.

2.3-1 Any Practitioner who does not satisfy a criterion may request in writing that it be waived. The Practitioner requesting the waiver bears the burden of demonstrating that his qualifications are equivalent to, or exceed, the criterion in question.

2.3-2 The Board of Trustees may grant waivers in exceptional cases after considering the findings of the Credentials Committee, Medical Board, and any other committees designated by the Board, the specific qualifications of the Practitioner in question, and the best interests of patient care in the Hospital and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other Practitioner or group of Practitioners.

2.3-3 No Practitioner is entitled to a waiver or to any procedural rights of review under the Bylaws or otherwise if the Board of Trustees determines not to grant a waiver.

2.3-4 A determination that a Practitioner is not entitled to a waiver is not a "denial" of appointment or clinical privileges or considered an Adverse Recommendation or Action.

Every Practitioner must meet the Patient Contact requirements as indicated for the Staff category to which he applies or is assigned. If at the time of reappointment, the Practitioner has failed to meet or exceeds the specified activity requirements during the preceding appointment period, he shall be automatically transferred to the appropriate Staff category for the term of the reappointment. If no services have been provided during the preceding appointment period, he may not be reappointed to the Staff, unless the Practitioner requests, in writing, a waiver which is approved by the Board of Trustees, upon recommendation of the Medical Board. Exceptions may be made for certain specialties in which special provisions have been recommended by the Department and approved by the Medical Board and the Board of Trustees. Transfer to another Staff category pursuant to this section or failure to be granted an waiver is not considered an Adverse Recommendation or Action and does not entitle the Practitioner to any procedural rights of review under the Bylaws or otherwise.

2.4 PRACTITIONERS UNDER CONTRACT WITH HOSPITAL

Any Practitioner contracted by the Hospital to provide patient care services must apply for and maintain Staff membership and clinical privileges in the same manner as other Practitioners.

2.5 EFFECT OF APPLICATION

The applicant must sign the application and in so doing:

(a) attests as a condition of consideration for appointment or reappointment, and as a condition of continued appointment, that any misstatement in, or omission from, the application is grounds for the Hospital to withdraw the application from further consideration;

(b) signifies his willingness to appear for interviews in connection with his application;

(c) agrees to abide by the terms of the Bylaws and related manuals and other policies of the Medical Staff and those of the Hospital if granted appointment and/or clinical privileges, and to abide by the terms thereof in all matters relating to consideration of the application without regard to whether or not appointment and/or privileges are granted;

(d) agrees to abide by generally recognized ethical and professional standards applicable to his profession;

(e) agrees to notify, promptly and in writing, the President of the Medical Staff of any change made or proposed in the status of his professional license or permit to practice, federal or state controlled substance registration, professional liability insurance coverage, membership/employment status or clinical privileges at other institutions / facilities / organizations, and on the status of current or initiation of new malpractice

claims, or other such information as required by the Bylaws;

(f) authorizes Hospital representatives to consult with other Hospitals, health care entities, prior associates and others, including insurance carriers, who may have information bearing on the applicant's qualifications for appointment and/or clinical privileges, and consents to their inspecting all records and documents that may be material to evaluation of said qualifications;

(g) releases from any liability all those who, in good faith and without malice, review, act on or provide information regarding the applicant's qualifications for Medical Staff appointment and clinical privileges.

Any release of liability shall be in addition to any immunity afforded by state and federal law, and shall apply regardless of whether the applicant executes a release form.

2.6 MISSTATEMENT, OMISSION, FALSIFICATION OR IMPROPER ALTERATION OF STAFF APPLICATION OR PATIENT RECORD

2.6-1 REPRESENTATION AND WARRANTY OF TRUTHFULNESS AND COMPLETENESS

(a) In submitting his application for either initial appointment or reappointment, every applicant or Medical Staff member expressly represents and warrants that the information contained therein is true, accurate, and complete to the best of his knowledge, information and belief.

(b) In entering or specifically authenticating any information in a Patient's medical record, every Practitioner or other Practitioner authorized to make medical record entries expressly represents and warrants that such information is true, accurate, and complete to the best of his knowledge, information, and belief or in the exercise of his best professional opinion and judgment.

2.6-2 SIGNIFICANT MISSTATEMENT OR OMISSION IN STAFF APPLICATION DENIED

For purposes of this Article, any misstatement or omission in those portions of the application , including, but not limited to the areas of education and training, certification by specialty boards, licensure, disciplinary or adverse action by any private or public institutions or agencies, other Hospital affiliations, nature and extent of privileges, clinical activity, liability insurance, medico-legal information, or personal medical history and condition shall be presumed and deemed a significant misstatement or omission.

2.6-3 FALSIFICATION/IMPROPER ALTERATION OF PATIENT MEDICAL RECORD DEFINED

In regard to patient medical records, any misstatement, omission, alteration, concealment, addition, amendment, or intentional destruction which, as determined by the Medical Board and/or the Hospital in consultation with the Medical Staff President, is not completed in accordance with Hospital policy or which gives the appearance of being done with the intent of significantly obscuring the data and/or misleading the unsuspecting reader as to the true facts in the case or course of events, shall constitute falsification or improper alteration of the medical record.

2.6-4 SANCTIONS FOR VIOLATION OF THIS ARTICLE

(a) As a condition of consideration for appointment or reappointment, or clinical privileges, and as a condition of continued appointment and clinical privileges, every Practitioner specifically agrees that any misstatement in, or omission from, the application is grounds for the Hospital to stop processing the application. If appointment has been granted prior to the discovery of a misstatement or omission, the Practitioner may be subject to corrective action. If the misstatement is discovered prior to granting privileges, the Practitioner will not be entitled to a hearing or appeal. The Practitioner will be informed in

writing of the nature of the misstatement or omission and permitted to provide a written response.

(b) A violation of this Section may constitute additional and independent grounds for summary suspension, as defined in the Bylaws.

2.6-5 ADVERSE RECOMMENDATIONS OR ACTION

Except as provided above, any Adverse Recommendation or Action taken pursuant to this Section shall entitle the Practitioner to the procedural rights stated in the Medical Staff Hearing and Appellate Review Plan.

III. CATEGORIES AND OBLIGATIONS OF THE MEDICAL STAFF

3.1 GENERALLY

Each Practitioner approved for appointment to the Medical Staff must be assigned to a specific Staff category. There are SIX categories of appointment to the Staff: Active, Active Ambulatory, Active Community Affiliate, Courtesy, Consulting, and Emeritus. New members of the Medical Staff will be required to satisfactorily complete a provisional period of not less than twenty-four (24) months.

3.2 LIMITATION OF STATUS

The prerogatives set forth under each Staff category are general in nature and, with the exception of the prerogative for privileges, may be subject to limitation by special conditions attached to a Practitioner's Staff appointment, by other sections of the Bylaws and the related manuals, or by other policies of the Hospital.

3.3 BASIC OBLIGATIONS ACCOMPANYING STAFF APPOINTMENT

Each Practitioner, regardless of assigned Medical Staff category, and each Practitioner exercising clinical privileges shall:

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

(b) abide by the Medical Staff Bylaws and related manuals, the bylaws of the Hospital, the Code of Conduct, and all other lawful standards, policies and rules 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 indicated in Section 13.9, and provide any requested information;

(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) maintain the confidentiality of medical records, to include (1) avoiding improper access to records of Patients with whom the Practitioner has no treatment relationship or other legitimate reason for access, and (2) maintaining proper controls on access to Hospital's electronic medical records by Practitioner's employees and agents;

(g) participate in Medical Peer Review activities of the Staff and Hospital, and maintain the confidentiality of the records and proceedings of such activities;

(h) provide or arrange for appropriate and timely medical coverage and care for Patients for whom he is responsible; and

(i) agree to provide and update the information requested on a Staff application or privilege request forms by notification in writing or electronic communication to the Medical Staff Office at the time of any change in the information and to provide all information requested by the Hospital or its Medical Staff, including but not limited to:

(1) voluntary relinquishment of medical staff appointment or clinical privileges to avoid disciplinary action or investigation at any healthcare facility must be reported within thirty (30) days of the relinquishment;

(2) voluntary or involuntary denial, limitation, reduction, suspension or termination of appointment or clinical privileges as a result of issues regarding the quality of

care, professional conduct or utilization of services by the Practitioner at another healthcare facility must be reported within thirty (30) days of the action taken;

(3) professional license or controlled substances registration restrictions, revocations, and denials, in whole or in part, in any state or at the federal level must be reported within three (3) days of the action by the agency;

(4) status of all current claims (e.g., settlement, entry of judgment, dismissal, etc) and of any new professional liability claims;

(5) any reports made concerning the Practitioner to the National Practitioner Data Bank (NPDB) when notified by the NPDB that such a report has been made must be reported within three (3) days of learning that such report has been submitted to the NPDB;

(6) any changes in health status which might impair the Practitioner's exercise of clinical privileges or ability to fulfill the essential functions of Staff appointment and/or which might require special accommodation on the part of the Hospital in order to allow the Practitioner to continue treating Patients must be reported within three (3) days of; and

(7) any criminal arrests, charges or convictions, including plea bargains or *nolo contendere* pleas, must be reported within three (3) days and this includes any state or federal felony, and any state or federal misdemeanor other than a Class C misdemeanor traffic offense.

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

3.4 ACTIVE STAFF CATEGORY

3.4-1 REQUIREMENTS FOR ACTIVE STAFF CATEGORY

An Active Staff member must:

(a) meet the basic qualifications of staff membership as outlined in Article II of the Bylaws and in Article II of the Credentials Manual;

(b) have at least twenty-four (24) Patient Contacts during the preceding twenty-four (24) months.

3.4-2 PREROGATIVES OF ACTIVE STAFF CATEGORY

Subject to such limitations as are imposed under Section 3.2 above, an Active Staff member may:

(a) vote on all matters presented at regular and special meetings of the Medical Staff and of the Department and committees of which he is a member;

(b) hold Staff or Department office, provided he satisfies the specific qualifications for the position involved;

(c) be appointed to Medical Staff, Department and Hospital committees and be appointed as committee chair; and

(d) exercise such clinical privileges as are granted to him.

3.4-3 OBLIGATIONS OF ACTIVE STAFF CATEGORY

An Active Staff member must, in addition to meeting the basic obligations set forth above:

(a) Participate in the organizational and Medical Peer Review (including quality/risk/utilization management) activities of the Staff, including service in Medical Staff and Department offices and on Hospital and Medical Staff committees, faithfully performing the duties of any office or position to which elected or appointed.

(b) Participate equitably in the discharge of Staff functions as reasonably assigned by the applicable Medical Staff official by: participating in the Hospital's medical education programs; providing on call coverage for unassigned Patients

and back up specialty coverage for the emergency room and on-call consultation; giving consultation to other Practitioners consistent with his delineated privileges; reviewing the performance of Practitioners during provisional status periods, FPPE, and OPPE; and fulfilling such other Medical Staff functions as may reasonably be required.

3.5 ACTIVE-AMBULATORY STAFF

3.5-1 REQUIREMENTS FOR ACTIVE-AMBULATORY STAFF CATEGORY

The Active-Ambulatory staff member must:

(a) meet the basic qualifications of staff membership as outlined in Article II of the Bylaws and Article II of the Credentials Manual;

(b) have at least one Patient Contact during the preceding twenty four months **but not more than 23 Patient Contacts;**

(c) be a Practitioner specializing in either Family Practice, Internal Medicine or Pediatrics.

3.5-2 PREROGATIVES OF ACTIVE-AMBULATORY STAFF CATEGORY

The Active-Ambulatory staff member may:

(a) seek limited admitting privileges as well as only those privileges specifically delineated as available to this category as determined by and specified on the appropriate Department's privilege delineation form;

(b) exercise only those privileges granted by the Board of Trustees;

(c) vote and serve on committees and may hold Department or staff office, provided he satisfies the specific qualifications for the position involved.

3.6 ACTIVE COMMUNITY AFFILIATE CATEGORY

3.6-1 REQUIREMENTS FOR ACTIVE COMMUNITY AFFILAITE CATEGORY

An Active Community Affiliate Staff member must:

(a) meet the basic qualifications of staff membership as outlined in Article II of the Bylaws and Article II of the Credentials Manual:

(b) maintain a relationship with the Hospital and one or more members of the Medical Staff for the purpose of referral for inpatient care and/or following Patients;

(c) maintain an office-based practice in the Hospital's service area.

3.6-2 PREROGATIVES OF ACTIVE COMMUNITY AFFILIATE CATEGORY

The Active Community Affiliate member:

(a) may be appointed to Medical Staff, Department, and Hospital committees not providing Medical Peer Review activities, with vote if so specified by the appointing authority;

(b) may round on their Patients and view medical record on-site or remotely, subject to Patient authorization, but may not make entries in the medical record, and may not be granted privileges;

(c) may order outpatient diagnostic tests such as laboratory, radiology, and may order rehabilitative therapy;

(d) may attend continuing medical education, Department and regular staff meetings

(e) may vote at Staff meetings, but not at Department meetings;

(f) is not required to complete CareConnect training necessary for inpatient care;

(g) may not serve as call coverage, proctor or participate in a Medical Peer Review capacity.

3.7 COURTESY STAFF CATEGORY

3.7-1 REQUIREMENTS FOR COURTESY STAFF CATEGORY

A Courtesy Staff member must:

(a) meet the basic qualifications of staff membership as outlined in Article II of the Bylaws and Article II of the Credentials Manual;

(b) have at least one (1) but no more than twenty-three (23) Patient Contacts during the preceding twenty-four months

Practitioners who do not meet the minimum Patient Contact requirements may maintain Courtesy Staff status by providing documentation from an Active Staff member attesting to the fact:

(1) that the Courtesy staff member participates in a formalized cross-coverage arrangement with the Active staff member; or

(2) that Courtesy staff member's only activity at this Hospital is to provide surgical assistance to the Active Staff member.

Under this exception, if the cross-coverage arrangement ceases or if the Courtesy staff member assisting in the OR begins to admit and operate independently of the primary surgeon or if the Active staff member elects to terminate his medical staff membership at the Hospital, the membership and privileges of the Courtesy staff member will automatically terminate.

(c) Must be a member in good standing and hold an active staff appointment or its equivalent at another Joint Commission accredited Hospital.

(d) At the conclusion of the initial provisional status period and at each reappointment time, provide such evidence of clinical performance at his principal institution in such form as may be required by the applicable Medical Staff and Hospital authorities in order to allow an appropriate judgment to be made with respect to his ability to exercise the clinical privileges requested.

3.7-2 PREROGATIVES OF COURTESY STAFF CATEGORY

A Courtesy Staff member may:

(a) admit or otherwise provide services to Patients subject to the limitations in Section 3.2 and those in the Medical Staff rules and Hospital admission policies;

(b) exercise such clinical privileges as are granted to him;

(c) be appointed to Medical Staff, Department, and Hospital committees, with vote if so specified by the appointing authority.

Courtesy Staff members are not eligible to hold Department or Staff office, vote at Department or Staff meetings, or chair committees.

3.7-3 OBLIGATIONS OF COURTESY STAFF CATEGORY

A Courtesy Staff member must, in addition to meeting the basic obligations set forth:

(a) Participate equitably in the discharge of the Staff functions as reasonably assigned by the applicable Medical Staff official by: participating in the Hospital's medical education programs, providing on-call coverage for attending unassigned Patients and back-up specialty coverage for the emergency room, if required by Department; giving consultation to other Staff members consistent with his delineated privileges; reviewing the performance of Practitioners during provisional status periods, FPPE and OPPE, and fulfilling such other staff functions as may be reasonably required.

3.8 CONSULTING CATEGORY

3.8-1 REQUIREMENTS FOR CONSULTING STAFF CATEGORY

A Consulting Staff member must:

(a) meet the basic qualifications of staff membership as outlined in Article II of the

Bylaws and Article II of the Credentials Manual;

(b) hold an active staff appointment or its equivalent at another Joint Commission accredited Hospital.

(c) At the conclusion of the initial provisional status period and at each reappointment time, provide such evidence of clinical performance at his principal institution in such form as may be required by the applicable Medical Staff and Hospital authorities in order to allow an appropriate judgment to be made with respect to his ability to exercise the clinical privileges requested.

(d) Must have a special expertise not generally available among the Active or Courtesy Medical Staff.

3.8-2 PREROGATIVES OF CONSULTING STATUS

A Consulting Staff member may:

(a) not have admitting privileges;

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

(c) exercise such clinical privileges as are granted to him;

(d) be appointed to Medical Staff Department and Hospital committees, with vote if so specified by the appointment authority, but may not hold Department or Staff office or serve as chairperson of any committee.

3.8-3 OBLIGATIONS OF CONSULTING STATUS

A Consulting Staff member must meet the basic obligations provided in Section 3.3.

3.9 EMERITUS STAFF

3.9-1 REQUIREMENTS FOR EMERITUS STAFF STATUS

Appointment to the Emeritus Staff is restricted to former Practitioners who have retired from clinical practice and are recognized for their long-standing service to the Hospital or other noteworthy contributions. Emeritus Staff are not required to meet the basic qualifications of staff membership as outlined in Article II of the Bylaws and Article II of the Credentials Manual.

3.9-2 PREROGATIVES OF EMERITUS STATUS

Emeritus Staff members may not consult, admit or attend Patients or otherwise hold clinical privileges; may attend meetings of the Medical Staff and applicable Department meetings (without vote); may serve on committees (with vote); may not hold Department or Staff office or serve as a chairperson of any committee; and will be exempt from application fees, dues, and assessments.

ARTICLE IV. CLINICAL PRIVILEGES

4.1 EXERCISE OF CLINICAL PRIVILEGES

A Practitioner granted clinical privileges at the Hospital may exercise only those clinical privileges specifically granted to him pursuant to these Bylaws and the Credentials Manual. A Practitioner may be granted clinical privileges in one or more of the Departments, and his exercise of privileges within the jurisdiction of any Department is always subject to the qualifications, rules and regulations of that Department and the authority of the Department Chair.

4.2 BASIS FOR PRIVILEGES DETERMINATIONS

Clinical privileges shall be based upon the applicant's education, training, experience, utilization practice patterns, health status, demonstrated competence and judgment, references and other relevant information as documented and verified in each applicant's credentials file. Additional factors that may be used in determining privileges are patient care needs; Hospital capability to support the type of privileges being requested by the applicant; the availability of qualified coverage in his absence; adequate professional liability insurance coverage for the clinical

privileges requested; any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration; any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another Hospital; and other relevant information, including a written report and findings by the chairman of each of the clinical Departments in which privileges are sought. If a Department has determined that certain privileges and associated responsibilities and obligations are required for maintenance of membership in the Department, then the applicant must request those privileges. Where appropriate, review of the records of Patients treated in other healthcare settings may be used to make privileges determinations.

The granting of privileges in connection with reappointment, including conclusion of the provisional period, or with a requested change in privileges may also be based upon observed clinical performance, documented results of the applicant's quality management activities, and in the case of additional privileges requested, verified evidence of appropriate training and experience supportive of the request.

4.3 PROCESS FOR PRIVILEGES DETERMINATIONS

Each Department must define in writing the privileges to be exercised by the members of the Department, including the criteria for requesting, qualifications for and any limitations applicable to those privileges. Such privilege delineation will be in writing and approved by the Credentials Committee, the Medical Board and the Board of Trustees.

Privilege delineation will be periodically reviewed and updated as necessary by each Department following the same procedure. At the time of reappointment all members of the Medical Staff must request and be approved for the continuing exercise of the privileges requested based on the defined criteria, qualifications and limitations, regardless of whether they have previously been granted the requested privilege.

The process for considering requests for clinical privileges and modifications of those privileges shall be set out in the Credentials Manual and include the following basic steps:

4.3-1 DEPARTMENT CHAIRMAN EVALUATION

After receipt and review of a complete application and verification of all required information, the Medical Staff Office will forward the complete application to the chairman of each Department in which clinical privileges are being requested for review. The Department Chair will review the application and make a recommendation to the Credentials Committee.

4.3-2 CREDENTIALS COMMITTEE EVALUATION

The Credentials Committee shall review the recommendations of the Department Chair, supporting documentation and relevant information available to it. The Credentials Committee shall prepare its written report and recommendations and transmit it to the Medical Board.

4.3-3 MEDICAL BOARD ACTION

At its next regular meeting after receipt of a recommendation from the Credentials Committee, the Medical Board shall consider the application and issue a recommendation.

4.3-4 BOARD OF TRUSTEES ACTION

Except in the case of an Adverse Recommendation or Action which shall be governed by the Medical Staff Hearing and Appellate Review Plan, at its next regular meeting after receipt of a recommendation from the Medical Board, the Board of Trustees shall review the recommendation and issue a decision.

4.4 PROCESS FOR TEMPORARY PRIVILEGES

Temporary privileges may be granted by the Hospital President or his designee to a Practitioner who is not an applicant to the Medical Staff in cases of an important patient care need and to an applicant for initial appointment to the Medical Staff who is pending review by the Medical Board and the Board of Trustees. The criteria and process shall be set out in the Credentials Manual and require the basic steps of recommendation by the Medical Staff President, verification of licensure and current competence, and designation of a specific time period which may not exceed 120 days. Temporary privileges are not renewable.

4.5 PROCESS FOR DISASTER PRIVILEGES

Disaster privileges may be granted by the Hospital President, Medical Staff President or Medical Staff Director of the Command Center when the emergency management plan has been activated as further detailed in the Credentials Manual and the plan. Credentialing shall include the basic steps of presentation of valid government-issued photo identification, and direct observation, mentoring, and/or clinical record review of volunteer staff.

4.6 PROCESS FOR NEW PRIVILEGES AND THOSE INVOLVING MULTIPLE

4.6-1 Requests for clinical privileges not currently offered will not be processed until a determination is made that the privileges will be offered and criteria for the privileges are established as set forth in the Credentials Manual. The basic steps of this process shall include review by the Credentials Committee and approval by the Board of Trustees.

4.6-2 Requests for clinical privileges traditionally exercised by Practitioners in one specialty will not be processed from Practitioners in another specialty until a determination is made regarding the ability of the other specialty Practitioners to exercise the privileges with equivalent safety and competency. The basic steps of this process shall include review by the Credentials Committee and approval of criteria for the other specialty by the Board of Trustees.

4.7 PRIVILEGES FOR HISTORY AND PHYSICAL EXAMINATION

The attending Physician is responsible for obtaining an adequate history and physical examination. A complete history and physical examination provided by a member of the Hospital Medical Staff shall be available on the medical record within twenty-four (24) hours of admission and prior to surgery or a procedure requiring anesthesia services. If a history and physical examination has been performed within thirty (30) days prior to admission, this report or a durable, legible copy of this report can be placed in the medical record at the time of admission provided there is documentation of an updated examinations and any changes placed in the medical record within 24 hours of admission prior to surgery or a procedure requiring anesthesia service. If there are no changes, use the statement “nothing has changed” or “no changes” and re-date and sign the document. Any history and physical examination performed over thirty (30) days prior to admission will be not accepted.

A qualified Physician member of the Medical Staff other than an Active Community Affiliate Member must perform a history and physical examination on a dental, oral surgery or podiatric Patient and must assess the risk and effect of a proposed surgical or special procedure on the total health status of the Patient prior to the proposed surgery or special procedure. In the case of ambulatory surgery, this history and physical examination and assessment of risk and effect must also be performed by a Physician member of the Medical Staff. For each oral surgery, dental or podiatric Patient, a Physician member of the Medical Staff must be responsible for the care of any medical problem that may be present at admission or that may arise during Hospitalization. It is the responsibility of the Dentist, Oral Surgeon or Podiatrist to secure services of Physician member to perform the history and physical examination.

4.8 ALLIED HEALTH PROFESSIONALS

The process and procedures governing the granting of and performance by Allied Health

Professionals of specified patient care services, including clinical privileges, are set forth in the Allied Health Professionals Rules and Regulations.

4.8-1 ALLIED HEALTH PROFESSIONAL SPONSORING PRACTITIONER

Every Allied Health Professional, except Allied Health Professional's designated as independent practitioners, must have a Sponsoring Practitioner. For purposes of these Bylaws, a "Sponsoring Practitioner" is a Practitioner who can attest to the Allied Health Professional's competency to perform all requested clinical privileges or scope of duties at initial application and on an ongoing basis. The Sponsoring Practitioner must be a Member of the Active, Active Ambulatory, Consulting or Courtesy Staff. More than one Practitioner can sponsor the same Allied Health Professional. The Sponsoring Practitioner has responsibility for oversight of the proper conduct of the Allied Health Professional within the Hospital, for the Allied Health Professional's observance of all bylaws, policies and rules of the Hospital and Medical Staff, and for the correction and resolution of problems that may arise. The Sponsoring Practitioner shall notify the Medical Staff office as soon as the Practitioner becomes aware of any reason that the Allied Health Professional cannot provide health care within accepted health care standards or in compliance with Hospital requirements, or that the Allied Health Professional no longer meets the Hospital's qualifications for clinical privileges or approved scope of practice. The Sponsoring Practitioner may or may not be a Supervising Practitioner.

If the Medical Staff membership of the Sponsoring Practitioner is terminated, the Allied Health Professional will have 60 days in which to obtain an alternative Medical Staff Member approved by the Medical Board to assume the responsibilities as the Sponsoring Practitioner. If such alternative Medical Staff Member is not identified and approved within the required time frame, the privileges of the Allied Health Professional shall be automatically terminated effective immediately.

4.8-2 ALLIED HEALTH PROFESSIONAL SUPERVISING PRACTITIONER

Every Allied Health Professional, except Allied Health Professional's designated as independent practitioners, must have at least one Supervising Practitioner. A Supervising Practitioner is the Practitioner who is providing the required direction, delegation and/or supervision of the Allied Health Professional with a specific patient or procedure. An Allied Health Professional Supervising Practitioner's obligation for the Allied Health Professional while under the Practitioner's direction, delegation and/or supervision include:

(a) Legal and ethical responsibility for the Allied Health Professional's performance in the Hospital.

(b) Responsibility for the proper conduct of the Allied Health Professional in the Hospital, for the Allied Health Professional's observance of all Medical Staff Bylaws, policies and rules and regulations of the Hospital and Medical Staff, and for the correction and resolution of any problems that may arise.

(c) Being physically present or immediately available by telephone to provide further guidance when the Allied Health Professional exercises clinical privileges and/or performs any task or function, except in life-threatening emergencies.

(d) Ultimate responsibility for directing the course of the patient's health care treatment.

(e) Ensuring that the Allied Health Professional provides services in the Hospital in accordance with accepted health care standards and in accordance with the Allied Health Professional's delineation of clinical privileges and/or approved scope of practice.

(f) Complying with all Medical Staff Bylaws, policies and rules and regulations of the Hospital and Medical Staff governing the use of Allied Health Professionals

in the Hospital, including refraining from requesting that the Allied Health Professional provide services beyond, or that might reasonably be construed as being beyond, the Allied Health Professional's authorized clinical privileges and/or scope of practice in the Hospital.

(g) Obtaining written consent from all patients of the Supervising Practitioner to be treated by the Allied Health Professional in accordance with such rules and regulations pertaining thereto that may be adopted by the Hospital from time to time and as are required under state law.

(h) Complying with all laws and regulations and all policies specific to the particular category of Allied Health Professional governing his direction, delegation and/or supervision of the Allied Health Professional.

(i) Notifying the Medical Staff office as soon as the Supervising Practitioner becomes aware of any reason that the Allied Health Professional cannot provide health care within accepted health care standards or in compliance with Hospital requirements, or that the Allied Health Professional no longer meets the Hospital's qualifications for clinical privileges or approved scope of practice.

(j) Notifying the Medical Staff office immediately if the Supervising Practitioner is no longer willing to serve as a Supervising Practitioner.

V. AUTOMATIC RELINQUISHMENT

5.1 FAILURE TO COMPLETE MEDICAL RECORDS/MEDICAL RECORDS TRAINING

Failure to complete medical records in the time period set forth in the Rules and Regulations shall result in an automatic suspension of all clinical privileges, after notification by the Health Information Management Department of delinquency as set out in the Rules and Regulations. Suspension shall continue until all delinquent records are completed and reinstatement accomplished in accordance with applicable Rules and Regulations. Failure to complete the medical records that caused relinquishment within the time required by the applicable Rules and Regulations shall result in automatic resignation from the Medical Staff. Privileges shall be automatically terminated along with membership if the Member has four (4) automatic suspensions in any consecutive twelve (12) month period.

Failure to complete the appropriate electronic medical record training as designated by the Medical Board may result in an Administrative Suspension, relinquishing all inpatient and outpatient admitting privileges. Completion of the training will result in reinstatement of privileges. Members must complete appropriate electronic training in order for their reappointment application to be considered complete and forwarded to the Credentials Committee. Members who have not obtained or completed such training shall be considered to have an incomplete reappointment application.

5.2 ACTION BY GOVERNMENT AGENCY OR INSURER

(a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below must be promptly reported to the Hospital President.

(b) An individual's appointment and clinical privileges shall be automatically relinquished if any of the following occur:

  (1) Licensure: Revocation, expiration, suspension or the placement of conditions or restrictions on an individual's license.

  (2) Controlled Substance Authorization: Revocation, expiration, suspension or the placement of conditions or restrictions on an individual's DEA or state controlled substance authorization.

  (3) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage or other action causing the coverage to fall below the minimum required by the Hospital or cease to be in effect, in whole or in part.

  (4) Medicare and Medicaid Participation: Termination, exclusion, or preclusion by

government action from participation in the Medicare/Medicaid or other federal or state health care programs.

(5) Criminal Activity: Indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or any misdemeanor involving (i) controlled substances; (ii) illegal drugs, (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or (iv) violence against another.

(c) Automatic relinquishment shall take effect immediately and continue until the matter is resolved, if applicable, and a request for reinstatement of appointment and privileges has been acted upon by the Credentials Committee, the Medical Board, and the Board of Trustees.

5.3 FAILURE TO PROVIDE REQUESTED INFORMATION

Failure to provide information pertaining to an individual's qualifications for appointment or clinical privileges, in response to a written request from the Credentials Committee, the Medical Board, the Hospital President, or any other committee authorized to request such information, shall result in automatic relinquishment of all clinical privileges until the information is provided. If the automatic relinquishment continues for more than sixty (60) days, it shall automatically become a termination of Privileges and membership.

5.4 FAILURE TO ATTEND SPECIAL CONFERENCES

(a) Whenever there is an apparent or suspected deviation from standard clinical practice involving any individual, the Department Chair or the Medical Staff President may require the individual to attend a special conference with Medical Staff leaders and/or with a standing or ad hoc committee of the Medical Staff.

(b) The notice to the individual regarding this conference shall be given by Special Notice at least three (3) days prior to the conference and shall inform the individual that attendance at the conference is mandatory.

(c) Failure of the individual to attend the conference shall be reported to the Medical Board. Unless excused by the Medical Board upon a showing of good cause, such failure shall result in automatic relinquishment of all or such portion of the individual's clinical privileges as the Medical Board may direct. Such relinquishment shall remain in effect until the matter is resolved. If the automatic relinquishment continues for more than sixty (60) days, it shall automatically become a termination of privileges and Membership.

ARTICLE VI. PRECAUTIONARY AND TEMPORARY ACTION

6.1 INITIATION

The Medical Staff President, the Chair of a Medical Staff Department, the Hospital President or the Board Chair shall each have the authority to suspend or restrict all or any portion of a Practitioner's clinical privileges whenever failure to take such action may result in imminent danger to the health and/or safety of any individual. A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the Hospital President and the Medical Staff President, and shall remain in effect unless it is modified by the Hospital President or Medical Board. The Hospital President shall provide the Practitioner with oral notice and Special Notice of the action, with a general statement of the reasons, as soon as practical. The Practitioner may be given an opportunity to refrain voluntarily from exercising privileges pending an Investigation. Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension or restriction.

6.2 MEDICAL BOARD PROCEDURE

6.2-1 The Medical Board shall review the matter resulting in a precautionary suspension or restriction within are reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the Practitioner will be given an opportunity to meet

with the Medical Board. The Practitioner may propose ways other than precautionary suspension or restriction to address the imminent danger. The Practitioner shall not have the right to be represented by legal counsel at this meeting.

6.2-2 After considering the matters resulting in the suspension or restriction and the Practitioner's response, if any, the Medical Board shall determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an Investigation. The Medical Board 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).

6.2-3 If the precautionary suspension or restriction is continued and constitutes an Adverse Recommendation or Action, the Practitioner shall be entitled to the procedural rights of review in Article 8.1 and the Hearing and Appellate Review Plan, and all further procedures shall be in accordance with those provisions.

ARTICLE VII. CORRECTIVE ACTION

7.1 INITIATION

Whenever the activities or professional conduct of any Practitioner is, or is reasonably likely to be, detrimental to patient safety or to the delivery of quality patient care, or are disruptive to Hospital operations, an Investigation of the allegations against such Practitioner may be requested by:

(a) any officer of the Medical Staff,
(b) the chairman of any standing committee of the Medical Staff,
(c) any Department Chair,
(d) Hospital President, or
(e) the Board of Trustees or its Chair.

Any individual who wishes to bring an issue or situation to the attention of the Medical Staff must deliver such information in writing to any officer of the Medical Staff, the chairman of any standing committee of the Medical Staff, any Department chairman or director of a clinical area, Hospital President or the Board of Trustees. However, the receipt of such written information is not a prerequisite to the initiation of an Investigation for or imposition of corrective action.

The following events are examples of conduct which may be the subject of corrective action:

(a) the conduct of a Practitioner is inappropriate or disruptive of Hospital operations,
(b) a Practitioner fails to meet any of the requirements of all Hospital and Medical Staff bylaws, rules, regulations, policies and procedures,
(c) a Practitioner has been subject to any disciplinary action by any other Hospital or health care entity or any licensing or regulatory agency,
(d) a Practitioner has engaged in immoral, unprofessional unethical, or unlawful conduct,
(e) a Practitioner has been charged with or convicted of any crime which reflects on the Practitioner's suitability to practice medicine,
(f) failure to maintain timely, legible and appropriate medical records, and
(g) unavailability or failure to respond to calls from the Hospital.

7.2 REQUESTS AND NOTICES

Requests for an Investigation for potential corrective action shall be in writing, submitted to or created by the Medical Board, and supported by reference to the specific activities or conduct which constitute the grounds for the request. A preliminary inquiry, which does not constitute an Investigation may be conducted by the Medical Board or a sub-committee thereof, in consultation with the Hospital President.

If an Investigation is commenced, the Hospital President shall notify the affected Practitioner by special notice, not later than the end of the fifth working day after the decision is made to conduct

an Investigation (providing that notification may be delayed if, in the judgment of the Hospital President or the Medical Board, informing the Practitioner immediately would compromise the Investigation or disrupt the operation of the Hospital or Medical Staff); that the matter is being investigated; that the Practitioner may be required to provide information or appear for an interview, that the Investigation and any appearance or submission of information does not constitute a hearing and none of the procedural rights or processes of Article VI of the Hearing and Appellate Review Plan apply and that he/she will be given notice of the recommendation of the Medical Board .

7.3 INVESTIGATION

After deliberation, the Medical Board shall, in consultation with the Hospital President, determine whether an Investigation of the matter is appropriate and must either act on the request, direct that an Investigation be undertaken or dismiss the request. If it is determined that an Investigation is appropriate, the Medical Board may conduct such Investigation itself or may assign this task to a Medical Staff officer, Department, or ad hoc committee or other organizational component. The individual being investigated shall not have the right to be represented by legal counsel at this meeting. The Medical Board may, at any time within its discretion, and shall at the request of the Board of Trustees, terminate the Investigation process and proceed with action as provided below. The Investigation procedures do not constitute a hearing.

7.4 MEDICAL BOARD ACTION

Within thirty (30) days, if practical, after completion of the Investigation and the receipt of the investigative report if conducted by other than the Medical Board, the Medical Board shall take action upon the request for corrective action. Such action may include, but is not limited to:

(a) a recommendation that no corrective action be taken;

(b) a recommendation that the Medical Board issue a letter of warning, a letter of admonition, or a letter of reprimand or impose special review requirements;

(c) recommending terms of probation or requirements of consultation or other special conditions;

(d) recommending reduction, suspension, limitation, or revocation of clinical privileges;

(e) recommending reduction of Staff category or limitation of any Staff prerogatives directly related to patient care;

(f) recommending suspension or revocation of Staff membership; or

(g) referring the matter back to such individual(s) or committee(s) it deems appropriate for further Investigation.

7.5 EFFECT OF MEDICAL BOARD ACTION

7.5-1 DEFERRAL

If the Medical Board’s action is to refer the matter for further Investigation, such referral for further Investigation shall specify the reasons for such referral, provide direction for further Investigation, and state time limits for such further Investigation.

7.5-2 RECOMMENDATION THAT IS NOT ADVERSE

If the Medical Board's recommended action is that corrective action be taken or that the Medical Board issue a letter of warning, a letter of admonition, probation, or a letter of reprimand or impose special review requirements, such recommendation or any other recommendation that is not an Adverse Recommendation or Action, together with all supporting documentation, shall be transmitted to the Board of Trustees. The affected Practitioner is not entitled to the procedural rights provided in the Hearing and Appellate Review Plan.

7.5-3 ADVERSE RECOMMENDATION OR ACTION

Any recommendation of the Medical Board that is an Adverse Recommendation or Action shall entitle the affected Practitioner to the procedural rights as provided in the Hearing and Appellate Review Plan and all further procedures shall be as set forth in that

Plan.

7.6 BOARD OF TRUSTEES ACTION

7.6-1 ON MEDICAL BOARD RECOMMENDATION THAT IS NOT ADVERSE

The Board of Trustees shall, in whole or in part, adopt or reject a recommendation of the Medical Board that is not an Adverse Recommendation or Action, or refer the recommendation back to the Medical Board for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made. The Medical Board shall determine the process to be followed in the event the Board of Trustees refers the matter back for further consideration.

7.6-2 WITHOUT BENEFIT OF MEDICAL BOARD RECOMMENDATION

If the Board of Trustees does not receive a recommendation from the Medical Board within a time period the Board of Trustees deems reasonable, it may, after notifying the Medical Board convene a joint conference to consider the issue which was the subject of the Investigation.

7.7 NOTICE OF FINAL ACTION

The Hospital President shall give written notice of the Board of Trustees' final decision to the affected Practitioner not later than the end of the fifth working day after the date of the Board of Trustees' final decision.

ARTICLE VIII. FAIR HEARING

8.1 RIGHT TO HEARING AND APPELLATE REVIEW

8.1-1 ADVERSE RECOMMENDATION OR ACTION

(a) A Practitioner is entitled to the procedural rights set out below and in the Hearing and Appellate Review Plan whenever the Medical Board makes one of the following recommendations which are defined as an Adverse Recommendation or Action:
   (1) denial of initial appointment to the Medical Staff;
   (2) denial of reappointment to the Medical Staff;
   (3) revocation of appointment to the Medical Staff;
   (4) denial of requested clinical privileges;
   (5) revocation of clinical privileges;
   (6) suspension of clinical privileges other than a temporary action under Section 6.1 hereof ; or
   (7) an observation or proctor requirement if the observer or proctor's approval is required to exercise clinical privileges;
   (8) an education, training or counseling requirement that must be satisfied prior to exercising clinical privileges;
   (9) mandatory concurring consultation or supervision requirement (i.e., the consultant or supervisor must concur or approve the course of treatment in advance); or
   (10) any other restriction or limitation of clinical privileges based on professional competence or conduct if such action, when final, would be reportable to the National Practitioner Data Bank.

(b) No other recommendations or actions shall entitle the Practitioner to these rights.

(c) The hearing shall be conducted in as informal a manner as possible while still in accordance with the provisions of this Article and the Hearing and Appellate Review Plan.

(d) These rights also apply if the Board of Trustees makes one of the above actions after a recommendation by the Medical Board that is not an Adverse

Recommendation or Action. In this instance, all references in this Article and the Hearing and Appellate Review Plan to the Medical Board shall mean the Board of Trustees unless the context clearly indicates otherwise.

8.1-2 ACTIONS NOT GROUNDS FOR HEARING

None of the following actions shall constitute an Adverse Recommendation or Action, provided that the Practitioner shall be entitled to submit a written explanation to be placed into his or her file:

(a) issuance of a letter of guidance, warning, or reprimand;
(b) imposition of probation, FPPE, or any limitation or restriction imposed equally on all Practitioner with the same or similar clinical privileges;
(c) imposition of conditions, monitoring, or a general consultation requirement (i.e., the Practitioner must obtain a consult but need not get prior approval for the treatment);
(d) any action regarding temporary, emergency or disaster privileges;
(e) automatic relinquishment or automatic resignation of appointment or privileges;
(f) imposition of a requirement for additional training or continuing education that may be satisfied while continuing to exercise clinical privileges;
(g) temporary action under Section 6.1;
(h) denial of a request for leave of absence, or for an extension of a leave;
(i) determination that an application is incomplete and/or withdrawal of an application from processing;
(j) determination that an application will not be processed due to a misstatement or omission; or
(k) determination of ineligibility based on a failure to meet threshold criteria, a lack of need or resources or because of an exclusive contract;
(l) any action taken pursuant to the terms of a contract between the Hospital and a Practitioner or the Practitioner's group.

8.2 NOTICE OF ADVERSE RECOMMENDATION OR ACTION

A Practitioner against whom an Adverse Recommendation or Action has been taken shall be given special notice of same by the Hospital President or his designee not later than the end of the fifth (5th) working day after such action has been taken. Such notice shall:

(a) advise the Practitioner of the nature of and reasons for the Adverse Recommendation or Action, with a statement of the alleged acts and omissions and a list of specific patient records or other subject matter forming the basis for the action;
(b) advise the Practitioner of his or her right to request a hearing;
(c) specify that the hearing must be requested within thirty (30) days of the date of receipt of such notice by submitting a written request to the Hospital President;
(d) state that failure to submit a written request for a hearing to the Hospital President within the specified time period shall constitute a waiver of rights to a hearing and to appellate review of the matter and all other rights to which the Practitioner may otherwise have been entitled under the Medical Staff Bylaws and/or other policies, procedures, rules, regulations, guidelines or requirements of the Hospital or its Medical Staff or otherwise;
(e) of his rights summarize the Practitioner's procedural rights as specified in this Article and the Hearing and Appellate Review Plan;
(g) state that following receipt of a properly filed hearing request, the Practitioner will be notified of the date, time and place of the hearing at least thirty (30) days in advance of the hearing date; and
(h) if the Adverse Recommendation or Action includes a precautionary suspension, state that the Practitioner may request that the hearing be expedited to the extent reasonably possible.

8.3 BASIC RIGHTS OF PRACTITIONER

8.3-1 The procedural rights of review in the Hearing and Appellate Review Plan shall include the following basic rights for the affected Practitioner, as well as the Medical Board or Board of Trustees, whichever issued the Adverse Recommendation or Action:

(a) To be present at the hearing;
(b) To representation by an attorney or other person of the Practitioner's choice;
(c) To have a record made of the proceedings as provided in the Hearing and Appellate Review Plan, copies of which may be obtained by the Practitioner upon payment of any reasonable charges associated with the preparation thereof;
(d) To call and examine witnesses;
(e) To introduce exhibits and present any evidence determined to be relevant by the Presiding Officer, as defined in the Hearing and Appellate Review Plan, regardless of its admissibility in a court of law;
(f) To cross-examine any witness on any matter relevant to the issues;
(g) To impeach any witness;
(h) To rebut any evidence;
(i) To submit a written statement at the close of the hearing;

and following the hearing:

(j) To receive the written recommendation of the Hearing Committee, as defined below, including a statement of the basis for the recommendations; and
(k) Following exercise or waiver of any appellate review to which the Practitioner is entitled, to receive a written decision of the Board of Trustees, including a statement of the basis for the decision.

8.3-2 Upon receipt of a timely written request from the Practitioner, for a hearing, the Hospital President shall schedule and arrange for a hearing and shall provide Special Notice to the Practitioner of the time, place and date so scheduled at least thirty (30) days in advance.

8.4 PROCESS FOR HEARING AND APPELLATE REVIEW

The process for appointing a Hearing Committee and a Presiding Officer, scheduling the hearing, prehearing proceedings, and conducting the hearing and appellate review if necessary, shall be set out in the Hearing and Appellate Review Plan and, in addition to the rights set out in Section 8.3 above, include the following basic steps:

8.4-1 The hearing shall be conducted by a Hearing Committee of not less than three (3) members of the Medical Staff or by a Presiding Officer as an independent hearing officer who is not a member of the Medical Staff, appointed by the Hospital President following consultation with the Medical Staff President. None of the members of the Hearing Committee shall be direct economic competitors of the Practitioner and, if a hearing officer is used and the basis for the Adverse Recommendation or Action is professional competence or conduct, the hearing officer must be a Practitioner.

8.4-2 Following the Practitioner's exercise of procedural rights of review in accordance with this Article and the Hearing and Appellate Review Plan, or waiver of those rights, the Board of Trustees shall make a final decision.

8.4-3 If a Practitioner entitled to a hearing requests statutorily mandated mediation as provided in the Texas Health & Safety Code, it must be requested in writing at the same time that the request for hearing is made. The timelines for the hearing will be temporarily suspended until the mediation is completed. If an agreement does not result from the mediation, the timelines for the hearing will resume. The procedures for mediation shall be set out in the Hearing and Appellate Review Plan.

ARTICLE IX ORGANIZATION OF THE MEDICAL STAFF

9.1 OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff shall be the Medical Staff President, Medical Staff President-Elect, Immediate Past Medical Staff President and Secretary-Treasurer of the Medical Staff. Officers must be members of the Active Staff in good standing, have no pending Investigations or Adverse Recommendations or Actions concerning Medical Staff appointment or clinical privileges, be willing to faithfully discharge the duties and responsibilities of the position, attend continuing education relating to Medical Staff leadership and/or credentialing functions prior to or during the term of the office, have demonstrated an ability to work well with others, and be board certified in their specialty at the time of nomination and election, and must maintain compliance with these requirements during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. Officers shall disclose any financial relationship with any other state-licensed institution that competes with the Hospital or any affiliate and must comply with the Hospital's conflict of interest policy. Officers may not simultaneously hold leadership positions on another Hospital Medical Staff. The Medical Staff officers shall be Physicians.

9.2 TERM OF ELECTED STAFF OFFICERS

The term of office of elected Medical Staff officers is one Medical Staff year. Elected officers assume office on the first day of the Medical Staff year. Elected officers may be elected for no more than three (3) consecutive terms in the same officer positions. Serving the remainder of a term shall not be counted as one of the three maximum consecutive terms.

9.3 ELECTION OF OFFICERS

Officers, other than the Immediate Past President, shall be elected at one of the semi-annual meetings of the Medical Staff. Only members of the Active, Active Ambulatory and Active Community Medical Staff shall be eligible to vote. All officers will be confirmed by the Board of Trustees. Officers shall be elected by a majority vote of the votes cast. If there are more than two nominees and no nominee receives a majority of the votes cast on the first ballot, there shall be a runoff election between the two nominees receiving the highest number of votes.

The Nominating Committee shall be appointed by the Medical Board as outlined in the Organization & Functions Manual. This Committee shall offer one or more nominees for each office. Nominations must be announced, and the names of the nominees posted at least thirty (30)days prior to the election. Nominations may also be made by a petition signed by at least 10% ofthe members of the Active Staff. Such a petition must be submitted to the Medical Staff Office atleast fifteen (15) days prior to the annual Medical Staff meeting.

9.4 VACANCIES

Vacancies in office during the Medical Staff year, except the office of Medical Staff President, shall be filled by the Medical Board of the Medical Staff. If there is a vacancy in the office of the Medical Staff President, the Medical Staff President-Elect shall serve the remainder of the term.

In the event the Immediate Past President is unable to serve, the Medical Board shall appoint a former past Medical Staff President to serve as the Immediate Past President.

9.5 DUTIES OF OFFICERS

9.5-1 THE MEDICAL STAFF PRESIDENT

The Medical Staff 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) 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;

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

(d) appoint committee chairmen and members in accordance with the provisions of these Bylaws, to all standing and special Medical Staff committees except the Medical Board and Nominating Committee;
(e) serve as chairman of the Medical Board and a voting member, and as an Ex-Officio member, without vote, on all Medical Staff committees unless otherwise provide in the statement of the committee;
(f) provide day-to-day liaison on medical matters with the Hospital President and the Board of Trustees;
(g) 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
(h) serve on committees as may be required.

9.5-2 MEDICAL STAFF PRESIDENT-ELECT

The Medical Staff President-Elect shall:
(a) assume all the duties and have the authority of the Medical Staff President in the event of the Medical Staff 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 Board and such other committees as may be required;
(c) automatically succeed the Medical Staff President when the President fails to serve for any reason; and
(d) perform such duties as are assigned to him by the Medical Staff President.

Should both the Medical Staff President and the Medical Staff President-Elect be unavailable in an emergency, the authority and duties of the Medical Staff President will be temporarily assumed by the available elected officers of the Medical Staff in the following order: Immediate Past Medical Staff President, Secretary-Treasurer, or member at large.

9.5-3 SECRETARY-TREASURER OF THE MEDICAL STAFF

The Secretary-Treasurer shall:
(a) be a member of the Medical Board and such other committees as specified;
(b) keep accurate and complete minutes of all Medical Board and Medical Staff meetings;
(c) call Medical Staff meetings on order of the Medical Staff President and record attendance;
(d) attend to all correspondence and perform such other duties as ordinarily pertain to his office;
(e) serve on committees as required.

9.5-4 IMMEDIATE PAST MEDICAL STAFF PRESIDENT

The Immediate Past Medical Staff President shall:
(a) be a member of the Medical Board and such other committees as specified;
(b) perform such additional or special duties as shall be assigned to him by the Medical Staff President, the Medical Board or the Board of Trustees;
(c) serve on committees as required.

9.6 REMOVAL OF ELECTED STAFF OFFICER

Removal of an elected staff officer may be accomplished for cause either: (1) by a two-thirds vote by secret ballot of the Staff members in good standing eligible to vote for general Staff officers who attend and vote at a special meeting called for that purpose, if such vote is ratified by the Medical Board and the Board of Trustees or (2) by the Board of Trustees on its own initiative.

When the Board of Trustees is contemplating action to remove an elected officer on its own initiative, it will refer the matter to a special combined committee composed of three (3) representatives each from the Board of Trustees and the Medical Staff, appointed respectively by the Chair of the Board of Trustees and the highest ranking elected Medical Staff officer not the subject of the removal action. The Hospital President also sits with this special committee as ex-officio member, without vote. The elected official in question will be provided an opportunity to speak to the special combined committee before removal. The Board of Trustees action after receiving the special committee's report is the final decision.

Grounds for removal shall be for failure to conduct those responsibilities assigned within these Bylaws, failure to perform the duties of the position held, or failure to follow other policies and procedures of the Medical Staff or the Hospital.

ARTICLE X - CLINICAL DEPARTMENTS AND OFFICERS

10.1 DESIGNATION OF CURRENT CLINICAL DEPARTMENTS

The Medical Staff shall be organized into the following Departments as further detailed in the Organizations and Functions Manual:

a. Anesthesiology
b. Emergency Medicine
c. Family Medicine
d. Medicine
e. Obstetrics/Gynecology
f. Orthopedics
g. Pathology
h. Pediatrics
i. Psychiatry
j. Radiology
k. Surgery

(from the org manual)

The Medical Board will periodically restudy the Department structure and recommend creation, elimination or combination of Departments as necessary for better organizational efficiency and improved patient care.

10.2 OFFICERS OF DEPARTMENTS

The officer positions in the Departments shall be:

(a) Department Chair
(b) Department Vice-Chair

Each Department Chair and Vice-Chair shall have the responsibility and authority to do everything necessary to carry out the functions delegated to them and their Department by the Board of Trustees or an appropriate committee thereof, by the Medical Board, by the Medical Staff President, by the Bylaws and the related manuals, by any other policies or rules of the Hospital or Staff, and, where applicable, by contract or job description.

10.3 QUALIFICATIONS

Each Department Chair and Vice Chair shall be a member of the Active Staff or Active Ambulatory, recognized for his current clinical ability in the clinical area covered by the Department, as applicable, and be certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process. He must meet the same qualifications as for general Staff officers. In addition, he must be a member in good standing of the Department of which he is to be an officer and remain in good standing throughout his term.

The term of office and method of election are set forth in the Organizations & Functions Manual.

10.4 RESPONSIBLITIES OF DEPARTMENT CHAIRS

Each Department Chair shall have the responsibility for performing the following functions:

(a) Account to the Department, Medical Board and Board of Trustees for all clinically related and administratively related activities within his/her department.

(b) Provide for the continuous surveillance of the professional performance of all individuals in the department with clinical privileges through ongoing professional practice evaluation, and when appropriate focused professional practice evaluation in accordance with Medical Staff policy.

(c) Recommend the criteria for clinical privileges that are relevant to the care provided in the Department.

(d) Provide for the review and investigation of the qualifications and conduct of all Practitioners seeking or holding privileges in the Department and make recommendations in a timely manner concerning all applications for Medical Staff Membership or clinical privileges within the Department in accordance with these Bylaws.

(e) Implement and maintain effective Medical Peer Review within the Department, including continuous assessment and improvement of the quality of care, treatment and services through performance improvement and quality and patient safety activities, process measurement, assessment, investigating clinical performance and conducting and initiating any corrective action required.

(f) Appoint, and when appropriate, remove, the members of all committees of the Department and designate the chair of each committee.

(g) Develop and enforce the Medical Staff Bylaws, rules and regulations, and policies and procedures within the Department that guide and support provision of services.

(h) Work with the Administration with regard to all administrative matters, patient care issues, and nursing care issues related to the Department.

(i) Delegate duties of the chair to such individuals or committees in the Department as the chair determines appropriate.

(j) Supply references and recommendations required by other institutions or organizations for Medical Peer Review purposes.

(k) Provide for the maintenance of complete and accurate minutes of all meetings of the Department with the assistance of staff provided by the Hospital.

(l) Assess and recommend to the Medical Board and the Hospital President offsite sources for needed patient care, treatment and services not provided by the department or the organization.

(m) Integrate the Department into the primary functions of the Hospital.

(n) Coordinate and integrate inter-departmental and intra-departmental services.

(o) Develop and implement policies and procedures that guide and support the

provision of care, treatment, and services.

(p) Make recommendations to Hospital Administration concerning a sufficient number of qualified and competent persons to provide care, treatment, and services.

(q) When appropriate, make recommendations to Hospital Administration concerning the number, qualifications, and competence of Department personnel who are not licensed independent Practitioners, but who provide patient care, treatment, or services.

(r) Help provide for the orientation and education for all persons in the Department relative to department issues.

(s) Recommend to Hospital Administration space and other resources needed by the Department.

(t) Make recommendations regarding the oversight and maintenance of quality control programs, as appropriate.

(u) Make recommendations to the Credentials Committee, Medical Board and the Administration concerning any proposed new procedures and services, including the training, education and experience required for Practitioners to exercise clinical privileges for new procedures or services.

10.5 DUTIES OF DEPARTMENT VICE-CHAIRMAN

The Department Vice-Chair shall have the authority of the Department Chair in his or her absence and have the following duties:

(a) As a representative of the Department, function in an advisory capacity to the Department Chair, particularly in the area of professional staff relationships;
(b) Serve as acting Chair when the Department Chair is not available and assume his responsibilities;
(c) Be available to serve as the representative of his Department on the Medical Board; and
(d) Have other authority and responsibilities as delegated to him by the Department Chair.

10.7 REMOVAL OF DEPARTMENT CHAIRMAN OR VICE-CHAIRMAN

Removal of a Department Chair or Vice-Chair may be initiated either:

(a) by a two-thirds majority vote of all eligible the Staff members in good standing in the department but no such removal is effective until ratified by the Medical Board and the Board of Trustees; or
(b) by the Medical Board if such action is ratified by the Board of Trustees; or
(c) by the Board of Trustees on its own initiative.

When the Board of Trustees is contemplating action to remove a Department officer, it will refer the matter to a special combined committee composed of three (3) representatives each from the Board of Trustees and the Medical Staff, appointed respectively by the Chair of the Board of Trustees and the Medical Staff President. The Hospital President sits with this special committee as an ex officio member, without vote. The Board of Trustees' action after receiving the special committee's report is the final action.

Grounds for removal shall be for failure to conduct those responsibilities assigned within these Bylaws, failure to perform the duties of the position held, or failure to follow other policies and procedures of the Medical Staff or the Hospital.

10.8 RESIGNATION

A Department Chair or Department Vice may resign at any time by giving written notice to the Medical Board. Resignation may or may not be made contingent on formal acceptance and takes effect on the date of receipt or at any later time specified in it.

10.9 VACANCIES

A vacancy in the office of a Department Chair or Vice Chair is filled by appointment of an acting Chair or Vice Chair by the Medical Board, subject to the Board of Trustees approval. This acting Chair or Vice Chair serves pending the outcome of a special election; provided however, the Medical Board may waive a special election if a regular election for the office is to be held within 100 days. In this case, the acting Chair serves until the regular election results are final, and the individual then elected assumes office immediately.

ARTICLE XI. COMMITTEES

11.1 MEDICAL BOARD

11.1-1 COMPOSITION

The Medical Board shall be comprised of the following:

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

A Member who is unavailable to attend a meeting of the Medical Board may participate by means other than being physically present, including without limitation via conference telephone, videoconferencing, or the Internet, as long as each participating member can receive communications from and transmit communications to other participating members concurrently. If the Medical Staff President is unavailable to attend any meeting, he may select a designee from the Medical Board to attend in his place.

On invitation of the Medical Board or the Medical Staff President, any Member may attend a meeting of the Medical Board provided the Member agrees to maintain the confidentiality of the proceedings.

11.1-2 RESPONSIBILITIES AND FUNCTIONS

The Medical Board shall serve as the executive committee of the Medical Staff and have broad responsibility for directing the professional activities of the Medical Staff. The Medical Board shall have the authority and responsibilities for implementation of the Bylaws, Rules and Regulations, Manuals 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. By these Bylaws, the Medical Staff delegates to the Medical Board the authority to carry out Medical Staff responsibilities and act on its behalf within the scope of its responsibilities as set out below, subject only to any limitations imposed by these Bylaws.

The duties of the Medical Board shall 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;

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

(c) to receive and act upon Medical Staff committee and department reports as well as those from other assigned activity groups, and to make recommendations concerning them to the Hospital President and the Board of Trustees;

(d) to implement policies of the Medical Staff 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 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 accreditation status of the Hospital;

(h) to oversee the enforcement of Hospital policies and procedures and Medical Staff Rules and Regulations and policies 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 clinical privileges;

(i) to refer situations involving questions of the clinical competence, patient care and treatment, case management or inappropriate behavior of any Practitioners to the appropriate committee or department for appropriate action in accordance with the corrective actions procedures outlined in the Medical Staff Hearing and Appellate Review Plan;

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

(k) to make recommendations to the Board of Trustees regarding the mechanism to review credentials and to delineate clinical privileges and appointment and reappointment applications 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 for all individuals credentialing using the Medical Staff process;

(m) to initiate and oversee the review of information available concerning the performance and clinical competence of staff members and other individuals with clinical privileges credentialed using the Medical Staff process, and as a result of such reviews, make recommendations to the Board of Trustees for reappointment and renewal or changes in clinical privileges;

(n) to make recommendations regarding the organization of quality management and patient safety 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 Practitioners, including the initiation of and/or participation in Medical Staff corrective action or review measures when warranted;

(p) to report through its Medical Staff President at each regular Medical Staff meeting;

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

    (1) the structure of the Medical Staff
    (2) the mechanism by which membership on the staff may be terminated, and
    (3) the mechanism for hearing procedures

(r) to assess and recommend to the relevant Hospital representative off-site sources

for needed patient care services not provided by the Medical Staff or the Hospital; and

(s) to coordinate and direct the quality and resource management functions including:

(1) review and recommend Medical Staff and Hospital- wide components of the Continuous Quality Improvement plan;
(2) review activities and conclusions of and recommendations for the process improvement committees and other Medical Staff and Hospital committees;
(3) monitor the effectiveness of the process improvement committees and actions taken;
(4) evaluate annually and revise as necessary the objectives, scope, organization and effectiveness of the quality improvement activities;
(5) serve in an advisory capacity to the process improvement committees;
(6) provide oversight for review of Hospital-wide indicators in Hospital departments;
(7) provide guidance and direction to the Quality Management Department in development and management of the program;
(8) appoint ad hoc subcommittee(s) to review interdisciplinary issues as they arise;
(9) recommend needed educational programs as identified through Quality Improvement;
(10) coordinate the creation of Hospital-wide criteria (as appropriate) for operative, other invasive and noninvasive procedures, medication use, processes related to the usage of blood and blood products, and medical record review; and
(11) oversee regulatory issues requiring broad level coordination such as but not limited to Medicare, Medicaid, the Texas Medical Foundation, The Joint Commission, College of American Pathology, and Texas Department of State Health Services.

11.1-3 MEETINGS

The Medical Board shall meet as often as necessary to fulfill its responsibilities. It communicates its discussions and actions that affect or define Staff policies, rules or positions to the Medical Staff at its regular Medical Staff meetings, Department meetings, staff newsletters and other means of communication. Copies of all minutes shall be transmitted to the Hospital President routinely, as prepared, and that recommendations of the Medical Board are transmitted to the Board of Trustees.

11.1-4 REMOVAL OF MEDICAL BOARD MEMBERS

The process for removing the members of the Medical Board who are Medical Staff officers is set out in Section 9.6. The process for removing the members of the Medical Board who are Department Chairs is set out in Section 10.6.

Except for the Hospital President, any other member of the Medical Board may be removed by a two-thirds majority vote of all eligible the Staff members in good standing, but no such removal is effective until ratified by the Medical Board and the Board of Trustees.

11.2 OTHER MEDICAL STAFF COMMITTEES

The Medical Staff shall establish standing committees other than the Medical Board 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 the Medical Staff Organization & Functions Manual. 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. The Medical Board shall have the authority to create or

abolish standing committees and may change the composition of standing committees. Medical Staff committees defined in this Article shall be considered the standing committees of the Medical Staff. They are as follows:

Medical Board
Bylaws Committee
Cancer Committee
Centralized Peer Review Committee
Clinical Information Committee
Clinical Quality and Patient Safety Committee
Credentials Committee
Clinical Practice Committee
Health & Rehabilitation Committee
Medical Ethics Committee
Nominating Committee
Patient Safety Clinical Risk Review Committee
Professional Activities Committee
Utilization Management

Standing committees shall have the responsibilities and in according to Medical Staff Organization & Functions Manual. Provided, however, in the event a Texas Health Resources committee assumes functions and responsibilities of a Medical Staff committee, the applicable Medical Staff committee will be dissolved, and in such event, its responsibility to conduct meetings will discontinue. Any Committee Chair, Department Chair or Officer of the Medical Staff may appoint a subcommittee of a standing committee or an ad hoc committee to meet specific needs not addressed by any standing committee.

11.2-1 CHAIR

Each committee shall have a Chair who shall be a member of the Active Staff or Active Ambulatory and shall be appointed by the Medical Staff President in consultation with the Hospital President. Unless otherwise specified in this Article, each Chair shall serve a one-year term beginning at the start of the Medical Staff year. There is no limit on the number of terms a committee Chair may serve. Each committee may choose to elect a Vice-Chair.

11.2-2 MEMBERS

Members of each committee (other than peer review) shall be appointed from the Active, Active Ambulatory, Courtesy and Affiliate Staff categories by the Medical Staff President in consultation with the Hospital President. Members from the Emeritus Staff category may be appointed as non-voting committee members based on justifiable need and recommendation of the committee Chair.

11.2-3 AD HOC MEMBERS

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. Hospital staff members shall serve ex officio without vote except as specified in this Article. 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 shall serve.

11.2-4 MEETINGS

Notice of committee meetings shall be made by the Chair and shall be available 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.

11.2-5 SPECIAL MEETINGS

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 department or 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 or by mail or electronically, and their vote returned to the committee Chair. 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.

11.2-6 REMOVAL

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 by a committee Chair who may fill the vacancy at his/her discretion.

11.2-7 MINUTES

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 thevotes 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 signed by the committee Chair or presiding officer and transmitted to the Medical Board after each meeting or as otherwise provided in these Bylaws.

11.2.8 DELEGATION OF COMMITTEE ACTIVITIES

In carrying out the Medical Peer Review committee responsibilities described in this section, committee chairs may designate subcommittees, certain outside individuals, agencies and/or organizations 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.

ARTICLE XII. PROCEDURES FOR MEDICAL STAFF MEETINGS

The procedures for calling and conducting meetings of the Medical Staff shall be as outlined in the Organizations & Functions Manual.

ARTICLE XIII. CONFIDENTIALITY, IMMUNITY, RELEASES AND GENERAL PROVISIONS

13.1 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, the Professional Activities Committee or the THR Board of Trustees, any director or committee of the Hospital; the Hospital President or his designees; registered nurses and other employees of the Hospital; the Medical Staff and any member, officer, clinical unit or committee thereof; 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.

13.2 AUTHORIZATIONS 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; and

(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.

13.3 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 Practitioner that violation of the confidentiality provided herein is grounds for immediate and permanent revocation of Medical Staff clinical privileges or specified services.

13.4 IMMUNITY FROM LIABILITY

No representative shall be liable to a Practitioner 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 Practitioner 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, or state or federal law.

13.5 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 facilities 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.

13.7 INFORMATION

The information referred to in this Article may relate to a Practitioner'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.

13.8 RELEASES

Each applicant or Practitioner 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.

13.9 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.

13.10 SPECIAL APPEARANCE

A Practitioner whose presence is being requested at a meeting where his Patient's clinical course of treatment is scheduled for discussion at the regular Department or committee meeting or a Practitioner whose presence is requested at a meeting for any reason shall be so notified by Special Notice which may include hand delivery with written receipt of acceptance. The chairman of the committee or other individual designated to request the Practitioner’s presence at the meeting shall give the Practitioner written notice of the time and place of the meeting at least twenty-four (24) hours prior to the date and time of the meeting. Whenever apparent or suspected deviation from acceptable clinical practice is involved, the notice should include a statement of the issues involved. This appearance shall not constitute a hearing, and the affected Practitioner is not entitled to any of the rights or procedures stated in the Medical Staff Hearing and Appellate Review Plan.

Failure of a Practitioner to appear at any meeting for which he was given written notice that his attendance was required, unless excused by the Medical Board upon a showing of good cause, as determined in the sole discretion of the Medical Board, may result in corrective action.

Failure to provide information pertaining to a Practitioner’s qualifications for appointment or clinical privileges, in response to a written request from the Credentials Committee, the Medical Board, the Hospital President, or any other committee (such as an investigating committee) authorized to request such information, shall result in automatic relinquishment of all clinical privileges until the information is provided.

13.11 MISSTATEMENT, OMISSION, FALSIFICATION OR IMPROPER ALTERATION OF STAFF APPLICATION OR PATIENT RECORD

Misstatement, omission, falsification or improper alteration of application(s) and/or patient records shall be addressed as outlined in Section 2.6 of the Credentials Manual.

13.12 ORGANIZED HEALTH CARE ARRANGEMENT

The Board of Trustees have adopted a policy to act as an Organized Health Care Arrangement (OHCA) under the Health Information Portability and Accountability Act of 1997 (HIPAA) and in accordance with the Texas Health Resources (THR) Organized Health Care Arrangement Policy. The Medical Staff of the Hospital acknowledges its participation with the Hospital in an Organized Health Care Arrangement with respect to jointly managed Patients. As this is a policy of the Hospital by their membership on the Medical Staff each Medical Staff member therefore 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 their participation in the OHCA. As stated in the OHCA policy, each participant is individually responsible for their own and their personnel's compliance with the Notice and its underlying policies. The Notice will not cover PHI created or received by individual Physicians 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.

ARTICLE XIV. ADOPTION AND AMENDMENT

14.1 MEDICAL STAFF AUTHORITY AND RESPONSIBILITY

The Board of Trustees holds the Medical Staff responsible for the development, adoption and periodic review of Medical Staff Bylaws and related manuals, all of which are consistent with Hospital policies and applicable laws and other requirements. This responsibility cannot be delegated. These Bylaws and related manuals shall be reviewed at least annually by the responsible Medical Staff committee and may be reviewed more frequently when deemed necessary by the Medical Staff or appropriate authorities thereof.

14.2 MEDICAL STAFF BYLAWS

14.2-1 INITIATION

Any new Bylaws or amendments to the Bylaws may be initiated (i) in writing upon petition signed by at least twenty percent (20%) of the voting Members, or (ii) upon the recommendation of the Bylaws Committee or Medical Board.

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 Board for review and comment.

The Medical Board will review and comment on the proposed new or amended Bylaws and then shall submit the proposal to the Medical Staff for approval with the Medical Board's comments.

14.2-2 VOTING BY THE MEDICAL STAFF

The Medical Board shall choose one of the following two methods, for the purpose of presenting amendments or new Bylaws to the Medical Staff:

(a) At the next regular meeting of the Medical Staff or at a special meeting called for such purpose, the amendment(s) or new Bylaws shall be voted upon at that meeting provided all eligible members have been provided a copy of the amendment(s) by mail at least fourteen (14) days prior to the meeting. To be

adopted, an amendment or new Bylaws must receive a majority of the votes cast by the voting staff who are present. For purposes of this subsection, there is no requirement for a Quorum: or

(b) By written notice which shall contain a ballot (transmitted by mail, fax, email or other electronic means) for the voting member to indicate his agreement/disagreement with the proposed amendment(s) to the Bylaws or new Bylaws, as well as instructions for completion and a return date, which shall be at least fourteen (14) days from the date of the ballot is distributed. To be adopted, an amendment must receive a majority of the votes cast by the voting staff on ballots returned by the deadline indicated.

14.2-3 APPROVAL BY THE BOARD OF TRUSTEES

Amendments or new Bylaws will become effective upon the affirmative vote of a majority of the Board of Trustees. Neither the Medical Board, nor the Medical Staff, nor the Board of Trustees may unilaterally amend these Bylaws. If the Board of Trustees rejects the proposed Bylaws or amendments, the proposed Bylaws or amendments not approved by the Board of Trustees shall be submitted to a Joint Conference Committee under the procedures of Section 14.6.

14.3 RELATED MANUALS/RULES, REGULATIONS

14.3-1 The related manuals, including the Medical Staff Credentials Manual, Hearing and Appellate Review Plan, General Rules and Regulations of the Medical Staff, Organization & Functions Manual, and Allied Health Professional Rules & Regulations, may be amended or repealed, in whole or in part, or a new one approved by the Medical Board, using the procedures below and with the approval of the Board of Trustees, in one of the following two ways:

(a) By the affirmative vote of a majority of the Medical Board present at a regular or special meeting of the Medical Board at which a Quorum is present. At least fourteen (14) calendar days prior to the Medical Board meeting and vote, the Medical Board 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 Medical Board for the Medical Board's consideration prior to voting on the proposal. The procedures for management of a conflict between the Medical Staff and the Medical Board on the approved change are set out below in Section 14.5 below OR;

(b) The Medical Staff may propose a new or amended manual or rule and regulation upon written petition signed by at least twenty percent (20%) of the Active Staff. The proposed manual or rule and regulation (or amendment) shall then be submitted to the Medical Staff President who shall then refer the proposed amendment to the Bylaws Committee for review and comment. Within fourteen (14) days after the Bylaws Committee's review, the proposal will be sent to the Medical Board for review and comment at a regular or specially called meeting. The proposed manual or rule and regulation or amendment along with the Medical Board's comments shall then be submitted to the Medical Staff upon providing at least fourteen (14) days' notice of the meeting. 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 manual or rule and regulation or amendment.

The Medical Board will not consider any new or amended manual, rule or regulation that does not comply with the Joint Commission standards, federal or state law and

regulations.

14.3-2 In cases of a documented need for an urgent amendment of the manuals or rules and regulations to comply with a law or regulations, the Medical Board may provisionally adopt an amendment and forward it to the Board of Trustees for approval without prior notification of the Medical Staff as required by subsection 14.2-1 above. In such case, the Medical Staff shall be notified of the amendment after approval. The notice shall advise the Medical Staff of the opportunity and procedures to submit written comments on the proposal to the Medical Board within ten (10) days of the notice. If there is no conflict over the amendment, no further action is required. If there is conflict over the amendment as reflected in written comments submitted by at least twenty percent (20%) of the voting members of the Medical Staff, the conflict resolution process below in Section 14.5 shall be implemented by the Medical Board.

14.3-3 Any changes to the proposed amendments or new manuals proposed by the Board of Trustees shall first be submitted to the Medical Staff for its recommendations, including thirty (30) working days for response, and any response timely made shall be carefully considered by the Board of Trustees prior to its action on the proposed amendments or revisions.

14.3-4 New and amended Rules and Regulations shall become effective once approved by the Board of Trustees. Once approved, the Rules and Regulations shall be upheld by the Board of Trustees. Neither the Medical Staff, the Medical Board, nor the Board of Trustees may unilaterally amend the Rules and Regulations.

14.4 MEDICAL STAFF POLICIES

14.4-1 Adoption or amendment of any policies of the Medical Staff may be accomplished by the Medical Staff by one of the following two methods:

(a) By the affirmative vote of a majority of the Medical Board present at a regular or specially called meeting of the Medical Board at which a Quorum is present. Any Medical Staff policy adopted by the Medical Board 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 Office to be forwarded to the Medical Staff President. The Medical Staff policy or amendment shall be then presented at its next regularly scheduled meeting. The proposed policy or amendment along with the Medical Board’s comments shall then be submitted to the Medical Staff at least fourteen (14) days before the meeting. 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 manual or rule and regulation or amendment.

14.4.-2 The conflict management procedures in Section 14.5 govern any conflicts between the Medical Staff and the Medical Board regarding adoption or amendment of a Medical Staff policy.

14.5 RESOLUTION OF CONFLICT BETWEEN THE MEDICAL STAFF AND THE MEDICAL BOARD

14.5-1 In the event of disagreement between the Medical Staff and the Medical Board on adoption or amendment of the manuals or Rules and Regulations 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, implementation of the following conflict management procedures may be requested.

14.5-2 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 Board appointed by the Medical Staff President. The Hospital President or designee and the Chief Quality Officer or designee shall be an Ex-Officio non-voting member of any Conflict Resolution Committee.

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 manual, 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.

Any recommendation which is approved by a majority of the Conflict Resolution Committee members present shall be submitted back to the Medical Board for consideration and a recommendation to the Board of Trustees.

14.5-3 The Conflict Resolution Committee shall report to the Medical Board 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.

14.6. RESOLUTION OF CONFLICT BETWEEN THE BOARD OF TRUSTEES AND THE MEDICAL BOARD

Whenever the Board of Trustees makes a decision contrary to the recommendation of the Medical Board, the matter may, at the request of the Medical Board, be submitted to a Joint Advisory Committee, composed of an equal number of representatives each from the Medical Staff and the Board of Trustees appointed respectively by the Medical Staff President and the Chair of the Board of Trustees. The Hospital President shall serve as an ex officio member. This Joint Advisory Committee shall convene to review the matter and submit its report the Board of Trustees within sixty (60) days after a matter is referred to it. The Board of Trustees then makes a final decision after receipt of the Joint Advisory Committee's recommendation. A member elected by the committee shall serve as Chair, with a member from the Medical Board serving in even years and a member of the Board of Trustees serving in odd years. The Hospital President shall serve as an ex officio member of the committee. 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 Board. 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 Board 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.

14.7 NOTICES

Any notices to the Medical Staff required by this Article XII shall be deemed effective when sent by mail, facsimile, or electronic transmission using the contact information currently on file in the Medical Staff office at the time of the notice.

14.8 BOARD OF TRUSTEES APPROVAL

Whether adopted or amended by the Medical Staff or the Medical Board, such manuals or Rules and Regulations shall become effective only when approved by the Board of Trustees. If approved, within ten (10) days of the Board of Trustees' approval, the Medical Staff office shall send each member of the Medical Staff notice of the adopted or amended Rules and Regulations by mail, facsimile, or electronic transmission. Nothing in this section is intended to prevent Practitioners from communicating with the Board of Trustees on the manuals or Rules or Regulations adopted by the Medical Staff or Medical Board in the manner established by the Board of Trustees. Once approved, the manuals or Rules and Regulations shall be upheld by the Board of Trustees.

TEXAS HEALTH PRESBYTERIAN HOSPITAL PLANO
CREDENTIALS MANUAL

ARTICLE I. PURPOSE

This Credentials Manual (Manual) has been created pursuant to and under the authority of the Medical Staff Bylaws of Texas Health Presbyterian Hospital Plano. The purpose of the Manual is to describe the current procedures for staff appointment and reappointment. The Definitions in the Bylaws apply to this Manual.

ARTICLE II. APPOINTMENT PROCEDURES

2.1 REQUEST FOR AND FILING OF APPLICATION

A request for an application shall be submitted to the Medical Staff Office. If the applicant meets the basic initial requirements to be considered (see Section 4.1 below), the Medical Staff Office will then forward an application form to the requesting individual. An application for Medical Staff appointment and clinical privileges must be submitted by the applicant electronically on the Hospital approved form.

2.2 APPLICATION CONTENT

All portions of the application must be completed. A notation to "See CV" is not acceptable. Every application must furnish full and complete information concerning at a minimum the following:

(a) Undergraduate, professional school, and postgraduate training, including the name of each institution attended with complete mailing address including street number and zip code, degrees granted, programs completed, dates attended, and, for postgraduate training, names of Practitioners responsible for monitoring the applicant's performance.

(b) All past and all currently valid medical, dental, podiatric and other professional licensure, permits or certifications, and Drug Enforcement Administration (DEA) and Department of Public Safety (DPS) controlled substance registration and any narcotics license issued by another state, with the issued and expiration dates and number of each. A copy of the current DEA registration must accompany the application.

(c) Clinical areas/specialties in which currently practicing.

(d) 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.

(e) Health status as pertinent to the applicant's ability to perform the essential functions of membership and exercise the requested clinical privileges safely and competently and information on any accommodations that may be required in the event of an impairment.

(f) Any drug, chemical, alcohol or behavioral problem which could affect the ability to perform the essential functions of membership and exercise the requested clinical privileges safely and competently.

(g) Prior and current professional liability insurance coverage and information on malpractice claims history and experience (claims, suits and settlements made, concluded and pending), including the names and addresses of present and past insurance carriers.

(h) Any pending or completed action, whether voluntary or involuntary, involving denial, revocation, cancellation, suspension, reduction, limitation, 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 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) professional liability insurance or managed care company.

(i) Location of offices; name or names of practice group(s) or association(s) associated with.

(j) Selected personal information, such as, local home and office addresses and telephone numbers, date of birth, and citizenship.

(k) Specific clinical privileges requested.

(l) Any prosecution, deferred adjudication, or conviction of a felony or a misdemeanor (including motor vehicle violations).

(m) References as required by section 2.4 below.

(n) Expected level of involvement in patient care at the Hospital.

(o) Name of a Practitioner with appropriate clinical privileges who has agreed to provide patient care back-up coverage.

(p) Evidence of the applicant's agreement with the confidentiality, immunity, and release provisions of the Medical Staff Bylaws and other related manuals.

(q) Evidence of applicant's compliance with the "Mandatory Immunization of Medical Staff Policy".

2.3 ADEQUACY OF INFORMATION AND COMPLETE APPLICATION

An application for appointment, reappointment or clinical privileges shall not be considered complete or acted on until the applicant and any third parties have provided all requested information and the Department and each committee has full and complete information upon which to make a recommendation as to the Practitioner's qualifications.

The Medical Staff Office, on behalf of the Department or committee, shall notify the applicant by written notice of the specific information being requested of the applicant, the time within which the information must be received, and that the application will be withdrawn from consideration if the information is not timely received.

The Medical Staff Office shall also notify the applicant by written notice if the information has been requested from a third party and not received within the requested time period and provide the applicant with a minimum of fifteen (15) days to contact the third party directly concerning the requested information. The written notice shall contain a summary of the information being requested, state the time within which the information must be received, and advise the Practitioner that the application will be withdrawn from consideration if the information is not timely received.

A committee reviewing an application for appointment, reappointment or clinical privileges may defer action for the purpose of obtaining additional information. If information is not received after following the procedures above, the application may be deemed incomplete and be withdrawn from consideration.

The Hospital President or his designee shall provide written notice to the applicant of withdrawal of an application from consideration due to incomplete information. Withdrawal from consideration is not an Adverse Recommendation or Action and the applicant shall not be entitled to any procedural rights of review under the Bylaws or otherwise as a result of such withdrawal.

2.4 REFERENCES

The application must include the names of at least three (3) professional references not newly associated or about to become partners with the applicant in professional practice or personally related to him. The references must have personal knowledge of the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism, and be willing to provide specific written comments on these matters upon request from the Hospital or Medical Staff authorities. The references must have acquired the requisite knowledge through recent (within past three years) observation of the applicant's

professional performance over a reasonable period of time. At least one must be from a colleague in the applicant's specialty.

2.5 CONTENT OF RECOMMENDATION

A recommendation to appoint, reappoint, or grant clinical privileges must be in writing and specifically indicate the clinical privileges to be granted and any conditions on the exercise of such privileges. Any denial, limitation, condition or restriction, including any Adverse Recommendations or Actions, shall include the reason or basis for the recommendation.

2.6 INTERVIEW

Any committee or Department responsible for reviewing or investigating an applicant or other Practitioner, or any individual acting on behalf of the committee or Department, may request an interview with the applicant or Practitioner. Failure to appear for an interview as requested and provide requested information shall result in an incomplete application under the procedures in Section 2.3.

2.7 USE OF INDEPENDENT REVIEWS

If approved by the Medical Staff President and the Hospital President, a Practitioner not appointed to the Medical Staff may be designated as an ad hoc member or agent of a Staff committee to assist with the Medical Peer Review of an applicant or other Practitioner.

2.8 TIME PERIODS FOR PROCESSING

All individuals and committees required to act on a complete application for Medical Staff appointment or reappointment and initial renewed or revised clinical privileges should do so in a timely and good faith manner. Except when additional information is needed or for other unforeseen reasons, each complete application should be processed within the following time periods:

INDIVIDUAL/COMMITTEE TIME

(a) Medical Staff Office – 30 days

(b) Department Chair/committee - 30 days after receiving file from (a)

(c) Credentials Committee - Next regular meeting after receiving reports from (b); but within 90 days total since receipt of the complete application

(d) Medical Board - Next regular meeting after receiving reports from (b) and (c)

(e) Board of Trustees - Next regular meeting after receiving reports, if any, from (b), (c), and (d); but in any event, within 60 days of receipt of (c).

These time periods are guidelines and are not directives that create any rights for an applicant to have an application processed within these precise periods. If the provisions of the Hearing and Appellate Review Plan apply, the time requirements provided therein govern the continued processing of the application.

ARTICLE III. SYSTEMS AND PROCEDURES FOR DELINEATING CLINICAL PRIVILEGES

3.1 EXERCISE OF PRIVILEGES

Special requirements for consultation may be made as a condition to the exercise of privileges granted to an individual Practitioner. Each Practitioner must provide or arrange for continuous medical care for his Patients in the Hospital and obtain appropriate consultation when treating a Patient with a problem or condition outside his training, education, experience, or usual area of practice, or when required by the rules or other policies of the Medical Staff. The Hospital must obtain appropriate consultation or refer the case to another qualified Practitioner when necessary for the safety of his Patient.

3.2 PROCEDURE FOR DELINEATING PRIVILEGES

Each application for appointment and reappointment must contain a request for the specific

clinical privileges desired by the applicant and the request shall be processed using the procedures for appointment and reappointment. Specific requests must also be submitted for privileges to be exercised pursuant to Article VII of this manual, for temporary privileges and Section 7.2 for modifications of privileges in the interim between re-appointments.

3.3 CLINICAL PRIVILEGES FOR NEW PROCEDURES

(a) Requests for clinical privileges to perform a significant procedure or service not currently being performed at the Hospital (or a significant new technique to perform an existing procedure ("new procedure") will not be processed until (1) a determination has been made that the procedure will be offered by the Hospital and until (2) criteria to be eligible to request those clinical privileges have been established.

(b) The Credentials Committee and the Medical Board shall make a preliminary recommendation to the Board of Trustees as to whether the new procedure should be offered, considering whether the Hospital has the capabilities, including support services, to perform the new procedure.

(c) The Credentials Committee shall request a recommendation from the applicable Department and conduct research and may as necessary, consult with experts including those on the Medical Staff and those outside the Hospital, and develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the new procedure, and (2) the extent of monitoring and supervision that should occur if the privileges are granted. The Credentials Committee may also develop criteria and/or indications for when the new procedure is appropriate. The Credentials Committee shall obtain Department approval of its recommendation and then forward its recommendations to the Medical Board, which shall review the matter and forward its recommendations to the Board of Trustees for final action.

3.4 CLINICAL PRIVILEGES THAT CROSS SPECIALTY LINES

(a) Requests for clinical privileges that traditionally at the Hospital have been exercised only by Practitioners from another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the ability of the Practitioners in the other specialty to request the clinical privileges in question with equivalent safety and competency.

(b) The Credentials Committee shall conduct research and consult with experts, including those on the Medical Staff (e.g., department chiefs, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other Hospitals, residency training programs, specialty societies).

(c) The Credentials Committee shall develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the clinical privileges in question, and (2) the extent of monitoring and supervision that should occur. These recommendations may or may not permit Practitioners from different specialties to request the privileges at issue. The Credentials Committee shall forward its recommendations to the Medical Board, which shall review the matter and forward its recommendations to the Board of Trustees for final action.

3.5 EMERGENCY SITUATIONS

(a) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a Patient(s) and in which any delay in administering treatment would add to that harm.

(b) In an emergency situation, a qualified member of the Medical Staff may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges.

(c) When the emergency situation no longer exists, the Patient shall be assisted by the Department Chair or the Medical Staff President to select a member which appropriate clinical privileges.

3.6 EXPERIMENTAL AND NEW PROCEDURES / TREATMENT MODALITIES / INSTRUMENTATION

Experimental drugs, procedures, or other therapies or tests may be administered or performed only after approval of the protocols involved by the Texas Health Resources Institutional Review Board and only by an approved investigator for that drug/procedure/therapy/test. A record of the approval by the Texas Health Resources Institutional Review Board must be maintained in the Medical Staff Office. Any other type of new, untried, or unproven procedure/treatment modality/instrumentation not considered experimental may be performed or used only after the regular credentialing process has been completed and the privilege to perform or use said procedure/treatment modality/instrumentation is one that is not generalizable from an established procedure/treatment modality/instrumentation in terms of involving the same or similar instrumentation and technique, the same or similar complications, the same or similar indications, or the same or similar expected physical outcome for the Patient as the established procedure/treatment modality/instrumentation.

3.7 DISASTER PRIVILEDGES

(a) In the event of a mass disaster, when the emergency management plan has been activated, Medical Staff members and employees may not be able to provide all the care required by individuals seeking treatment at the Hospital's facilities.

(b) Under such circumstances, the Hospital President or the President of the Medical Staff or the Medical Staff Director of the Command Center is authorized to grant disaster privileges or permission to treat Patients to volunteer Physicians, nurses, and other professionals upon receipt of satisfactory evidence that such individuals are currently licensed in some state or are otherwise capable of providing services to Patients. Volunteer Practitioners must at a minimum present a valid government-issued photo identification issued by a state or federal agency and at least one of the following:

1. A current Hospital picture identification card that clearly identifies professional designation.
2. A current license, certification, or registration.
3. Primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession).
4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organizations or groups.
5. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).
6. Identification by current organization member(s) who possesses personal knowledge regarding the volunteer Practitioner's qualifications.

Primary source verification of licensure, certification, or registration, if required by laws and regulation to practice a profession, begins as soon as the immediate situation is under control, or within 72 hours from the time the volunteer licensed independent practitioner present him or herself to the hospital, whichever comes first. If primary source verification of a-volunteer licensed independent 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:

a) Reason(s) it could not be performed within 72 hours of the practitioner's arrival
b) Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment, and services
c) 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. Primary source verification of

licensure is not required if the volunteer licensed independent practitioner has not provided care, treatment, or services under the disaster privileges.

(c) The Medical Staff will provide direct observation, mentoring and/or clinical record review to oversee the professional performance of volunteer Practitioners who are assigned disaster responsibilities. Based on its oversight of each volunteer licensed independent Practitioner, the Hospital will determine within 72 hours of the Practitioner's arrival if granted disaster privileges should continue.

(d) Temporary badges will be issued to volunteer Practitioners in order to readily identify individuals who have been granted disaster privileges.

(e) Furthermore, notwithstanding any existing delineation of privileges or scope of authority, during a mass disaster, current Medical Staff members, employees and volunteer Practitioners are authorized to take whatever steps they reasonably believe are necessary to save or preserve the life or health of Patients or the protect the public health.

ARTICLE IV. PROCESSING THE APPLICATION

4.1 PRE-PROCESSING ASSESSMENT

The following information will be assessed by the Medical Staff Office initially to ascertain that an applicant satisfies the basic requirements for staff membership before an application is provided or considered:

(a) Name;

(b) Location (actual or anticipated) of office. A proximity map with defined boundaries will be established and periodically reviewed as provided in Section 2.2-10 of the Bylaws;

(c) Board certification in the area of practice for which privileges will be requested; and

(d) Name of Practitioner for medical back-up coverage purposes.

4.2 INELIGIBILITY

If it is determined that the requesting Practitioner may be ineligible for Medical Staff appointment under Section 4.1, the Medical Staff Office shall refer the application for review to the Credentials Committee Chair or the Committee. If Chair or the Committee agree that the Practitioner is ineligible for appointment under said law, regulations, or basic membership requirements, the Hospital President shall so inform the Practitioner by Special Notice and shall decline to proceed with further processing of the application.

If the requesting Practitioner is ineligible because he is seeking only clinical privileges for particular services which either are not provided at the Hospital or are provided but pursuant to an exclusive contract policy, the Hospital President shall so inform the Practitioner.

A Practitioner whose application is not processed pursuant to this Section 4.2 shall not be entitled to the procedural rights of review under the Bylaws or otherwise.

Unless the applicant is ineligible pursuant to the above, the Medical Staff Office shall proceed with processing a complete application in accordance with the Medical Staff Bylaws and related manuals.

4.3 APPLICANT'S BURDEN

The applicant has the burden of producing complete and accurate information the Hospital or its Medical Staff deems necessary for a proper evaluation of his qualifications, and of resolving any doubts about the qualifications required for Medical Staff appointment or the requested Medical Staff category or clinical privileges, and of satisfying any reasonable requests for information or clarification made by appropriate Staff or Hospital authorities. The Medical Staff Office shall use the procedures in Section 2.3 if the application is incomplete or additional information is needed.

4.4 VERIFICATION OF INFORMATION

The complete application is submitted to the Medical Staff Office. Working with the Credentials

Committee Chair, the Medical Staff Office organizes and coordinates the collection and verification of the references, licensure and other information submitted or required, and notifies the applicant of any gaps in or any other problems in obtaining the information required as provided in Section 2.3.

Verification shall include, without limitation:

(a) a reasonable effort to confirm with the primary source all information contained on the application with the exception of undergraduate education;

(b) requesting other specific information and ratings, as appropriate, from at least the most recent affiliations on all aspects of the applicant's performance at that affiliation which may bear on his qualifications for Staff appointment or the privileges requested, including ability to work with others, medical record documentation, participation in staff activities, availability for patient care, medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communications skills, and professionalism; and

(c) requesting such information from applicable governmental agencies or data banks as is required under state and federal law.

The Medical Staff Office notifies the applicant in writing of any information inadequacies or verification problems. The notice shall indicate the nature of the additional information the applicant is to provide and the time frame for response as provided in Section 2.3.

In addition to any other requests made of an applicant under this section, if the evidence of the applicant's current clinical competence to exercise the privileges requested is not sufficient to permit the applicable Medical Staff and Hospital authorities to make an informed judgment as to his competence in exercising the clinical privileges requested, the applicant shall have the burden of providing evidence of clinical performance at his other institutional affiliations in such form as may be required by said authorities. The Medical Staff Office shall notify the applicant of the need for additional information, assistance, and/or an interview using the procedures in Section 2.3. The applicant then has the burden of producing the required and requested information and resolving any doubts about the data.

Failure to completely respond and comply with a request within twenty-one (21) days for additional information, assistance or an interview regarding any portion of the application is deemed an incomplete application, voluntary withdrawal of the entire application for reappointment, and will automatically result in expiration of appointment upon the date current appointment is due to expire.

The Credentials Committee and the Medical Board shall determine whether an application is deemed incomplete. An applicant whose application is deemed incomplete shall be given Special Notice of that fact. An applicant whose application is deemed incomplete is not entitled to any of the procedural rights or processes outlined in the Medical Staff Hearing and Appellate Review Plan.

When the pertinent collection and verification activities are accomplished, the application along with the request for clinical privileges will be forwarded to the Department Chair in which the applicant seeks privileges to evaluate the application and all supporting material as required under section 5.5 below.

4.5 ANALYSIS OF FILES TO DETERMINE COMPLETENESS AND REVIEW BY DEPARTMENT CHAIRMAN

An application is deemed complete when:

(a) all questions have been answered or the application is accompanied by an explanation of why answers were not available, and the application is signed;

(b) a request for delineation of privileges form has been completed, signed and returned;

(c) Texas license to practice, DEA and DPS certificates have been verified as current and

clarification of any issues has been provided by the applicant;

(d) professional liability insurance has been verified as current, claims history has been obtained and information concerning malpractice lawsuits filed, judgments or settlements, is received;

(e) verification of all training (medical school, internship, residency, fellowship) has been received;

(f) verification of current / past Hospital affiliations where applicant holds/held staff membership and clinical privileges has been received;

(g) peer references as requested have been received;

(h) any other documentation and/or information requested from the Practitioner has been received;

(i) any questions concerning the applicant's health status and ability have been answered; and;

(j) evidence of applicant's compliance with the "Mandatory Immunization of Medical Staff Policy" has been received.

When concerns are raised during the application process regarding an applicant's health status and ability, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a Physician(s) satisfactory to the Committee. The results of the examination will be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee will be considered a withdrawal of the application, and all processing of the application will cease. The Credentials Committee may seek the assistance of the Health and Rehabilitation Committee to review any information received and to make a recommendation about the Practitioner's health status and ability.

4.6 REVIEW, REPORT AND BASES FOR RECOMMENDATIONS AND ACTIONS

Each individual, Department or committee providing a recommendation or reviewing an application shall have available the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants as deemed necessary subject to the approval of the Hospital President. The report of each individual, Department or committee should include recommendations as to approval or denial of, and any special limitations on, Staff appointment, Department and, as applicable, category of Staff appointment and prerogatives, and clinical privileges. All documentation and information received by any individual, Department or committee during or as part of the evaluation process must be included with the application as part of the applicant's credentials file and, as appropriate or requested, transmitted with reports and recommendations. The reasons for each recommendation or action to deny, restrict or otherwise limit must be stated.

4.7 DEPARTMENT CHAIRMAN EVALUATION

The Department Chair will be notified by the Medical Staff Office to review the file and may interview the applicant and request any additional information using the procedures in Section 2.3.

If the applicant is a Podiatrist or Dentist, the Medical Staff Office arranges for a peer to review the application prior to its being forwarded to the Chair for his review.

The Department Chair shall advise the Credentials Committee in writing as to whether the applicant possesses the necessary qualifications and satisfies the Department's criteria for exercise of the clinical privileges requested and whether any conditions should be imposed on his exercise of such privileges.

4.8 CREDENTIALS COMMITTEE EVALUATION

The Credentials Committee shall review the recommendations of the Department Chair, supporting documentation and relevant information available to it. If the Credentials Committee requires further information, the applicant must be notified in writing of the additional information needed as provided in Section 2.3. Once the application is complete, the Credentials Committee

shall prepare its written report and recommendations and transmit it to the Medical Board.

4.9 MEDICAL BOARD ACTION

At its next regular meeting after receipt of a recommendation from the Credentials Committee, the Medical Board shall consider the application and issue a recommendation.

(a) If the recommendation of the Medical Board is not an Adverse Recommendation or Action, the Hospital President shall forward it to the Board of Trustees for final action.

(b) If the recommendation of the Medical Board is an Adverse Recommendation or Action, the Hospital President shall inform the applicant by Special Notice and all further procedures shall be as provided in the Medical Staff Hearing and Appellate Review Plan.

4.10 BOARD OF TRUSTEES ACTION

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

(a) If the Board of Trustees' decision is not an Adverse Recommendation or Action, the Hospital President shall notify the applicant of the decision within 20 days of the decision.

(b) If the Board of Trustees' decision is an Adverse Recommendation or Action, the Hospital President shall inform the applicant by Special Notice of the decision and all further procedures shall be as provided in the Medical Staff Hearing and Appellate Review Plan.

(c) If the Board of Trustees' decision is to refer the recommendation back to the Medical Board 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 Board's subsequent recommendation after referral is an Adverse Recommendation or Action, it shall be processed as provided in Section 4.9(b) above.

4.11 NOTICE OF FINAL DECISION

A decision and notice to appoint includes: (1) the Staff category to which the applicant is appointed; (2) the Department and (3) the clinical privileges he may exercise; (4) any special conditions attached to the appointment; and (5) the term of appointment.

ARTICLE V. REAPPOINTMENT

5.1 DETERMINATION OF ELIGIBILITY FOR REAPPOINTMENT

At least sixty (60) days prior to the expiration of a Practitioner's current appointment, activity data is obtained to determine eligibility for reappointment. A Practitioner for whom no activity has been identified will be advised of that fact and given the option to:

(a) resign as of the date of the expiration of his current appointment; or

(b) provide reason(s) why, despite no utilization, he wishes to maintain his membership and clinical privileges. Acceptable reasons for maintaining staff membership and privileges in the absence of patient activity include but are not limited to the following:

(1) participation in a call group which has identified patient activity at this Hospital. Reappointment in this circumstance is dependent upon sponsorship by an Active member of the Medical Staff, as verified by the Medical Staff Office; or,

(2) demonstration of tangible recent change in practice such as establishment of a practice on the Hospital Campus; or,

(3) another reason as determined at the sole discretion of the Credentials Committee, subject to the approval of the Medical Board and the Board of Trustees.

At least one hundred twenty (120) days prior to the expiration of the term of appointment, the Practitioner who has been approved as provided above will be provided with a

reappointment application.

5.2 SUBMISSION OF APPLICATION FOR REAPPOINTMENT

At least ninety (90) days prior to the expiration of the term of appointment, the Practitioner shall furnish, in writing, on the application for reappointment:

(a) complete information and all documents necessary to bring his file current on the items listed in Section 2.2 of this manual;

(b) specific request for the clinical privileges requested for the upcoming term, including any basis for changes from the privileges currently held;

(c) name of at least one (1) professional reference not associated with the applicant in professional practice or personally related to him, who have personal knowledge of the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communications skills, and professionalism, and who will provide specific written comments on these matters upon request from the Hospital or Medical Staff authorities. The named individual must have acquired the requisite knowledge through recent observation of the applicant's professional performance over a reasonable period of time within the last three years. The individual named should be from a colleague in the applicant's specialty.

(d) requests for changes in Department or Medical Staff category assignments.

The Practitioner must sign the reappointment application and in so doing accepts the same conditions as stated in Section 2.5 of the Bylaws in connection with the initial application.

If the Staff member has not returned his completed application for reappointment or requested an extension in writing by the ninetieth (90th) day prior to the expiration of his current appointment, the Medical Staff Office shall send him Special Notice that his application has not been received and that he has a seven (7) day grace period from the date of receipt of the notice in which to submit the application.

Failure to provide the fully completed reappointment application with all of the above information, prior to or within the grace period, results in automatic expiration of Medical Staff appointment at the end of the current term.

5.3 VERIFICATION OF AND REQUESTS FOR ADDITIONAL INFORMATION

The Medical Staff Office verifies the information provided on the reappointment application generally in the same manner as provided in Section 4.4 for the initial application process. The Medical Staff Office notifies the Practitioner in writing of any information inadequacies or verification problems. The notice shall indicate the nature of the additional information the Practitioner is to provide and the time frame for response as provided in Section 2.3.

In addition to any other requests made of a Practitioner under this section, if the evidence of the Practitioner’s current clinical competence to exercise the privileges requested is not sufficient to permit the applicable Medical Staff and Hospital authorities to make an informed judgment as to his competence in exercising the clinical privileges requested, the Staff member shall have the burden of providing evidence of clinical performance at his other institutional affiliations in such form as may be required by said authorities. The Medical Staff Office shall notify the applicant of the need for additional information, assistance, and/or an interview using the procedures in Section 2.3. The Practitioner then has the burden of producing the required and requested information and resolving any doubts about the data.

Failure to completely respond and comply with a request within twenty-one (21) days for additional information, assistance or an interview regarding any portion of the application, with the exception of new and/or increased clinical privileges, is deemed an incomplete application and voluntary withdrawal of the entire application for reappointment and will automatically result in expiration of appointment upon the date current appointment is due to expire.

Failure to respond completely and comply with a request, within twenty-one (21) days of same, for additional information, assistance or an interview to support a request for new and/or increased clinical privileges is deemed an incomplete application and voluntary withdrawal of the application for the clinical privileges which are the subject of the request for additional information, assistance or the interview.

The Credentials Committee and the Medical Board shall determine whether an application is deemed incomplete. The Practitioner's obligations hereunder are not affected by the Hospital's failure to provide timely notice of the date of expiration of staff appointment. A Practitioner whose application is deemed incomplete shall be given Special Notice of that fact. A Practitioner whose application is deemed incomplete is not entitled to any of the procedural rights or processes outlined in the Medical Staff Hearing and Appellate Review Plan.

5.4 PREPARATION OF FILE FOR REVIEW

The Medical Staff Office consolidates for review, at the time of reappointment, all available and relevant information regarding the Practitioner's professional and collegial activities, performance and conduct at the Hospital. Such information, which together with the information obtained under Section 2.2 above, shall form the basis for recommendations and action, and shall include, without limitation:

(a) current clinical competence, clinical judgment, and technical skill in the treatment of Patients.
(b) ethical behavior and patterns of care and utilization shown in the findings of quality management program activities;
(c) participation in relevant continuing education activities;
(d) number of Patient Contacts at the Hospital;
(e) final judgments, settlements, or claims in any professional liability actions involving the Practitioner;
(f) health status and ability to safely and competently exercise the clinical privileges requested and perform the essential functions of Staff membership;
(g) participation in Medical Staff duties, including committee assignments and emergency call;
(h) timely and accurate completion and preparation of medical records;
(i) behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel as it relates to patient care, the orderly operation of the Hospital, and ability to work with others;
(j) compliance with all applicable bylaws, policies, rules, and procedures of the Hospital and Medical Staff;
(k) voluntary or involuntary termination of medical staff membership or limitation, reduction or loss of clinical privileges at another Hospital;
(l) use of Hospital facilities for Patients, taking into consideration Practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty, provided that other Practitioners shall not be identified;
(m) capacity to satisfactorily treat Patients as indicated by the results of the Hospital's performance improvement and professional and peer review activities;
(n) appropriate resolution of any verified complaints received from Patients and/or other staff;
(o) applicant's compliance with the "Mandatory Immunization of Medical Staff Policy";
(p) any other pertinent information that may be relevant to the Staff member's status and privileges at the Hospital, or his medical practice outside the Hospital.

5.5 BASIS FOR RECOMMENDATIONS AND ACTION

Each individual, Department or committee providing a recommendation or reviewing an application for reappointment shall have available the full resources of the Medical Staff and Hospital as well as the authority to use outside consultants as deemed necessary. The report of each individual, Department or committee required to act on a reappointment shall meet the requirements of Section 2.5. Any dissenting views at any point in the process must be

documented including the reason for the differing view and the information on which it is based and the alternative recommendation, if any. This dissenting position must be transmitted with the majority report.

5.6 DEPARTMENT EVALUATION

The Medical Staff Office notifies the Chair of each Department in which the member is requesting appointment or privileges as to when the reappointment application, the supporting information and the Staff member's credentials file, or relevant portions thereof, with the information required by Section 2.2 above are available for review.

The Chair (or Vice-Chair as requested by the Chair) of each Department in which the Practitioner requests or has exercised privileges shall review the reappointment application and its supporting information, the information gathered under Section 5.2 above, and other pertinent aspects of the Staff member's file and evaluate the information for continuing satisfaction of the qualifications for Staff appointment, the clinical Department and category of assignment and the privileges requested. In the case of a Department Chair's reappointment, the review under this section shall be conducted by the Vice Chair of the Department. If a Chair requires further information, he shall, through the Medical Staff Office, notify the Practitioner of the information required as provided in Section 5.3 above.

If the applicant for reappointment is a Podiatrist or a Dentist, the Medical Staff Office arranges for a peer to review the application for reappointment and renewal of privileges.

5.7 CREDENTIALS COMMITTEE EVALUATION

The Credentials Committee shall review the reappointment application and its supporting information, the information gathered under Section 2.2 above, other pertinent aspects of the Practitioner’s file, the Department Chairmen's reports and all other information available to it and evaluate it for continuing satisfaction of the qualifications for Staff appointment, and category of assignment and the privileges requested. If the Credentials Committee requires further information, it shall, through the Medical Staff Office, notify the Practitioner of the information required as outlined in Section 5.3 above.

The Credentials Committee shall prepare a written report, including recommendations for, and any special limitations on, reappointment or non-reappointment and Staff category and Department and clinical privileges, or if no such recommendations are made, the reason therefor. The Credentials Committee's report is transmitted with the Department Chair's, and supporting documentation, as required, to the Medical Board.

5.8 MEDICAL BOARD EVALUATION

The Medical Board shall review the reappointment application and its supporting information, the information gathered under Section 2.2 above, other pertinent aspects of the Practitioner's file, the Department Chairmen's reports, and Credentials Committee's reports and all other relevant information available to it. The Medical Board shall defer action on the reappointment or prepare a written report, including recommendations for, and any special limitations on, reappointment or non-reappointment, clinical unit(s) and Medical Staff category assignment, and clinical privileges, or if no such recommendations are made, the reason, therefore.

a) If the recommendation of the Medical Board is not an Adverse Recommendation or Action, the Hospital President shall forward it to the Board of Trustees for final action.

(b) If the recommendation of the Medical Board is an Adverse Recommendation or Action, the Hospital President shall inform the applicant by Special Notice and all further procedures shall be as provided in the Medical Staff Hearing and Appellate Review Plan.

5.9 BOARD OF TRUSTEES ACTION

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

(a) If the Board of Trustees' decision is not an Adverse Recommendation or Action, the Hospital President shall promptly notify the Practitioner within 20 days of the decision.

(b) If the Board of Trustees' decision is an Adverse Recommendation or Action, the Hospital President shall inform the applicant by Special Notice of the procedural rights as provided in the Medical Staff Hearing and Appellate Review Plan and all further procedures shall be as set forth in that plan.

(c) If the Board of Trustees' action is to refer the recommendation back to the Medical Board for further consideration, the referral must state the reasons for such referral and set a time limit within which a subsequent recommendation must be made to the Board of Trustees. If the Medical Board's subsequent recommendation after referral is an Adverse Recommendation or Action, it shall be processed as provided in the Medical Staff Hearing and Appellate Review Plan.

5.10 TIME PERIODS FOR PROCESSING

Transmittal of the notice to a Staff member and his providing updated information is to be carried out in accordance with Section 2.8 above. Thereafter and except for good cause, all persons and groups required to act should complete such action so that all reappointment reports and recommendations and are acted on by the Board of Trustees prior to the expiration date of the Practitioner's appointment. The time periods specified in Section 2.8 are to guide the acting parties in accomplishing their tasks. If delay without good cause occurs at any step in the processing and is attributable to a Medical Staff or Hospital authority, the next higher authority may immediately proceed to consider the reappointment application and all the supporting information or may be directed by the Medical Staff President on behalf of the Medical Board or by the Hospital President on behalf of the Board of Trustees to so proceed.

If the delay is attributable to the Practitioner's failure to provide information required by Section 2.2, his Medical Staff appointment terminates on the expiration date. Such expirations is not an Adverse Recommendation or Action.

These same provisions apply in processing requests for modification of staff membership and/or clinical privileges.

ARTICLE VI. TEMPORARY PRIVILEGES

6.1 TEMPORARY CLINICAL PRIVILEGES

(a) Temporary privileges may be granted by the Hospital President, or his designee, on recommendation of the Medical Staff President, the Department Chair or their designee, when there is an important patient care, treatment or service need. Specifically, temporary privileges may be granted for: (i) the care of a specific Patient; (ii) a Practitioner serving as locum tenens for a member of the Medical Staff; or (iii) the purpose of proctoring or teaching. Prior to granting temporary privileges in these situations, the Hospital President shall verify current licensure and current competence. Temporary privileges may be granted by the Hospital President, upon recommendation of the Medical Staff President, when an applicant for initial appointment has submitted a completed application and the application is pending review by the Medical Board and the Board of Trustees, following a favorable recommendation by the Credentials Committee. Prior to a grant of temporary privileges in this situation, the credentialing process must be complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested and compliance with privileges criteria, and consideration of information from the Data Bank. In order to be eligible for temporary privileges under this subsection, the Practitioner must demonstrate that there are no current or previously successful challenges to his licensure or registration and that he has not been subject to involuntary termination of medical staff membership, or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility.

(b) Prior to temporary privileges being granted, the Practitioner must agree in writing to be bound by the Bylaws, Rules and Regulations and other Manuals, policies, procedures and protocols

of the Medical Staff and the Hospital.

(c) Temporary privileges shall be granted for a specific period of time, as warranted by the situation. In no situation should the initial grant of temporary privileges be for a period exceeding 120 days.

(d) Temporary privileges shall expire at the end of the time period for which they are granted.

6.2 SUPERVISION REQUIREMENTS

In exercising temporary privileges, the Practitioner shall act under the authority of the Department Chair or his designee. Special requirements of supervision and reporting may be imposed on any Practitioner granted temporary clinical privileges.

6.3 TERMINATION OF TEMPORARY CLINICAL PRIVILEGES

(a) The Hospital President or designee may, at any time after consulting with the Medical Staff President, the Chair of the Credentials Committee, or the Department Chair, terminate temporary admitting privileges. All temporary clinical privileges shall be terminated when the Practitioner's inpatients are discharged.

(b) If the care or safety of Patients might be endangered by continued treatment by the Practitioner granted temporary privileges, the Hospital President, the Department Chair, or the Medical Staff President may immediately terminate all temporary privileges. The Department Chair or the Medical Staff President shall assist the individual's Patients to select another member of the Medical Staff to assume responsibility for their care until they are discharged.

(c) The granting of temporary privileges is a courtesy and may be terminated for any reason.

(d) Neither the denial nor termination of temporary privileges or placement of any conditions on temporary privileges shall entitle the Practitioner to a hearing or appeal under the Bylaws or otherwise.

ARTICLE VII. REAPPLICATION AND MODIFICATIONS OF MEMBERSHIP STATUS OR PRIVILEGES AND EXHAUSTION OF REMEDIES

7.1 REAPPLICATION

Except as otherwise provided in the Medical Staff Bylaws or this manual or as determined by the Medical Board in light of exceptional circumstances, an applicant or Practitioner who has received a final Adverse Recommendation or Action is not eligible to reapply to the Medical Staff for a period of five (5) years from the date of the notice of the final decision. This provision shall also apply if the applicant or member withdrew an application or resigned following issuance of an Adverse Recommendation or Action, effective the date of the resignation or the date the application was withdrawn.

Except as provided herein, an applicant or Practitioner who has resigned or withdrawn an application for appointment, Staff category assignment, or clinical privileges is not eligible to reapply to the Medical Staff or for the denied/resigned/withdrawn, category or privileges for a period of one (1) year from the effective date of the resignation or application withdrawal. Any such reapplication is processed in accordance with the procedures set forth in the Bylaws and Article II of this Manual. As part of the reapplication, the applicant or Practitioner must submit such additional information as the applicable authorities of the Medical Staff and the Board of Trustees may reasonably require, to determine that the basis of the earlier adverse decision or recommendation no longer exists. If such information is not provided, the reapplication will be considered incomplete and deemed voluntarily withdrawn and will not be further processed. No applicant or Practitioner may submit or have in process at any given time more than one application for initial appointment, reappointment, or Staff category assignment, or the same clinical privileges.

The Practitioner or applicant may request a waiver of the one (1) year period if the Practitioner or applicant lost medical staff membership due to delinquent medical records or the application of the Practitioner or applicant was denied as incomplete due to the lack of vaccination documentation. The Practitioner or applicant must request the waiver from the Credentials

Committee and pay a fee of $1,000 for consideration.

7.2 REQUESTS FOR MODIFICATION OF APPOINTMENT STATUS OR PRIVILEGES AND NOTICE OF RELINQUISHMENT OF PRIVILEGES

A Practitioner may, either in connection with reappointment or at any other time, request modification of his Medical Staff category or clinical privileges by submitting a written request to the Medical Staff Office. A request for a change in staff status or privileges must contain all pertinent information supportive of the request and is processed according to the procedures outlined in Article V of this manual, including such verification with primary sources external to the Hospital and compilation of such internal data as necessary to properly evaluate the request.

A Practitioner who determines to no longer exercise or to restrict or limit the exercise of particular privileges which he has been granted shall send written notice, through the Medical Staff Office, to the applicable Department Chair, and to the Medical Staff President indicating the same and identifying the particular privileges involved and, as applicable, the restriction or limitation. The exception is if a department has determined, subject to the approval of the Medical Board and the Board of Trustees, that certain privileges and associated responsibilities and obligations are required for maintenance of membership in the Department, in which case the Practitioner must retain those privileges.

7.3 RESIGNATION FROM THE MEDICAL STAFF

A Practitioner may, at any time, resign from the Medical Staff by giving written notice through the Medical Staff Office to the Medical Board. Such resignation should specify the reason and the effective date and is subject to approval of the Board of Trustees. A Practitioner who resigns from the Medical Staff is obligated to fully and accurately complete, with signatures, all portions of all medical records for which he is responsible prior to the effective date of the resignation. Failure to do so shall result in an entry in the Practitioner's credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances. If a Practitioner is scheduled to provide emergency or call coverage after the time of resignation, the Practitioner is responsible for locating appropriate coverage.

7.4 EXHAUSTION OF ADMINISTRATIVE REMEDIES

Every applicant and member of the Medical Staff agrees that when corrective action is initiated or taken pursuant to the Medical Staff Hearing and Appellate Review Plan or when an Adverse Recommendation or Action is proposed or made, he will exhaust or waive all of the administrative remedies afforded in the various sections of the Medical Staff Hearing and Appellate Review Plan.

ARTICLE VIII. COLLEGIAL INTERVENTION

8.1 This Manual encourages the use of progressive steps by Medical Staff leaders and Hospital management, beginning with 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.

(a) Collegial efforts may include, but are not limited to counseling, sharing of comparative data, monitoring, performance improvement plans, and additional training or education.

(b) All collegial intervention efforts by Medical Staff leaders and Hospital management are part of the Hospital's performance improvement and professional and peer review activities.

(c) The relevant Medical Staff leader(s) (includes officers, Department Chair, Committee Chair, as appropriate to the situation) will document the collegial intervention efforts in the Practitioner's confidential file and the Practitioner will have an opportunity to review it and respond in writing. The response will be maintained in that Practitioner's file along with the original documentation.

(d) Collegial intervention efforts are encouraged, but are not mandatory, and will be within the discretion of the appropriate Medical Staff leaders and Hospital

management.

(e) The Medical Staff President, in conjunction with other leaders, as appropriate, and the Hospital President, will determine whether to direct that matter be handled in accordance with another Policy, or to direct it to the Medical Board or another committee, as appropriate for further determination.

ARTICLE IX. LEAVE OF ABSENCE

9.1 GENERALLY

It shall be mandatory that any member of the Medical Staff apply for a Leave of Absence for any period of absence which will extend longer than ninety (90) days. A Leave of Absence may be granted for “Good Cause”. “Good Cause” as used in this Article shall include, but not be limited to, the poor health of the member or a family member, further medical training or military service.

Members of the Medical Staff desiring Leaves of Absence must submit a written request to the Department Chair through the Medical Staff Office. The written request must state the purpose of the Leave of Absence and date the Leave of Absence is to begin and end. The Department Chair’s recommendation shall be submitted to the Credentials Committee for its review. The Credentials Committee shall forward its recommendation to the Medical Board. The Medical Board shall forward its recommendation to the Board of Trustees for final action. The Medical Staff Office shall notify the Practitioner, the Department Chair, the Credentials Committee and the Medical Board of the decision of the Board of Trustees.

9.1-1 If the member requests his Leave of Absence to have an effective date prior to the Board of Trustees’ receipt of the request, and such request is granted, the approval will be retroactive to the requested date.

9.1-2 With the exception of military leaves of absence, a Leave of Absence may not exceed one (1) year. Any member on a leave of absence for any reasons (with the exception of military leaves of absence) who, for any reason whatsoever, absents himself on leave from the Medical Staff obligations beyond the one (1) year maximum permissible period, shall be deemed voluntarily resigned from the Medical Staff and shall be required to reapply for Medical Staff appointment and privileges in accordance with the appointment process outlined in the Bylaws and this Credentials Manual.

9.1-3 Unless provided for elsewhere in this Article, while on an approved Leave of Absence, a Practitioner shall not have privileges to admit or treat Patients, nor have any other of the prerogatives or responsibilities of membership. However, unless the member is unable, the member shall be responsible for completing medical records for Patients he cared for before the Leave of Absence.

9.1-4 While on an approved Leave of Absence, if the Practitioner is due for reappointment, the member will be required to complete the reappointment process during the Leave of Absence. Failure to complete the reappointment process shall be deemed a voluntary resignation from the Medical Staff.

9.2 EXTENSION OF LEAVE OF ABSENCE

If the member has designated an ending date for his Leave of Absence which is less than the one (1) year allowable for Leaves of Absences, and the member is not available to return at the end of his designated period, he may apply to the Department Chair for an extension of up to one (1) year. The Department chairman shall forward this recommendation to the Credentials Committee which will forward its recommendation to the Medical Board. The Medical Board shall forward its recommendation to the Board of Trustees for final approval.

If the extension is to begin prior to the date of receipt by the Board of Trustees and the extension

is approved, it will be made retroactive to the ending date of the prior leave period.

The Medical Staff Office will notify the Medical Staff member, the Department Chair, the Credentials Committee and the Medical Board of the decision of the Board of Trustees.

9.3 CONDITIONAL REINSTATEMENT

In appropriate cases, such as a Leave of Absence to attend to an ailing spouse, child or parent, the Board of Trustees may grant a Leave of Absence for a defined period of time and the Member may be reinstated (prior to approval of Full Reinstatement by the Board of Trustees) by the Medical Staff President or Hospital President, upon the conclusion or resolution of the matter upon which the leave was based. In such cases, the Member must verify to the Medical Staff President or Hospital President that the matter that necessitated the leave has been resolved and that no other events have occurred during the Leave of Absence which could affect the Member's ability to practice.

Such conditional reinstatement (prior to the approval of the Credentials Committee, Medical Board and the Board of Trustees) is not available when a Leave of Absence is based upon the health of the Member or other matter which could affect the Member's ability to practice, or if during the Leave of Absence, the Member has not practiced for a substantial period of time.

In the case of conditional reinstatement, the Member is reinstated conditionally but the application must continue to be processed through the same procedure as the full reinstatement and must ultimately receive final approval by the Board of Trustees.

9.4 FULL REINSTATEMENT

Members of the Medical Staff on an approved leave of absence for the purpose of active duty with the Armed Forces of the United States shall be reinstated to the Medical Staff in accordance with the applicable state and federal laws.

With the exception of military leaves of absence, requests for reinstatement must be addressed to the applicable Department Chair and be received in the Medical Staff Office not less than sixty (60) days prior to the termination of the leave and will be processed in the same manner as a request for leave of absence.

In his request for reinstatement, the member shall demonstrate that the reasons for the leave of absence no longer exist. In order to qualify for reinstatement, the Medical Staff member must:

(a) Submit to the Department Chair, a request for reinstatement demonstrating that the reasons for the leave of absence no longer exist;
(b) Provide in the request, a summary of relevant activities while on leave;
(c) Demonstrate that he currently meets all the qualifications for membership and clinical privileges;
(d) Demonstrate that he meets the qualifications for the category of membership to which he is requesting reinstatement;
(e) Provide a certification from his treating Physician that the Practitioner is able to return to Hospital practice if leave of absence is for health reasons or any other matter which could affect the Member's ability to practice; and
(f) Submit such other information as requested by the Department Chair, Credentials Committee, Medical Board and the Board of Trustees.

The Credentials Committee and/or the Department Chair may request an interview with the member before making a recommendation to the Medical Board regarding the request for reinstatement. The Credentials Committee or the Department Chair may require a FPPE and evaluate the results before making a positive recommendation for reinstatement to the Credentials Committee or the Medical Board.

The Medical Board shall make a recommendation to the Board of Trustees. The final decision as to reinstatement shall be made by the Board of Trustees.

A determination that a member be denied reinstatement by the Board of Trustees shall be considered an Adverse Recommendation or Action and may be appealed as pursuant to the Hearing and Appellate Review Plan.

Failure to request reinstatement in a timely manner, to provide a complete submission in response to a request for information or to submit to a requested interview shall be deemed a voluntary resignation from the Medical Staff.

TEXAS HEALTH PRESBYTERIAN HOSPITAL PLANO
MEDICAL STAFF HEARING and APPELLATE REVIEW PLAN

ARTICLE I. PURPOSE

This Medical Staff Hearing and Appellate Review Plan ("Manual") is intended to establish guidelines for hearing and appellate review processes, accountability to and communication with the Hospital's Board of Trustees. It is intended that the processes and actions outlined and authorized in this Manual are taken in the course of Medical Peer Review and professional review activity by Medical Peer Review committees and professional review bodies, as those terms are defined by state and federal law, and their participants and witnesses and that all records and proceedings generated be covered by the immunities and protections available under applicable state and federal law.

ARTICLE II. HEARING AND APPEAL PROCEDURES

All hearing and appellate reviews shall be in substantial compliance with the procedural safeguards to provide the Practitioner the rights to which he is entitled. Additional hearing procedures consistent with the procedural requirements of this Article and applicable state and federal law may be developed and approved by the Medical Board, subject to the approval of the Board of Trustees.

ARTICLE III. PREHEARING PROCEDURES

3.1 REQUEST FOR HEARING AND WAIVER

3.1-1 The Practitioner shall have thirty (30) days following the date of receipt of notice of an Adverse Action under this Article within which to request a hearing or an appellate review. Failure to request a hearing or an appellate review within that time period shall constitute a waiver of his right to same.

3.1-2 The failure of a Practitioner to request a hearing or an appellate review to which he is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his right to such hearing and to any appellate review to which he might otherwise have been entitled on the matter.

3.1-3 When the Practitioner waives his right to a hearing regarding an Adverse Recommendation or Action of the Medical Board, the decision shall become and remain effective against the Practitioner pending the Board of Trustees' final decision on the matter. The Hospital President or his designee shall promptly notify the Practitioner of his status by Special Notice. If the waiver pertains to an Adverse Recommendation or Action of the Board of Trustees, the decision is final and effective on waiver. The Hospital President shall notify the Practitioner by Special Notice of the final decision within five (5) days of the waiver.

3.2 NOTICE OF HEARING

3.2-1 Within thirty (30) days of receipt of a timely written request from a Practitioner, for a hearing, the Hospital President, in consultation with the Medical Staff President shall schedule and arrange for a hearing and notify the Practitioner of the time, place and date so scheduled, by certified mail.

3.2-2 The hearing date shall be not less than thirty (30) days nor more than sixty (60) days (unless waived) from the date of receipt by the Practitioner of the notice of the hearing, provided, however, that a hearing for a Practitioner who is under an Adverse Recommendation or Action which is then in effect shall be held as soon as arrangements may reasonably be made. A Practitioner who requests an expedited hearing shall have waived the right to thirty (30) days advanced hearing notice requirement.

3.2-3 The notice of hearing shall include the members and specialty of the Hearing Committee with an explanation of the procedure for making any objections (see Section 3.3 below) and a list of the witnesses expected to testify at the hearing in support of the Adverse Recommendation or Action. The notice shall also advise the Practitioner of the requirement to provide a list of the witnesses that the Practitioner intends to present to the Hospital President in writing at least ten (10) days prior to the date of the hearing.

3.3 COMPOSITION OF HEARING COMMITTEE

3.3-1 The hearing shall be conducted by a Hearing Committee which shall be either at least three (3) members of the Medical Staff or a Presiding Officer appointed by the Hospital President in consultation with the Medical Staff President. One of the members of the Hearing Committee so appointed shall be designated as Chair.

3.3-2 No individual who is a direct competitor, has a conflict of interest or has actively participated in the consideration of the Adverse Recommendation or Action shall be appointed a member of the Hearing Committee. Knowledge of the facts of a case shall not automatically disqualify an individual from serving on a Hearing Committee. If a hearing officer is used, it must be a Practitioner if the Adverse Recommendation or Action involves professional competence or conduct.

3.3-3 All objections to the composition of the Hearing Committee must be made in writing to the Hospital President within ten (10) days of receipt of notice of the composition of the committee or they are waived. Unless a Presiding Officer has been appointed, the Hospital President shall consider all objections raised and have final authority to overrule or sustain any objections regarding the composition of the Hearing Committee.

3.3-4 Contact with the Hearing Committee members by anyone other than the Hospital President or Presiding Officer prior to the hearing or outside of the formal hearing proceeding itself is not permitted. Failure to comply by a Medical Staff member may result in corrective action

3.4 EXCHANGE OF DOCUMENTS AND DISCOVERY

3.4-1 At least fourteen (14) days in advance of the hearing, the Practitioner shall be given Special Notice of the records and documents the Medical Board, or the Board of Trustees intends to present at the hearing and a copy of those documents unless previously provided. At least ten (10) days in advance of the hearing, the Practitioner must provide the designated representative of the Medical Board or the Board of Trustees, through the Hospital President, with Special Notice of the records and documents that the Practitioner intends to present at the hearing and a copy. These notices may be amended on Special Notice to the other party. If additional records or documents are presented during the hearing, the other party shall be given a reasonable opportunity during the hearing to examine the records or documents before the hearing proceeds.

3.4-2 If any expert is to be presented as a witness by either party, the expert must be identified as a witness as provided in Section 3.2-3 above and the other party provided with the following in accordance with Section 3.4-1 above:

(a) A copy of the expert's curriculum vitae;
(b) A written report from the expert setting forth the substance of the expert's testimony, opinions, and grounds for the opinions;
(c) A copy of any literature or references relied upon by the expert in reaching the opinions; and

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

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

3.4-3 There are no rights to discovery by either party except as specifically provided in this Manual. Under no circumstances may the affected Practitioner access information or documents concerning another Practitioner.

3.5 CONDUCT OF HEARING

3.5-1 MAJORITY PRESENCE

There shall be at least a majority of the members of the Hearing Committee present when the hearing takes place. No member may vote by proxy. A member who has been absent for a portion of the hearing must review the transcript of any portion missed before participating in deliberations.

3.5-2 RECORD OF HEARING

An accurate record of the hearing shall be kept by a court reporter retained by the Hospital.

3.5-3 PRESENCE OF MEDICAL STAFF MEMBER

The personal presence of the Practitioner for whom the hearing has been scheduled shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his or her rights to a hearing as provided in the Medical Staff Bylaws and this Manual and the waiver provisions shall apply. The Practitioner shall be subject to cross-examination and questioning by the Hearing Committee in the hearing regardless of whether he or she chooses to testify.

3.5-4 BURDEN OF PROOF

The Practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the Adverse Recommendation or Action lacks any substantial factual basis or that such basis or the conclusions drawn therefore are either arbitrary, unreasonable or capricious.

3.5-5 WAIVER OF TIME FRAMES

The Practitioner may waive the time frames specified for the hearing in this Hearing Plan. Once convened, postponement of a hearing beyond the time set forth in this Article shall be made only with the approval of the Hearing Committee. Granting of such postponements shall only be for good cause shown and in the sole discretion of the Hearing Committee.

3.5-6 PRESIDING OFFICER

An individual independent from the Hospital may be appointed by the Hospital President, following consultation with the Medical Staff President, to serve as Presiding Officer for the hearing and, if not, the Chair of the Hearing Committee shall serve as the Presiding Officer. An independent Presiding Officer may or may not be an attorney at law but must be experienced in conducting hearings.

The Presiding Officer shall preside over the hearing, determine the order of procedure during the hearing, provide that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, maintain decorum and

rule on such matters of procedure as are relevant to the conduct of the hearing. If the Presiding Officer is an attorney, he or she may also advise the Hearing Committee and be present during deliberations to assist with preparation of the report but may not vote.

3.5-7 RULES OF EVIDENCE

The hearing need not be conducted strictly according to rules of evidence relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which reasonable persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible in a civil or criminal action. The Practitioner for whom the hearing is being held shall, prior to the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record. Participants in the hearing shall be informed of the matters to be noticed and those matters shall be noted in the record of the hearing. The Practitioner for whom the hearing is being held shall be given the opportunity, on request, to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the Presiding Officer. The committee shall also be entitled to consider any pertinent material contained on file in the Hospital, and all other information which can be considered in connection with applications for appointment/reappointment to the Medical Staff and for clinical privileges pursuant to the Medical Staff Bylaws; provided the Practitioner is advised of such consideration and provided with a copy of such material or information during the hearing. Witnesses other than the Practitioner and the Medical Board or Board of Trustees representative shall not be permitted to be present in the hearing other than during the times of their testimony.

3.5-8 MEDICAL BOARD OR BOARD OF TRUSTEES REPRESENTATION

The Medical Board, when its action has prompted the hearing, shall appoint one of its members or some other Practitioner, or members, 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 to present evidence in support of the Adverse Recommendation or decision. The Hospital President shall arrange for the assistance and participation of legal counsel for the representative.

3.5-9 RIGHTS DURING THE HEARING

The Practitioner shall have the following rights: to be represented by an attorney or another person of his or her choice; to call and examine witnesses; to introduce written evidence; to examine any witness on any matter relevant to the issue of the hearing; to challenge any witness; to rebut any evidence; and to submit a written statement at the close of the hearing or within five (5) working days thereafter. The representative under Section 3.5-8 shall have the same rights.

3.5-10 TESTIMONY

All testimony shall be given as if it were in a court of law. The Presiding Officer may order that oral evidence be taken on oath or affirmation administered by any person entitled to notarize documents or administer oaths.

3.5-11 RECESS AND RECONVENING

The Hearing Committee may, without Special Notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, including the submission of any written statements, the hearing shall be closed. The Hearing Committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the involved parties and the Practitioner for whom the hearing was convened. Upon reaching findings and its decision, the hearing shall be adjourned.

3.5-12 FINAL ADJOURNMENT AND REPORT

Within ten (10) working days after adjournment of the hearing, the Hearing Committee shall make a written report and recommendation and shall forward the same, together with the hearing record and necessary documents, to the Hospital President for forwarding to the Medical Board. The report may recommend confirmation, modification, or rejection of the Adverse Recommendation or Action, and shall include a statement of the reason for its recommendation. The Hospital President shall forward a copy of the Hearing Committee's report to the Practitioner by Special Notice in a timely manner.

3.5-13 HOSPITAL REPRESENTATIVES

Representatives of the Hospital may be present at all times during the hearing for the purpose of observing and verifying compliance with the Bylaws and relevant procedures.

3.6 MEDICAL BOARD ACTION

The recommendation of the Hearing Committee shall be presented to the Medical Board for action at the next regular meeting or a special called meeting. If the recommendation of the Medical Board following such hearing is still an Adverse Recommendation or Action, the Practitioner shall then be entitled to an appellate review by Board of Trustees before a final decision on the matter is made. Grounds for appeal shall be limited to substantial failure to comply with this Manual and/or the Bylaws of the Hospital or Medical Staff during or prior to the hearing, so as to deny a fair hearing.

ARTICLE IV. APPELLATE REVIEW

4.1 NOTICE OF RIGHT TO APPEAL

The Hospital President, or his designee, shall provide written notice to the Practitioner of any action of the Medical Board, following a hearing conducted under Article III, which is An Adverse Recommendation or Action. The notice shall advise the Practitioner of the right to request appellate review by filing a written request with the Hospital President within thirty (30) days of receipt of the notice Such notice to the Practitioner shall specify that the appellate review shall be held only on the record of the hearing and any other matters subsequent which were considered by the Medical Board in reaching the Adverse Recommendation or Action. The notice shall also advise the Practitioner of the standards for the appellate review, the requirement to submit a written statement and that any request for oral argument must be submitted at the time of submission of the request for appellate review. The written statement and oral argument, if requested, shall be limited to the provisions of Section 4.7 below.

4.2 WAIVER OF RIGHT

If such appellate review is not requested within thirty (30) days of receipt of the notice, the Practitioner shall be deemed to have waived his right to any appeal and to have accepted such Adverse Recommendation or Action, which shall be forwarded to the Board of Trustees for a final decision.

4.3 DATE OF APPELLATE REVIEW

Unless waived, at least (30) days after receipt of the request for appellate review, the Board of Trustees shall schedule a date for such review, including time and place, and shall, through the Hospital President or his designee provide Special Notice to the Practitioner of the same. The date of the appellate review shall not be less than thirty (30) days, nor more than sixty (60) days, from the date of the request for appellate review, except that when the Practitioner requesting the review is under an Adverse Recommendation or Action which is then in effect, such review shall be scheduled as soon as the arrangements for it reasonably can be made. A Practitioner who

requests expedited review shall have waived the right to thirty (30) days' notice.

4.4 APPLELLATE REVIEW COMMITTEE

The appellate review shall be conducted by the Board of Trustees or by a subcommittee of Board of Trustees of not less than three (3) members appointed by the Chair (hereinafter referred to as the "Appellate Review Committee" even if conducted by the Board of Trustees).

4.5 WRITTEN STATEMENT

The Practitioner shall have access to any material, favorable or unfavorable, that was considered subsequent to the hearing in making the Adverse Recommendation or Action. The Practitioner must submit a written statement based on the record listing all procedural matters with which the Practitioner disagrees, and the reasons for such disagreements. Such written statement shall be submitted to the Appellate Review Committee through the Hospital President, by Special Notice and be received at least ten (10) days prior to the scheduled date for the appellate review. The Hospital President shall provide a copy to the Medical Board representative who may submit a statement in response which must be received by the Hospital President at least three (3) days before the scheduled date for the appellate review. If submitted, the Hospital President shall provide a copy thereof to the Practitioner upon receipt by Special Notice.

4.6 REVIEW

The Appellate Review Committee shall review the record created in the proceedings and shall consider the written statements submitted. If oral argument is requested as part of the review procedure Appellate Review Committee in its discretion may allow the Practitioner to be present at such appellate review, to speak against the Adverse Recommendation or Action, and to answer questions asked by any member of the Appellate Review Committee. The Medical Board through its representative shall also be represented and permitted to speak in favor of the Adverse Recommendation or Action and shall answer questions from any member of the Appellate Review Committee.

4.7 SCOPE OF APPEAL

The appellate review shall be limited to a determination that:

4.7-1 the Adverse Recommendation or Action is being taken in the reasonable belief that it will further quality health care;
4.7-2 there has been a reasonable effort to obtain the facts of the matter;
4.7-3 there is a reasonable belief that the Adverse Recommendation or Action is warranted by the known facts;
4.7-4 the Adverse Recommendation or Action is supported by substantial evidence and the conclusions are not arbitrary, unreasonable or capricious, and
4.7-5 there has been substantial compliance with the procedures in the Hearing and Appellate Review Plan.

No new evidence may be presented, and no discussion of evidence shall be considered. New or additional matters not raised during the original hearing or in the Hearing Committee report, nor otherwise reflected in the record, shall not be introduced during the appellate review.

4.8 DECISION OF COMMITTEE

The Appellate Review Committee shall make a written report with its findings and recommendations to affirm, reverse or modify the Adverse Recommendation or Action. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Article V have been completed or waived.

ARTICLE V. FINAL DECISION BY THE BOARD OF TRUSTEES

5.1 TIMING OF DECISION

Within thirty (30) days after the conclusion of the appellate review, the Board of Trustees shall make its final decision in the matter, including a statement of the basis of the decision, and shall send notice thereof within five (5) days through the Hospital President to the Medical Board and, by Special Notice to the Practitioner. The notice shall include the findings and recommendation of the Appellate Review Committee.

5.2 FINALITY OF DECISION

Notwithstanding any other provision of these Bylaws and this Manual, no Practitioner shall be entitled as a right to more than one (1) hearing and one (1) appellate review on any matter which shall have been the subject of action by the Medical Board, the Board of Trustees or by a duly authorized committee of the Board of Trustees.

ARTICLE VI. MEDIATION

6.1 RIGHT TO MEDIATION

A Practitioner who requests mediation pursuant to Section 241.101(d) of the Texas Health & Safety Code based on: (i) being subject to an Adverse Recommendation or Action; or (ii) an allegation that the Credentials Committee has not acted on a complete application for appointment or reappointment within ninety (90) days of its receipt, shall be provided with an opportunity for mediation as set forth in this Manual. The Practitioner requesting statutory mediation shall be referred to as an "Eligible Practitioner" for purposes of this Article.

6.2 PROCESS

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: (i) receipt of the notice of an Adverse Recommendation or Action; or (ii) the ninetieth (90th) day from the Credentials Committee's receipt of a complete application. Submission of a request for mediation temporarily suspends any hearing timelines in the Bylaws and this Manual.

6.2-1 The mediation should be scheduled and completed within thirty (30) days of receipt of the request and, in the case of an Adverse Recommendation or Action, shall be scheduled before a hearing is scheduled. If the Eligible Practitioner has waived his other hearing rights as provided herein, mediation must be scheduled before the matter is submitted to the Board of Trustees for a final decision.

6.2-2 The Eligible Practitioner and the Hospital will share the costs of the mediator equally. The mediator will be selected by mutual agreement of the Eligible Practitioner and the Hospital President and must be qualified as required by Section 241.101(d) of the Texas Health & Safety Code, unless the parties mutually agree in writing to use a mediator not meeting such requirements.

6.2-3 The mediation shall occur either at the Hospital or the mediator's office and shall be limited to a half day of mediation, unless otherwise agreed by the Hospital President.

6.2-4 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.

6.3 MEDIATION AGREEMENT

Unless otherwise provided by the Board of Trustees, the Hospital's representatives at the mediation shall have the authority to sign any agreement with the Eligible Practitioner reached in

the mediation. Any mediation agreement shall be in writing signed by the Eligible Practitioner and the Hospital's representatives (and their attorneys if participating) and shall be binding and final.

6.3-1 Execution of a mediation agreement shall constitute a waiver of all of the Eligible Practitioner's rights under the Bylaws or this Manual, and otherwise if the mediation was requested as the result of an Adverse Recommendation or Action. Under no circumstances may be 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.

6.3-2 If the parties do not reach an agreement in the mediation, the Eligible Practitioner does not have any further rights to mediation and the hearing, if requested by the Eligible Practitioner within the required time period, shall be scheduled as provided herein.

6.4 RIGHT TO NOTICE

Nothing in the Bylaws or this Manual requires the Hospital to notify an Eligible Practitioner of his/her right under Section 214.101(d) of the Texas Health & Safety Code to request mediation.

TEXAS HEALTH PRESBYTERIAN HOSPITAL PLANO
MEDICAL STAFF RULES & REGULATIONS

ARTICLE I. PURPOSE

Generally, these Rules and Regulations are intended to establish rules and regulations for the conduct of and processes relating to Practitioners who have applied for or been granted Medical Staff appointment and/or clinical privileges by the Board.

ARTICLE II. ADMISSION

2.1 ADMISSIONS

Patients shall be admitted to or provided services by the Hospital for inpatient, outpatient, observation or other services only on the orders of a member of the Medical Staff with admitting privileges; provided, however, that a Physician order is not necessary for admission of a Patient to an outpatient psychiatric program. Patients transferred from another facility must be admitted to a Physician member of the Medical Staff who must acknowledge responsibility for the Patient by signing a Memorandum of Transfer following the arrival of the Patient. Patients who schedule and present to the Hospital for mammography services may be self-referred and do not require admission by a Physician.

Only qualified medical personnel (Physician, Labor and Delivery Registered Nurses, or other qualified medical personnel as designated by and approved by the Board of Trustees) may perform medical screening examinations or provide management and expeditious care for obstetrical Patients.

A single member of the Medical Staff shall be responsible, unless otherwise designated by the bylaws, policies, procedures, rules, regulations, manuals, guidelines and requirements of the Hospital and its Medical Staff, for:

(a) the medical care and treatment of each Patient in the Hospital (see Section 3.6 for dental and podiatric Patients);
(b) the completeness and accuracy of the medical record;
(c) necessary special instructions; and
(d) transmitting reports of the condition of the Patient to the referring Practitioner and to relatives of the Patient subject to confidentiality limitations.

Whenever these responsibilities are transferred to another member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record. The admitting Physician shall be responsible for verifying the other member's acceptance of the transfer. The admitting Practitioner shall provide the Hospital with any information concerning the Patient that is necessary to protect the Patient, other Patients, or Hospital personnel from infection, disease or other harm, and to protect the Patient from self-harm. All Patients admitted to the Hospital must have written or verbal orders. All members providing services in the emergency room must complete their charts before they leave the Hospital premises.

2.2 UNASSIGNED PATIENTS

Patients presenting to the Emergency Department, or requiring for admission who have no attending member, shall be assigned by the Emergency Department Physician to a member of the staff in the department to which the Patient's illness indicates assignment in accordance with the respective department's emergency department on-call policy.

2.3 ADMISSION ORDERS

Except for emergency admissions, no Patient shall be admitted to the Hospital without an admission order which should include at a minimum an admitting diagnosis, reason for admission

and level of care. The provisional admitting diagnosis for emergency admissions shall be provided as soon as possible following the Patient's admission.

2.4 TIMELY VISITATION AFTER PATIENT ADMITTED/TRANSFERRED

The attending Practitioner or his Practitioner designee (i.e., another member of the Staff in good standing with the requisite privileges to care for the Patient) must see the Patient and enter a note in medical record within the applicable time frame provided below or within any shorter time frame if required by the Patient's condition:

(a) Patients designated as emergency cases and those admitted directly to or transferred into an intensive or critical care area from the admitting office, emergency department, or general care area - within 4 hours.

(b) Non-Psychiatric Patients admitted via emergency department to a general care area -- within 12 hours.

(c) Psychiatric Patients and elective admissions -- within 24 hours.

(d) NICU per NICU Admission/Transfer protocol.

(e) Step down unit—within 6 hours.

(f) OB patients—immediately when notified of delivery or that delivery is imminent.

2.5 ROUNDING ON PATIENTS

2.5.1 Admitting/Attending Practitioner. Upon admission, all patients should be seen by the admitting Practitioner as provided in Section 2.4 hereof. Patients must be rounded on daily by the admitting/attending Practitioner or his/her designee. The Practitioner, rather than the designee, must see the patient upon request of the patient (or his/her decision maker), a Hospital employee, or another Practitioner within twenty-four (24) hours for a non-urgent matter and six (6) hours if medically urgent.

2.5.2 Consulting Practitioner. Patients for whom a consult is requested by the attending Practitioner should be seen by the requested consulting Practitioner within the time period set out in Section 4.6 (24 hours for routine and 6 hours for STAT requests) and rounded on daily thereafter by the consulting Practitioner and/or designee until all clinically relevant issues pertinent to that consultation have been resolved. The Practitioner, rather than the designee, must see the patient upon request of the patient (or his/her decision maker), a Hospital employee, or another Practitioner within twenty-four (24) hours for a non-urgent matter and six (6) hour if medically urgent. The consulting Practitioner or his/her designee must communicate in writing via the medical record when signing off of the case or varying from daily rounding.

2.5.3 Hospice/Palliative Care. Patients receiving inpatient hospice care or palliative care should be seen no less than every three (3) days by the Practitioner, but the Practitioner should beavailable by telephone at all times between rounding.

2.5.4 Practitioner Responsibility. The Physician is responsible for the oversight of any advanced practice nurse or physician assistant who acts as the Physician's designee.

ARTICLE III. PATIENT CARE DOCUMENTATION

3.1 HOSPITAL RECORDS

All medical records are the property of the Hospital and shall not leave the premises of the Hospital except upon receipt of a court order, subpoena, or statute. Release of the medical records at the Patient's request shall require a consent for release of these records in accordance with Hospital policy.

3.2 ACCESS TO RECORDS

With the exception of mental health records to which there is limited access as set forth below,

access to all medical records of a Patient shall be accorded to staff members in good standing and who are rendering care to the Patient or are prospective providers of care for the purpose of securing their service or who require the information for purposes of authorized Medical Peer Review, preserving the confidentiality of personal information concerning individual records of the Patient.

Psychiatrists in good standing on the Medical Staff and who are rendering care to the Patient or are prospective providers of care for the purpose of securing their services or who require the information for purposes of authorized Medical Peer Review shall have access to the mental health records of a Patient admitted to the Hospital. In non-urgent situations, Medical Staff members, other than members of the Department of Psychiatry, who are treating Patients who also are under treatment by the Department of Psychiatry, shall contact the Psychiatric Unit to be added to the treatment team prior to accessing a Psychiatric Patient's mental health record. With the exception of the psychiatric notes, Medical Staff members who are not members of the Department of psychiatry and who are participating in the diagnosis, evaluation, and/or treatment of psychiatric Patients may have access to mental health records of such Patients by use the "break the glass" function of the electron health record. Medical staff members who are not members of the Department of Psychiatry and are not involved in the diagnosis, evaluation, and/or treatment of a psychiatric Patient are not authorized to access a mental health record of a psychiatric Patient.

Mental health records that have been accessed using the "break the glass" function will be subject to special audit by the Department of Psychiatry and the Hospital's privacy officer or his/her designee.

3.3 MEDICAL RECORDS INFORMATION

It is the responsibility of the attending Practitioner to prepare a complete, accurate, timely, and legible medical record for each Patient and to document in this electronically in the electronic medical record. This record shall include:

- identification data;
- complaint and reason for admission;
- history of present illness;
- past medical history including allergies;
- family history;
- review of systems;
- physical examination;
- conclusions or impressions drawn from medical history and physical examination;
- provisional or admitting diagnosis;
- evidence of known advance directives;
- evidence of informed consent when required by organization policy;
- all orders;
- treatment goals, plan of care and revisions to plan of care;
- all special, diagnostic and procedural reports, tests and results, including consultation, clinical laboratory, radiology, pathology, and others;
- all reassessments;
- every medication ordered or prescribed;
- every dose of medication administered (including the strength, dose, or rate of administration, administration devices used, access site or route, know drug allergies, and any adverse drug reaction);
- every medication dispensed or prescribed on discharge;
- record of communication with the Patient regarding care, treatment and services;
- clinical observations, including results of therapy and treatment, nursing notes, medications records, vital signs and other information necessary to monitor the Patient's condition;
- medical or surgical treatment;
- operative reports;
- progress notes;
- final diagnosis;

condition on discharge;
discharge summary with outcome of Hospitalization, disposition of care, and provisions for follow up care;
any medications dispensed or prescribed on discharge;
discharge plan and discharge planning evaluation;
patient-generated information, if applicable;
follow-up or autopsy report when available;
Physician queries.

For Patients receiving continuing ambulatory care services, the medical record shall contain a summary list of all significant diagnoses, procedures, drug allergies, and medications.

Records of Patients who have received emergency care contain the following additional information:

(a) time of arrival;
(b) whether the Patient left against medical advice;
(c) any emergency care, treatment and services provided to the Patient before arrival;
(d) the conclusions at termination of treatment including final disposition, condition, and instructions for follow-up care.

No medical record shall be deemed complete until all information is entered in the electronic medical record, except on order of the Clinical Information Committee. See Section 5.1 of the Bylaws on specific rules and regulations to the extent of relinquishment of admitting privileges and/or staff privileges to assure the timely completion of records both for documentation and for timely submission of various claims for payment by the Hospital.

3.4 HISTORY AND PHYSICAL

The attending Physician is responsible for obtaining an adequate history and physical examination (H&P). A complete H&P, provided by a member of the Hospital Medical Staff, shall be available on the medical record no later than twenty-four (24) hours after admission and prior to surgery or a procedure requiring anesthesia services.

If a H&P as been performed within thirty (30) days prior to admission, this report or a durable, legible copy of this report can be placed in the medical record at the time of admission provided there is documentation of an updated examination and any changes placed in the medical record 24 hours after admission and prior to surgery or a procedure requiring anesthesia services. If there are no changes, the Physician should enter the following or a similar statement in the medical record: “This patient has been examined and there have been NO changes in the patient's medical status. The necessity of the procedure or care is still present.” The Physician should re-date and sign the document. Any History and Physical Examination performed over thirty (30) days prior to admission will be not accepted.

H&Ps must be recorded and placed on the chart before any surgical procedure or procedure requiring anesthesia services is undertaken unless the surgeon states that any delay incurred for this purpose would constitute a hazard to the Patient.

The H&P for inpatient admissions and transfers should include: date and time of assessment, chief complaint, present illness, past history including previous surgery, family history, comprehensive physical examination, medications and allergies, clinical impression and plan of treatment. The H&P for outpatient records should include: date and time of assessment, chief complaint, present illness, past history including previous surgery, family history, abbreviated physical examination, medications and allergies, impression, and plan of treatment.

When an H&P is provided by a Physician who is not a member of the Hospital’s Medical Staff, the attending Practitioner may include that H&P in the Patient’s chart provided the attending

Practitioner documents an updated examination as explained above.

A medical consultation will suffice for the H&P if all elements of the H&P, as indicated above, are included and it meets the time requirements above.

Members of the Allied Health Professional staff may perform all or part of the medical history and physical examination, if granted such privileges.

In addition to the H&P, an adequate admission note shall be written upon admission. For an emergency admission, a brief description of the Patient's condition should be immediately noted in / affixed to the chart pending availability of the complete H&P.

3.5 ORAL AND MAXILLOFACIAL SURGEONS

An Oral and Maxillofacial Surgeon who has successfully completed an accredited postgraduate residency program in Oral/Maxillofacial Surgery and who demonstrates current competence in performing a complete H&P examination may be granted the privileges to do so and to assess the medical risks of the proposed procedure to the Patient. Consultation will be obtained when appropriate. In all circumstances, a Physician member of the Medical Staff must be responsible for any medical or psychiatric problem that is identified at admission or that may arise during Hospitalization and is not specifically within the scope of practice of the Oral and Maxillofacial Surgeon.

3.6 DENTISTS AND PODIATRISTS

By preadmission arrangement or immediately following admission, a Physician member of the Medical Staff must perform an H&P on a dental/podiatric Patient. When significant medical abnormality is present, the final decision on whether to proceed must be agreed upon by the Dentist/Podiatrist and the Physician consultant. The applicable Department Chair will decide the issue in case of dispute. In all instances, a Physician member of the Medical Staff must be responsible for the care of any medical problem that may be present at admission or that may arise during Hospitalization and is not specifically within the scope of practice of the Dentist or Podiatrist.

Dentists are responsible for the part of their Patient's H&P examination that relates to Dentistry. The H&P report provided by the Dentist will also include the indication for the surgery and the indication for the type of anesthesia requested.

Podiatrists are responsible for the part of their Patient's H&P examination that relates to podiatry. The H&P report provided by the Podiatrist will also include the indication for the surgery and the indication for the type of anesthesia requested.

3.7 RE-ADMISSION WITHIN 30 DAYS

If the Patient is re-admitted within 30 days for the same or related problem, an interval H&P examination may be used provided that the original information is available.

3.8 PROGRESS NOTES

Pertinent progress notes must be recorded at the time of observation and must be sufficient to permit continuity of care and transferability of the Patient. Final responsibility for an accurate description in the medical record of the Patient's progress rests with the attending Practitioner Whenever possible, each of the Patient's clinical problems must be clearly identified in the progress notes and correlated with specific orders, with reasons for instituting various tests or treatment given and results of test and treatments record. If documentation exists outside the Hospital, which substantiates the reason for admission or for a procedure, the attending Practitioner should indicate the nature and content of that documentation. Progress notes by the attending or covering Practitioner must be written at least daily, excluding the Department of Psychiatry.

The Department of Psychiatry's progress notes must be accomplished as follows:

(a) Inpatients: Physician or their Practitioner designee must make daily rounds with documentation in the Patient's charts and must sign the treatment plan. Physicians must also attend treatment team meeting a minimum of three times a week.

(b) Partial Hospital: Physicians must see the Patient a minimum of two times a week with documentation in chart and they must sign the treatment plan. Physicians must also attend treatment team meeting at least twice a week.

3.9 SYMBOLS AND ABBREVIATIONS

Clinical abbreviations, acronyms and symbols may be used only if found in Stedman's Abbreviations, Acronyms, and Symbols, and will be taken in the context of the relevant body system being referenced in the documentation.

No abbreviations will be accepted in or on:

(a) Consent Forms, and
(b) Final Diagnosis(es) Section of Discharge Summary or other diagnostic statements.

The Clinical Practice Committee and the Clinical Information Committee approves and publishes a list of "Do Not Use" abbreviations in medical record documentation which may not be used.

3.10 CHANGES IN EXISTING ORDERS

If an existing order is changed, a line should be drawn through the order and the initials of the Practitioner deleting the order should be documented.

3.11 AUTHENTICATION

All medical record entries must be dated, timed and authenticated by the responsible Medical Staff Practitioner at the time of entry. Only authorized individuals make entries in the medical record. Entries made by Practitioners do not require countersignatures for their medical record entries; APN and PAs do not require countersignatures for orders and progress notes; and all others shall require countersignature consistent with law and regulation.

ARTICLE IV. CARE OF THE PATIENT

4.1 DIAGNOSTIC AND THERAPEUTIC ORDERS

4.1-1 PATIENT ORDERS

A. Medical Staff Members. All orders shall be given by a Physician, Oral/Maxillofacial Surgeon, Dentist, Podiatrist, Advance Practice Nurse (APN), or Physician Assistant (PA) licensed in Texas and shall be electronic (preferred) or in writing unless exempted from this requirement by these Rules & Regulations. Orders shall be entered or written clearly and completely, timed, dated, and authenticated. It is the responsibility of the Practitioner or AHP issuing the order to designate testing priority (i.e. Stat, ASP, Timed) in his order, if not routine. After normal business hours, emergency procedures maybe scheduled through the Administrative Supervisor. Faxed orders will be accepted.

Orders which are illegible, improperly written or ambiguous will not be carried out until rewritten or understood by the caregiver responsible for carrying out the order.

B. Orders from Non-Medical Staff Members. Physicians, Oral/Maxillofacial Surgeons, Dentists or Podiatrists, Optometrists, Chiropractors, APNs and PAs who are not members of the Medical Staff or do not have Allied Health Clinical Privileges at the Hospital but who are (a) responsible for the care of the patient; (b) licensed in the state of Texas and acting within their scope of practice under Texas laws; and (c) not on the exclusion list of the Office of Inspector General (OIG), and, in the case of APNs and PAs, the

supervising physician is also not on the OIG exclusion list may order to order diagnostic tests and therapy for their office patients on an outpatient basis only for the following services:

1. Laboratory
2. Neurodiagnostic
3. Nutritional Counseling
4. Pulmonary Noninvasive Diagnosis
5. Phlebotomy
6. Rehabilitation Services (Physical Therapy, Occupational Therapy, Speech Therapy, and Cardiac Rehab)
7. Patient education and counseling services
8. Diabetic Education
9. Electrocardiogram
10. Echocardiogram
11. Transesophageal echocardiogram
12. X-rays
13. MRI

In addition, any Physician, Oral/Maxillofacial Surgeon, Dentist, Podiatrist, Optometrists, Chiropractors, APN or PA who is not on the Medical Staff or does not have Allied Health Clinical Privileges but who meets the qualifications above is granted the authority by the Medical Staff to order radiology procedures.

If the Texas license of the ordering Physician, Or/Maxillofacial Surgeon, Dentist, Podiatrist, Optometrists, Chiropractors, APN or PA can be verified, Hospital will assume that the individual is acting within the scope of his/her Texas license.

4.1-2 VERBAL ORDERS

All verbal and telephone orders should be authenticated as close to the time of issuance as possible, but in all instances, (except as indicated below) should be authenticated the earlier of the following:

(a) the next time the Practitioner provides care to the Patient or documents in the record;
(b) within 48 hours of when the order was written

Do Not Resuscitate Orders must be authenticated by the ordering Physician within twenty-four (24) hours of issuance and shall be issued in accordance with Hospital policy.

No verbal or telephone orders will be permitted for administration of chemotherapy.

Verbal and telephone orders must be communicated personally by a Physician, Oral/Maxillofacial Surgeon, Dentist, APN or PA or through his licensed designee and may be taken only by a duly authorized person functioning within his/her defined sphere of competence. A "duly authorized person" must be a member of the Medical Staff, or an employee who is a registered nurse, a licensed vocational nurse, a registered pharmacist, a respiratory care Practitioner, a licensed physical therapist, occupational therapist, speech therapist, radiologic technologist, dietitian, social worker or medical technologist. Questions about verbal orders must be resolved prior to administration of a medication.

Verbal or telephone orders should be limited to emergent situations where immediate written or electronic communication is not feasible.

The duly authorized person receiving the verbal or telephone order from the Physician,

Oral/Maxillofacial Surgeon, Dentist, Podiatrist, APN or PA or through his licensed designee shall read back the order to the Practitioner or AHP to assure accuracy. Inpatient verbal orders shall be entered directly into the electronic record. The Physician, Oral/Maxillofacial Surgeon, Dentist, Podiatrist, APN or PA shall authenticate the verbal or telephone order. Orders may be signed by a covering Physician, Oral/Maxillofacial Surgeon, Dentist, or Podiatrist. A Nurse Practitioner or Physician Assistant may only sign off on orders they have written.

4.1-3 ORDERS BY ALLIED HEALTH PROFESSIONALS

Allied Health Professionals (AHP) who are granted privileges may write orders only as delineated by the approved applicable Hospital AHP privilege form.

4.2 PHYSICIAN RESPONSIBILITY FOR SERVICES PROVIDED BY ALLIED HEALTH PRACTITIONERS

Each Physician is responsible for the daily, continuing care of his Patients at the Hospital. The Hospital requires that all services provided by Allied Health Practitioners, as defined in the Medical Staff Bylaws, to Patients at the Hospital be under the direction and supervision of a Physician member of the Medical Staff as further detailed on the clinical privilege delineation for the AHP.

A Physician who utilizes the services of an Allied Health Practitioner in the care of his Patients at the Hospital agrees, by accepting Medical Staff appointment and/or clinical privileges at the Hospital, to provide appropriate direction and supervision of services rendered by Allied Health Practitioners, to his Patients and that the Physician is responsible for the care and treatment rendered by Allied Health Practitioners under his direction and supervision.

4.3 ADMISSION LABORATORY/RADIOLOGY PROCEDURES

There are no requirements for routine laboratory/radiology work on admission to the Hospital. Laboratory/Radiology results, if done in a licensed laboratory/radiology facility (State License) may, at the discretion of the attending Practitioner and/or anesthesiologist, be incorporated into the patient record.

4.4 AUTOMATIC CANCELLATION OF ORDERS

When the Patient goes to surgery or is transferred to another patient care area or level of service all previous orders are automatically discontinued except for a DNR or an order that complies with a Patient's advanced directive. All other orders must be re-written pursuant to Section 4.1 of the Rules & Regulations.

The use of terms "renew", "repeat", and continue orders" alone without reference to the specific order to which they refer is not acceptable.

4.5 PRE-PRINTED ORDERS

Members of the Medical Staff may develop pre-printed admission orders for Patients with common admitting diagnoses. However, such orders shall be made specific for each individual Patient by written or telephone instructions before being implemented for that Patient Preprinted orders must be dated, timed and authenticated by the ordering Practitioner on the last page.

4.6 CONSULTATION

With respect to seriously ill Patients in which the diagnosis is obscure, or when there is a doubt as to the best therapeutic measures to be utilized, consultation is recommended. Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment rests with the attending Practitioner. It is strongly suggested that all Patients admitted to the Medical/Surgical ICUs receive consultation from a Physician board certified in critical care who routinely treats Patients in the critical care setting. A psychiatric consultation should be obtained for psychiatrically unstable Patients.

Consultation is required for termination of a Patient's pregnancy after the first trimester. The Physician obtains written consultation from a committee of not less than two active Medical Staff members selected by the Chair of the OB/GYN Department. Documentation of this consultation must be included in the Patient's medical record.

The responsibility for obtaining all consultations rests with the attending / treating Practitioner. Consultations must be requested on a Practitioner -to-Practitioner basis or, by the Practitioner completing the consultation request form which must include the reason for the consultation. A Physician on call, other than a Psychiatrist, must respond to a non-urgent request for a consultation within twenty-four (24) hours. A Physician on call, other than a Psychiatrist, must see the patient for a consultation within six (6) hours if the need for a consult is medically urgent as determined by the Physician requesting the consult. For all other consults, the Consulting Physician, other than a Psychiatrist or Dermatologist, must see the patient for a consultation within six (6) hours if the need for a consult is medically urgent as determined by the Physician requesting the consult.

4.7 TREATMENT OF FAMILY MEMBERS

Members of the Medical Staff shall not write any orders or participate in the Patient's care involving a member of his/her immediate family (spouse, parents/in-laws, children, or significant other) or for any Patient for which the Physician holds Power of Attorney.

Members of the Medical Staff shall not be allowed to participate in, or be in attendance at, any major surgical procedure (with the exception of cesareans) involving any member of his/her immediate family (spouse, parents/in-laws, children, or significant other) or for any Patient for which the Physician holds Power of Attorney.

In the event of an emergency, isolated setting or when no other qualified Practitioner or appropriate healthcare personnel is available, treatment of a family member may be initiated and continued until such time as the Patient's care can be assumed by other appropriate qualified healthcare personnel.

ARTICLE V. MEDICATION ADMINISTRATION

5.1 DRUG STANDARD

Drugs used shall, as a minimum standard, meet the requirements of the US Pharmacopoeia National Formulary, New and Non-official Drugs, with the exception of drugs for approved clinical investigations. Additional standards may be required by the Pharmacy & Therapeutics Committee. Patients may continue medications prescribed prior to the Hospitalization as long as their Physician has been so notified and gives an order to that effect consistent with the Pharmacy & Therapeutics Committee policy and all such medication is noted in the medical record. All medications must be administered through the Pharmacy.

Drugs administered to Patients in the Hospital must be obtained from the Hospital Pharmacy. Exceptions to these rules shall be charted by the Practitioner in the Patient's medical record.

Investigational Drugs shall be handled in strict compliance with F.D.A. regulations. The Practitioner shall obtain approval for the use of investigational drugs through the Texas Health Resources Institutional Review Board. Such drugs shall be dispensed from the Hospital Pharmacy upon the authority of the investigator authorized to conduct the study.

5.2 DOSAGE TIME

Controlled substances, antibiotics or other drugs or agents as designated by the Pharmacy & Therapeutics Committee that are ordered without time limitation of dosage shall be reviewed by the attending Practitioner after seventy-two (72) hours. It is preferred that orders for controlled substances be written as closed orders with a definite duration. Drugs shall not be discontinued without notifying the attending Practitioner. Medications are given at routine administration times

unless specified otherwise.

ARTICLE VI. SPECIAL TREATMENT PROCEDURES

6.1 RESTRAINTS

Procedures regarding the application of restraints are defined in the Hospital policy on Patient restraints. This policy is available on all patient care units and all Patient procedural areas from the nursing/departmental supervisor of the area.

6.2 SECLUSION

Seclusion, which is defined as placement of a Patient alone in a room, may only be employed on the psychiatry unit by Physician order according to the provisions of the restraint/seclusion policy approved by the Department of Psychiatry.

ARTICLE VII. SURGICAL AND HIGH-RISK PROCEDURES

7.1 PRE-OPERATIVE RECORDS FOR OPERATIVE AND HIGH-RISK PROCEDURES AND/OR THE ADMINISTRATION OF MODERATE OR DEEP SEDATION OR ANESTHESIA

The Patient's medical record shall contain a History and Physical Examination as outlined in Article III, Section 3.4 of these Rules & Regulations.

History and physical examinations must be recorded and placed on the chart before any surgical or high-risk procedures and/or the administration of moderate or deep sedation or anesthesia is undertaken unless the operating Practitioner documents in the medical record that any delay incurred for this purpose would constitute a hazard to the Patient.

The surgeon should place a provisional diagnosis and, if applicable, the clinical stage of a tumor, in the Patient’s pre-operative record.

7.2 PRE-OPERATIVE ASSESSMENTS AND EDUCATION FOR THE ADMINISTRATION OF MODERATE OR DEEP SEDATION OR ANESTHESIA

The Practitioner must complete a pre-sedation or pre-anesthesia assessment on any Patient for whom moderate or deep sedation or anesthesia is planned. If the Patient will have deep sedation or anesthesia, the assessment must be completed within 48 hours prior to surgery by an anesthesiologist, Certified Registered Nurse Anesthetist, or other Member with privileges to administer the sedation or anesthesia.

Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered, the anesthesiologist, Certified Registered Nurse Anesthetist, or other Member must provide the Patient with pre-procedural education, according to his or her plan for care. The anesthesiologist, Certified Registered Nurse Anesthetist, or other Member must reevaluate the Patient immediately before administering moderate or deep sedation or anesthesia.

7.3 CONSENT REQUIRED

It is the responsibility of each member of the Medical Staff to obtain the informed consent from the Patient or his legal representative, except in emergencies as defined by the informed consent policy. Informed consent should be obtained prior to the commencement of a procedure or Patient transfer to another facility. The risks and benefits of the procedure and the risk and benefits should be documented by the Practitioners on the consent form. A copy of the informed consent must be placed on the medical record.

When two primary surgeons are co-surgeons performing separate procedures, each surgeon is responsible for obtaining his own separate consent form. Patient permission should be obtained for any vendor or outside party to be present in the procedure or the operating room in accordance with THR policy.

7.4 POST OPERATIVE AND HIGH-RISK PROCEDURES RECORDS AND/OR RECORDS AFTER THE USE OF MODERATE OR DEEP SEDATION OR ANESTHESIA

Operative and procedure reports must be entered into the medical record immediately after surgery and/or high-risk procedures and/or the administration of moderate or deep sedation or anesthesia and before the Patient is transferred to the next level of care. If the Practitioner performing the operation or high-risk procedure accompanies the Patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or area of care.

The operative or other high-risk procedure report must include the following information:

(a) The name(s) of the licensed independent Practitioner(s) who performed the procedure and his or her assistant(s) or other Practitioners who performed surgical tasks;
(b) The name and Hospital identification number of the Patient;
(c) Pre-operative diagnosis;
(d) The name of the procedure performed;
(e) A description of the procedure and techniques;
(f) Type of anesthesia used;
(g) Complications, if any;
(h) Findings of the procedure;
(i) Any estimated blood loss, if any;
(j) Any specimen(s) removed or altered, if any;
(k) Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any;
(l) Surgeons or Practitioners name(s) and a description of the specific significant surgical tasks that were conducted by Practitioners other than the primary surgeon/Practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues);
(m) The postoperative diagnosis;
(n) Date and times of the procedure.

The completed operative or procedure report shall be authenticated by the Practitioner who performed the procedure.

When the completed operative report cannot be entered or placed in the medical record immediately after surgery, a progress note must be entered in the medical record immediately before the Patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis. The operative report must be completed and in the medical record within twenty-four (24) hours after surgery.

Postoperative documentation records the Patient's vital signs and level of consciousness; medications (including intravenous fluids), blood, blood products, and blood components; any unusual or unanticipated events or postoperative complications, including blood transfusion reactions; and management of such events. Postoperative documentation also records the Patient's discharge from the post-sedation or post anesthesia care area by the responsible Practitioner or according to discharge criteria, as well as the name of the Practitioner responsible for discharge.

7.5 POST OPERATIVE ASSESSMENTS FOR THE ADMINISTRATION OF MODERATE OR DEEP SEDATION OR ANESTHESIA

The anesthesiologist, Certified Registered Nurse Anesthetist, or Member administering deep sedation or anesthesia must document a postanesthesia evaluation within forty-eight (48) hours following surgery. For outpatients, the post anesthesia evaluation must be performed prior to discharge.

7.6 TISSUE EXAMINATION AND REPORTS

All tissue removed during a procedure (with the exception of those stated below) shall be promptly labeled as to patient and anatomic site upon being passed from the operative field, packaged in preservative as designated, and sent for pathological examination by a pathologist on

the Medical Staff. Each specimen must be accompanied by a requisition stating pertinent clinical information and, to the degree known, the preoperative and postoperative diagnoses. The pathologist shall document receipt and make such examination as necessary to arrive at a pathological diagnosis. Any authenticated report of the pathologist's examination shall be made a part of the medical record. Gross only examination may be requested for traumatized or accessory digits, bunions; hammertoes; row carpectomies; radial heads removed for acute trauma; extraocular muscles removed in repair of strabismus; nasal septa; varicose veins.

The pathologist is authorized to initiate microscopic examination if in the pathologist's opinion such examination is indicated either by the gross appearance or the clinical history.

Tissues and articles removed during a procedure which may be sent for pathological examination at the discretion of the operating surgeon shall be limited to: foreign bodies; artifacts; therapeutic radiation sources; prostheses not contributing to Patient illness, injury or death; foreskin from infants; ribs removed exclusively for enhancing operative exposure in Patients without a history of malignancy; normal bone from osteotomies; unused normal bone and tissue removed for purposes of autologous tissue grafts (e.g. tendons, nerves, saphenous veins); normal tissue removed as a result of cosmetic surgery that is not contiguous with a lesion and that is taken from a Patient who does not have a history of malignancy (e.g., fat from liposuction; skin from eyelids); placentas from routine and uncomplicated deliveries which do not meet departmental criteria for examination; teeth without attached soft tissue.

7.7 ANESTHESIA CARE

When utilizing a Certified Registered Nurse Anesthetist, the directing/supervising anesthesiologist must:

(a) concurrently medically direct no more than three Certified Registered Nurse Anesthetists in the performance of the technical aspects of anesthesia care;

(b) be responsible for the pre-anesthetic medical evaluation of the Patient, prescription and implementation of the anesthesia plan, and personal participation in the most demanding procedures of the plan (including without limitation induction and emergence);

(c) follow the course of anesthesia administration at frequent intervals, remaining physically available on site for the immediate treatment of emergencies and providing indicated post-anesthesia care;

(d) not simultaneously provide 1:1 care to other Patients; and

(e) clearly and explicitly establish that the attending surgeon or attending proceduralist has approved the assignment of a Certified Nurse Anesthetist to provide professional anesthesia services to his/her Patient, on a case-by-case basis or by mutual agreement on a regular and/or periodic basis.

The Practitioner or Certified Registered Nurse Anesthetist administering anesthesia will maintain a complete anesthesia record. Evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the Patient's condition will be documented in the medical record in accordance with Hospital policy and these Rules. The risks and benefits of anesthesia administration must be documented in the pre-anesthesia record as well as on the Anesthesia Consent form.

7.8 FOLLOW-UP CARE

Postoperative patients may be moved directly to the Critical Care Unit on the discretion of the anesthesiologist.

A note must be documented using the hospital's Immediate Post Anesthesia Note template immediately after a procedure by the anesthesiologist/anesthetist at the transition of the level of

care from the procedural area (i.e. OR to PACU, Cath Lab to ICU, etc.).

If the patient is an inpatient and unable to participate in the immediate post anesthesia assessment (i.e. verbalize or indicate they understand), a follow-up note must be documented by the anesthesiologist/anesthetist or their appropriately credentialed designee, within 48 hours of the procedure utilizing the hospital's EHR template.

The medical record shall document the use of approved discharge criteria to determine the patient's readiness for discharge.

ARTICLE VIII. INFECTION CONTROL

8.1 GENERAL AUTHORITY

The Infection Control Committee has the authority to institute any appropriate control measure or study when there is reasonably felt to be a danger to Patients or personnel from an infectious source.

8.2 REPORTING OF INFECTIONS/COMMUNICABLE DISEASES

Every Medical Staff member should report promptly to the infection control department infections which develop after discharge and which may have been acquired during the Patient's Hospitalization.

8.3 HANDWASHING

All members of the Medical Staff are expected to comply with the Hospital's established hand-washing protocols.

ARTICLE IX. IMMEDIATE QUESTIONS OF CARE

9.1 CHAIN OF COMMAND

If a nurse or other health care professional involved in the care of a Patient has any reason to doubt or question the care provided to the Patient or feels that appropriate consultation is needed and has not been obtained, such individual shall, pursuant to Hospital policy, contact a Patient's attending Practitioner to resolve a clinical problem. If the problem does not resolve, the Patient's medical record should be evaluated to determine other Practitioners involved with the Patient's care (consulting Practitioners). The clinical nurse or other health care professional should contact another nurse or health care professional in their unit for advice and who may in turn contact the Patient's attending Practitioner. If the problem is not resolved, the Director or, in his/her absence, the House Supervisor, should be contacted. They, in turn, should assess the situation and may:

Contact the Patient's attending Practitioner
Contact the Chair of the appropriate Medical Staff Department
Contact the Vice Chair of the appropriate Medical Staff Department (if Chair is not available)
Contact the Medical Staff President
Contact the President Elect of the Medical Staff (if President is not available)
Contact the Administrator on Duty

In the event a Medical Staff officer is unavailable to perform an assigned function, such as a chief of department, the order of Medical Staff officer succession to perform the function is as follows:

President
President-Elect
Immediate Past President

ARTICLE X. DISCHARGE

10.1 DISCHARGE SUMMARY

A Patient shall be discharged from the Hospital by order of the Patient's attending Physician or his designee. When a Patient is transferred within the same organization from one level of care to

another and the caregivers change, a transfer summary may be substituted for the discharge summary. A transfer summary briefly describes the Patient's condition at time of transfer, and the reason for the transfer. When the caregivers remain the same, a progress note will suffice. In all instances, the content of the discharge summary shall contain the reason for Hospitalization, significant findings, instructions to the Patient and family, as appropriate, be sufficient to justify the diagnosis and treatment, include follow-up instructions and shall state the condition of the Patient, outcome of Hospitalization, disposition of care, final diagnosis, complications and procedures performed at the time of discharge. In cases where a short-stay discharge instruction sheet is given to the Patient, a copy of that instruction sheet should also be placed on the Patient's chart. All summaries shall be authenticated by the responsible Practitioner. In cases where a Patient is in the Hospital less than 48 hours, the final progress note signed by the Patient's attending Physician may serve as the discharge summary if the summary contains the outcome of the hospitalization, the case disposition and any provisions for follow-up care.

10.1-1 A Patient transferred to another facility shall be personally examined and evaluated to determine medical need by the Practitioner authorizing the transfer. The Practitioner shall determine and order life support measures as medically appropriate, determine and order utilization of appropriate personnel and equipment for transfer, and be responsible for securing a receiving Physician and Hospital appropriate to the Patient's needs. The Physician shall comply with documentation requirements in the Memorandum of Transfer per Hospital policy.

10.1-2 The discharge summary for newborns should include the weight and condition of the infant at discharge.

10.2 PATIENTS WHO LEAVE AGAINST MEDICAL ADVICE (AMA)

Should a Patient leave the Hospital against the advice of the attending Practitioner or without proper discharge, a notation of the incident shall be made in the Patient's medical record and the Patient will be asked to sign the acknowledgment form indicating that he understands he is leaving against medical advice. If the Patient refuses to sign the acknowledgment form, appropriate documentation regarding same shall be made in the medical record.

10.3 PATIENT TRANSFERS

No Patient will be transferred without such transfer being approved by the responsible Practitioner or other Practitioner in the absence of the responsible Practitioner for any reason. Transfers shall be made in accordance with Hospital policy.

10.4 FINAL DIAGNOSIS

A final diagnosis shall be made available to the Medical Records Department within seventy-two (72) hours of the availability of the completed chart to the attending Practitioner.

10.5 UTILIZATION REVIEW

Patients with extended Hospitalization should have the reasons documented by the attending Physician in the progress notes. Discharge planning should be initiated as soon as the need for such services is determined.

10.6 HOSPITAL DEATHS

In the event of a death, the deceased shall be pronounced dead by the attending Physician or his designee within a reasonable period of time. The body may not be released to the morgue or a funeral home until an entry has been made and signed in the deceased's medical record by a Physician member of the Medical Staff. All other matters with respect to release of the body, reporting of deaths, and issuance of a death certificate are carried out in accordance with current Hospital policy and local law.

10.7 AUTOPSIES

It is the responsibility of every member of the Medical Staff to secure autopsies whenever appropriate. The Medical Staff is involved in the use of criteria for autopsies. The following criteria shall be used: 1) in those cases where the exact cause of the clinical event which led to death is uncertain, 2) or where insight into the cause, nature or course of a disease process may be obtained. Written consent for autopsy must be obtained from the deceased Patient's next of kin or as otherwise permitted by law. The requesting Physician should list any specific questions on the permit that could be clarified during the postmortem examination. Policy and procedures for autopsy are defined in the Administrative Policy Manual.

10.8 MEDICAL RECORD DELINQUENT PROCEDURES

Health Information Management will audit incomplete and delinquent medical records each Tuesday. If a Practitioner has incomplete records outstanding for at least fourteen (14) days following the date the record was assigned to him, Health Information Management will send the Practitioner a pending suspension letter via fax or email.

Practitioners completing all of their medical records after receiving notice are strongly encouraged to contact Health Information Management to let them know the queue(s) has been cleared.

On the Monday prior to Tuesday's suspension, Health Information Management will send a reminder fax or email to the affected Practitioner or Practitioner's office with a final prompt to complete all medical records.

Practitioners with incomplete medical records deficient for twenty-one (21) days following the discharge date will be suspended on Tuesdays at 7:00 am. Notification will be sent via fax or emailwith a copy to Administration. Administration will also receive a list of the names of all Physicians on the delinquent list 20 days out, and Administration will also make a call to each Practitioner or his office.

All incomplete records in the queue(s) must be completed for the suspension to be lifted. The affected Practitioner must notify Health Information Management that all records have been completed. Health Information Management of medical records completion will only occur between 10:00 AM and 5:00 PM, Monday through Friday. Accordingly, suspensions will only be lifted during these same business hours. The final notice sent to Practitioners before suspension is imposed will advise that suspension will not be reversed after these hours or weekends.

After his third administrative suspension for incomplete medical records within a rolling twelve-month period, the Practitioner will be asked to meet with the Medical Staff Professional Affairs Committee. After his third administrative suspension for incomplete medical records within a rolling twelve-month period, the Practitioner will receive a letter from the Medical Staff President warning him that a fourth administrative suspension will result in termination of his Medical Staff membership and clinical privileges.

Practitioners subject to automatic suspension for incomplete medical records will be reported monthly to the Medical Board. In addition, a record of each 21-day automatic relinquishment imposed shall be made part of the Practitioner's quality file.

A total of four (4) or more 21-day automatic suspensions within any consecutive twelve-month period will result in actions as outlined in Article V, Section 5.1 of the Medical Staff Bylaws Hearing and Appellate Review Plan.

If a Practitioner is on the delinquent list for more than 58 consecutive days, the Practitioner's appointment and clinical privileges will terminate.

10.9 PRIMARY SUSPENSION FOR H&P AND OPERATIVE REPROT DELINQUENCIES

Health Information Management will check for the H&P after 24 hours of admission and the Operative Report 24 hours after the patient's surgery/procedure. If the H&P or Operative Report

is missing after 24 hours, Health Information Management will notify the Practitioner by phone. If the H&P or Operative Report is not completed by 8:00 AM the next business day after notification, the Practitioner will be placed on Primary Suspension.
Practitioners placed on primary suspension may not:

(a) Admit patients except for previously scheduled admissions or elective surgery,
(b) Schedule elective surgery for new inpatients or outpatients, or
(c) Treat ambulatory care patients.

Practitioners placed on primary suspension may:

(a) Admit emergent patients,
(b) Continue to provide care for all patients admitted prior to date of primary suspension,
(c) Continue with previously scheduled admission or elective surgeries, and
(d) Fulfill his/her emergency call room rotation obligation.

The Practitioner will be notified of the Primary Suspension by email or fax. The notification will include a statement that Full Suspension will be imposed if delinquent entries are not completed within twenty-one (21) days from the date of the notice. If the Practitioner does not complete the H&P or Operative Report after Primary Suspension within twenty-one (21) days, the Practitioner will be suspended and receive notice of Full Suspension by fax or email.

ARTICLE XI. PROVISION OF EMERGENCY CARE

11.1 PARTICIPATION IN THE ON-CALL ROSTER

Each member of the Medical Staff shall participate in coverage to the Emergency Department in his respective specialty per his department’s policy which is subject to periodic review and approval by the Medical Board and Board of Trustees. If there is adequate coverage by other Practitioners in the specialty, Active Staff members 55 years of age or older with at least three years of ED call, or any member who has participated in ED call for 15 years or longer, will not be required to participate in ED call responsibilities for unassigned Patients in his specialty, and may opt out of ED call responsibilities.

Unless specifically exempted by the Medical Board and the Board of Trustees for good cause shown, each member of the Staff assigned to the ED on-call roster agrees that, when he is the designated Practitioner on call, he will accept emergency transfers from other Hospital emergency departments in accordance with the Emergency Medical Treatment and Active Labor Act and responsibility during the time specified by the published schedule for providing care to any Patient in any unit of the Hospital referred to the service for which he is providing ED on-call coverage including providing in-house consultations as requested. If there is a conflict with the published schedule, it is the Staff member’s responsibility to arrange appropriate coverage arrangements and notify the Medical Staff Office within five days. All Practitioners on call must respond to call within 30 minutes. If the Practitioner assigned to the ED on-call roster is delegating his service to a covering Practitioner, it is the Practitioner’s responsibility to ensure that the covering Practitioneris a member of the Hospital Medical Staff and has privileges adequate to discharge responsibilitiesand respond in the above noted time frame.

11.2 PROVISION OF EMERGENCY SERVICES

Each member of the Medical Staff must assure timely, adequate professional care for his Patients in the Hospital or for Patients currently under his care presenting themselves to the emergency room by being available or having available an eligible, alternate Practitioner with whom prior arrangements have been made.

A Practitioner remotely managing a Patient must be within the metropolis in order timely respond to the Patient’s needs. In the event the Practitioner is outside of the metropolis, the Practitioner must relinquish any patient management to his/her covering Physician and must not attempt to manage the Patient. If the Patient is likely to need a procedure, direct assessment, or bedside

intervention by the Practitioner, the Practitioner must be within 30 minutes of the Hospital if managing the Patient. If the Practitioner is not within 30 minutes of the Hospital, the Practitioner must relinquish management to his/her covering Physician.

There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community.

In a disaster, all Active staff members shall be assigned to posts as needed in accordance with the Hospital's Disaster Management Plan. It is the Physician's responsibility to report to his assigned stations as requested.

TEXAS HEALTH PRESBYTERIAN HOSPITAL PLANO
ORGANIZATION & FUNCTIONS MANUAL OF THE MEDICAL STAFF

ARTICLE I. PURPOSE

This Organization and Functions Manual ("Manual") has been created pursuant to and under the authority of the Medical staff Bylaws of Texas Health Presbyterian Hospital Plano. The purpose of the manual is to further describe the current structure of the Medical Staff and to define the mechanisms that the Medical Staff will utilize to accomplish the functions as outlined in the current Medical Staff Bylaws.

ARTICLE II. CLINICAL DEPARTMENTS AND OFFICERS

2.1 REQUIREMENTS FOR AFFILIATION WITH DEPARTMENTS

Each Department is a separate organizational component of the Medical Staff, and every Staff member must have a primary affiliation with the Department which closely reflects his professional training, experience, and current practice. A Practitioner may be granted clinical privileges in one or more of the other Departments and his exercise of clinical privileges within the jurisdiction of any Department is always subject to the Department decisions as reflected in Department minutes of that department and the authority of the Department Chair.

2.2 FUNCTIONS OF DEPARTMENTS

(a) Each Department shall recommend to the Credentials Committee written criteria for membership and the assignment of clinical privileges within the Department and its divisions. Such criteria shall be consistent with and subject to the bylaws, policies, procedures, rules and regulations of the Medical Staff and the Hospital. These criteria shall be effective when approved by the Board of Trustees.

(b) Each Department shall participate in the Medical Staff mechanism for monitoring and evaluation of the quality and appropriateness of care within the Department. The findings and conclusion of monitoring and evaluation shall be presented at departmental meetings or in some other manner designed to communicate such findings and conclusions. Written reports shall be maintained reflecting the results of all evaluations performed and actions taken.

(c) Each Department shall report results of evaluations to the appropriate Medical Staff committees. Copies of these reports shall be confidential and maintained as directed by the Medical Board and the Hospital President.

(d) Each Department shall provide adequate emergency Department coverage via written policy developed by the Department and approved by the Medical Board and the Board of Trustees.

(e) The minutes of each Department meeting shall reflect the conclusions, recommendations and actions of the activities in compliance with the above provisions and shall be made available to the Medical Board and the Board of Trustees.

(f) Each Department shall establish a mechanism for accomplishing peer review, for reviewing initial applications and reappointment applications, and for advising the Department Chair as requested.

2.3 TERM OF OFFICE AND ELIGIBILITY FOR RE-ELECTION

The term of office of a Department Chair and Department Vice-Chair is two (2) Medical Staff years. A Department Chair or Department Vice-Chair may succeed himself but for no more than two (2) consecutive terms. This limitation on the maximum number of terms may be waived if, in the selection process provided, it is determined that such waiver is in the best interest of the Department, the Hospital and its Patients. Department Chairmen and Vice-Chairmen assume office on the first day of the Medical Staff year following their election, except that an officer selected to fill a vacancy assumes office immediately up selection.

2.4 ATTAINMENT OF OFFICE

(a) Any Department Chair or Vice-Chair who has served a two-year term shall have the option to request that his name be placed in nomination to be elected to serve an additional two-year term subject to the limitations of Section 2.3 above.

(b) Should a Department Chair decline the opportunity to succeed himself, the then Vice-Chair shall have the option, but is not required, to have his name placed in nomination to be elected as Chair.

(c) No later than the third scheduled Department meeting of each year, except if a Department meets monthly or bi-monthly, in which case, the 3rd to last meeting, the Department will nominate candidates for Chair and Vice-Chair subject to Sections (a) and (b) above.

(d) Within two weeks of the meeting at which nominations are made, a ballot will be prepared and mailed, either by US Post, Campus delivery system, or electronically, to all members of the Department eligible to vote pursuant to Article III of the Medical Staff Bylaws.

(e) A date by which ballots must be received, which shall not be less than twenty-one (21) days from the date the ballot is deposited in the US Mail or in the Campus delivery system or electronically, will be indicated on the ballot. Ballots may be returned by mail in the self-addressed envelope included with the ballot, by fax to the Medical Staff Office, or electronically.

(f) Immediately following the due date, the ballots received will be tabulated and the candidate for each office (Chair and Vice-Chair) receiving a majority of the votes cast shall be elected.

(g) The results of the election shall be reported to the Medical Board and the Board of Trustees for approval and confirmation that the officers elected satisfy the qualifications for the position.

(h) Those Departments whose Chair serves as a result of a contract for services between his group and the Hospital are exempt from these election procedures. However, prior to November of each year, those Departments shall report to the Medical Board and to the Board of Trustees the name of the individual who will be serving as Chair and Vice Chair of the Department for the coming Medical Staff year.

2.5 MEDICAL DIRECTORS OF SPECIAL UNITS

A unit medical director contracted by the Hospital shall have the responsibility and authority to carry out the duties assigned to him by the contract or job description if applicable. Each medical director is responsible for overseeing the care of Patients in the unit and may intercede in the care of a Patient when and to the extent he deems necessary.

ARTICLE III. MEDICAL PEER REVIEW

3.1 MEDICAL PEER REVIEW COMMITTEE STATUS

Each committee (whether Staff or Department, standing, special, subcommittee, or joint committee, hearing committee or appellate review body), as well as the Medical Staff when meeting as a whole, shall be constituted and operate as a "medical peer review committee," "medical committee," and "professional review body," as such terms are defined by State and/or Federal law, and is authorized by the Board of Trustees through these Bylaws to engage in Medical Peer Review as defined below. This provision shall also apply to any Hospital or other committees engaged in Medical Peer Review at the Hospital.

3.2 MEDICAL PEER REVIEW DEFINED

"Medical peer review" means the evaluation of medical and health care services, including the evaluation of the qualifications and professional conduct of Practitioners and other individuals holding or applying for clinical privileges, and of patient care, treatment, and services provided by them. The term includes but is not limited to:

(a) the process of credentialing for initial appointment, reappointment, the granting of clinical privileges, and reinstatement from leave of absence;

(b) the process of issuing an Adverse Action, including but not limited to corrective action, and affording procedural rights of review as provided in the Medical Staff Bylaws and the Fair Hearing and Appellate Review Plan;

(c) any evaluation of the merits of a complaint relating to a Practitioner or AHP holding clinical privileges and issuance of a recommendation or action in that regard;

(d) any evaluation of the accuracy of a diagnosis or quality of the patient care, treatment, or services provided by one of the above individuals or other health care providers within the Hospital, including but not limited to implementation of the Hospital's quality assurance plan and the review of patient care, treatment, or services by another Practitioner, whether or not a member of the Staff;

(e) a report made to an individual or a committee engaged in Medical peer review or to a licensing agency;

(f) implementation of the duties of a committee engaged in Medical peer review by a member, agent, or employee of the committee; and

(g) "Medical peer review" as defined in the Texas Medical Practice Act and "professional review activity" as defined by the Federal Health Care Quality Improvement Act.

3.3 AGENTS AND MEMBERS

The Hospital President, other members of Administration, the Medical Staff Office, and all other Hospital departments supporting Medical Peer Review activities shall be considered agents of the Staff committees and the Staff as applicable when performing the authorized functions and responsibilities of the committees. Practitioners, whether or not members of the Staff, who are requested by a Staff committee or the Board to review the patient care, treatment, or services of another Practitioner and/or who do so as an authorized function of the Staff or a Staff committee, Department or Department committee, or the Board shall be considered agents of the committee or the Board when performing such review in good faith. Any good faith action by an agent or member of the Staff or a Staff committee, Department or Department committee, or the Board when performing such functions and responsibilities shall be considered an action taken on behalf of the Staff, appropriate Staff committee, Department, appropriate Department committee, or the Board as applicable, not an action taken in the agent's or member's individual capacity. This shall include, but not be limited to, actions by a Staff or Department officer, Practitioners serving in medico-administrative positions, and the Hospital President.

3.4 CONFIDENTIALITY

3.4.1 GENERAL

All records and proceedings of the Staff, all Departments, all Staff and Department committees (whether standing, special, subcommittees, or joint committees, or a hearing committee or appellate review body), and the Board, including but not limited to any minutes of meetings, disclosures, discussion, statements, actions, or recommendations in the course of Medical Peer Review, shall be privileged and confidential, subject to disclosure only in accordance with written Staff and Hospital policies, unless otherwise required by State and/or Federal law, and shall be privileged to the fullest extent permitted by State and/or Federal law.

3.4.2 OBLIGATION TO MAINTAIN CONFIDENTIALITY

All Staff members and others holding clinical privileges, as well as those applying for such status, and all other individuals participating in, providing information to, or

attending meetings of the Staff, Staff committees, Departments or their committees, or the Board, or serving as agents or members thereof, are required to maintain the records and proceedings related to any Medical peer review activities as confidential, subject to disclosure only in accordance with Staff and Hospital policies, unless otherwise required by State and/or Federal law.

3.4.3 WAIVER

Waiver of the privilege of confidentiality as to the records and proceedings of any meeting or committee subject to this Section shall require the written consent of the chair of the committee or presiding officer and the Hospital President.

3.4.4 MAINTENANCE AND ACCESS

The records and proceedings of all meetings and committees subject to this Section shall be the property of the Hospital and maintained by the Medical Staff Office. They will be available for inspection by the Medical Board, the Hospital President, the Board, and any employees and agents of the Hospital whose authorized functions necessitate access. A member of a Staff committee, Department, or Department committee may also inspect the records and proceedings of that Staff committee, Department, or Department committee which were generated during his/her service as a committee or Department member, as long as he/she is currently a member of the Staff. Access is also permitted pursuant to Hospital policy and as required by State and/or Federal law, accreditation requirements, or third-party contract of the Hospital. Access of a Practitioner to records and proceedings that address the Practitioner shall be only as required by law or as approved by the Hospital President.

3.5 IMMUNITY FROM LIABILITY

3.5.1 IMMUNITY

The Staff and its members, the Board, the Hospital, and any committees, representatives, agents, employees, or members thereof, and third parties as defined below, will have absolute immunity. This immunity shall be to the fullest extent permitted by State and Federal law and shall include any permissive and mandatory reporting provided for by State and Federal law.

3.5.2 AUTHORIZATIONS AND RELEASES

All applicants for appointment to the Staff, reappointment, and/or clinical privileges shall execute a release of liability consistent with the immunity and release of liability provisions in these Bylaws and an authorization for the Hospital, the Staff, and third parties to disclose confidential information as necessary for Medical peer review in the course of application and at all times thereafter; provided that, the effectiveness of the immunity provisions of these Bylaws is not contingent on execution of these authorizations and releases. Further, the immunity provisions in these Bylaws and any releases of liability shall be in addition to and not in limitation of any immunity afforded by State and Federal law.

3.6 MANDATORY REPORTING

The Hospital President, in consultation with the Medical Staff President, shall be responsible to comply with any mandatory reporting requirements of the Hospital under State and/or Federal law pertaining to Staff membership and/or clinical privileges. Nothing in this section or the other provisions of the Bylaws shall prevent an individual Staff member or member of the Board from making any other report to State and/or Federal agencies as permitted or required by law.

3.7 CONFLICT OF INTEREST – MEDICAL PEER REVIEW

3.7.1 DISCLOSURE

Whenever a Practitioner is participating in Medical Peer Review and/or performing a

function for the Staff or a Department, or a committee thereof, or the Hospital, and the Practitioner's personal or professional interests could be reasonably interpreted as being in conflict with the interests of the Staff, Department, committee, Hospital, or individual under review, the Practitioner shall disclose those interests and the potential for conflict to the appropriate decision makers prior to such participation. The appropriate chairperson or the Medical Staff President, with the approval of the Hospital President, or the Hospital President may require the Practitioner to refrain from any participation in decisions that may be affected by or affect the Practitioner's interests.

3.7.2 DISQUALIFICATION

A Practitioner shall not be eligible to participate in, or be present during, any meeting, discussion, or deliberation of a committee or Department of which he/she is a member regarding his/her clinical privileges or Staff membership or any other Medical peer review activity involving the Practitioner, except to the extent specifically provided for in the Bylaws, Rules and Regulations, a Manual, or Staff policy, or when invited by the chairperson.

Any family members or business partners of a Practitioner shall not be eligible to participate in, or be present during, any meeting, discussion, or deliberation of any committee or Department regarding the Practitioner's clinical privileges or Staff membership or any other Medical Peer Review activity involving the Practitioner. "Family member" shall mean a Practitioner's (i) parents or stepparents, including spouses of the same, (ii) ancestors, (iii) spouse, (iv) child or stepchild, grandchild, or great grandchildren, (v) siblings, whether related by whole or half blood, or (vi) the spouse of an individual described in clause (iv) or clause (v), and shall include adoptive relationships of the above.

ARTICLE IV. MEDICAL STAFF MEETING PROCEDURES

4.1 MEDICAL STAFF MEETINGS

The regular Medical Staff meetings will be held semi-annually in the months of June and December.

4.2 SPECIAL MEETINGS

A special meeting of the Medical Staff may be called by the Medical Staff President, the Hospital President, President of the Board of Trustees, the Board of Trustees or its authorized committee, a majority of the Medical Board or pursuant to a petition signed by at least twenty (20) percent of the members of the Active Staff in good standing. The request for the special meeting must state the reason for or business to be conducted at the meeting and that shall be the only business conducted at the meeting. A special meeting shall be held within ten (10) days of a proper request.

4.3 DEPARTMENT AND COMMITTEE MEETINGS

Department and committees may, by resolution provide the time for holding regular meetings. A Department must meet at least quarterly or more frequently as necessary. The frequency of committees is as required by the Bylaws for each committee and otherwise as established by the resolution creating a committee.

4.4 SPECIAL MEETINGS OF DEPARTMENT OR COMMITTEES

A special meeting of any Department or committee may be called, respectively by the Department Chair or committee chair, or, or one-fourth of the current voting members of the Department or committee in good standing but not less than two. The Medical Staff President may also call a special meeting of a Department or committee. The request for the special meeting must state the reason for or business to be conducted at the meeting and that shall be the only business conducted at the meeting. A special meeting shall be held within ten (10) days of a proper request.

4.5 ATTENDANCE REQUIREMENTS

Practitioners are encouraged but are not required to attend Medical Staff Department, general Medical Staff, or committee meetings.

4.6 NOTICE OF MEETINGS

Written notice of a meeting shall be provided to all Provisional Active and Active members at least ten (10) days prior to the meeting.

4.7 QUORUM

(a) Medical Board - the presence of at least fifty-one percent (51%) of the voting members of the Medical Board shall constitute a Quorum.

(b) All Other Meetings - For any other meetings, unless otherwise provided in the Bylaws or this Manual, a Quorum shall constitute the members present and voting.

4.8 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a Quorum is present is the action of the group. Action may be taken without a meeting by the Medical Staff, Department or committee by presentation of the question to each member eligible to vote, in person or by mail, and their vote returned to the chairman of the group or the Medical Staff President in the case of a Medical Staff vote. Such vote shall be binding so long as the question is voted on by at least the number of voting members of the group that would constitute a Quorum. There is no voting by proxy or absentee ballot.

4.9 AGENDA AND PROCEDURE

Except as provided above for special called meetings, the Medical Staff President for Medical Staff meetings and the Department or committee chairman shall establish the agenda for each meeting. Meetings will be conducted according to the current edition of Robert's Rules of Order. In the event of conflict between the Bylaws and Robert's Rules of Order, the Bylaws shall control.

ARTICLE V. COMMITTEE STRUCTURE

5.1 COMMITTEE CHAIRMAN

All committee chairmen shall be appointed by the Medical Staff President in consultation with the Medical Board. All committee chairmen shall be selected from among persons appointed to the Active Staff.

5.2 COMPOSITION AND APPOINTMENT OF MEMBERS

A Medical Staff committee created in the Bylaws or otherwise is composed as stated in the description of the committee. Medical Staff members of each committee, except as otherwise provided in these bylaws, shall be appointed by the Medical Staff President following consultation with the Medical Board and must be members in good standing. Allied health professionals and representatives from Administration and Hospital Departments as are appropriate to the functions to be discharged may be appointed by the Hospital President. Each designated member of a committee participates with vote, unless the statement of committee composition designates the position as non-voting. The Hospital President or his designees shall be members ex officio without vote, of all Medical Staff committees unless the statement of committee composition designates the position as voting. With the exception of the Medical Board, the Medical Staff President may, in consultation with the committee chairman, make additional appointments to any committee as deemed necessary for the committee to carry out its functions.

5.3 TERM, PRIOR REMOVAL AND VACANCIES

Except as otherwise expressly provided, each appointed committee member serves a one-year term, coinciding with the Medical Staff Year, unless he sooner resigns or is removed from the

committee or the Medical Staff and may be reappointed to the committee for an unlimited number of terms.

A Practitioner serving on a committee, (except one serving Ex-Officio), may be removed by the Medical Staff President from the committee for failure to maintain himself in good standing as a Staff member or if he is unable to meet the responsibilities and obligations of the committee. A vacancy in any committee is filled for the un-expired portion of the term in the same manner in which original appointment is made.

ARTICLE VI. COMMITTEES OF THE MEDICAL STAFF

6.1 BYLAWS COMMITTEE

6.1-1 COMPOSITION

The Bylaws Committee shall consist of at least three (3) members of the Medical Board appointed by the Medical Staff President

6.1-2 RESPONSIBILITIES AND FUNCTIONS

(a) Maintain the Medical Staff Bylaws and Rules and Regulations and accompanying manuals on an ongoing basis.
(b) Periodically conduct an in-depth review of the Bylaws, Rules and Regulations and accompanying manuals.
(c) Submit written recommendations in accordance with the Bylaws for change in these documents.

6.1-3 MEETINGS

The Bylaws Committee shall meet as often as needed.

6.2 PATIENT SAFETY CLINICAL RISK REVIEW COMMITTEE

6.2-1 COMPOSITION

The Clinical Risk Review Committee shall be composed of a minimum of the following:
(a) The Chief Medical Officer as Chair
(b) The Co-Chair, Vice Chair or designee of the Medical Staff Departments of all high volume, high risk services as determined by the Medical Staff President;
(c) A representative from Administration
(d) A representative from Nursing
(e) A representative from Ancillary Services, as necessary
(f) A representative from Claims Management
(g) A representative from Performance Improvement
(h) A representative from Risk Management
(i) A representative from Legal Services, as necessary

6.2-2 RESPONSIBILITIES AND FUNCTIONS

(a) Develop and implement methods for identification, evaluation and prevention of issues which may cause injuries to Patients, visitors, employees, volunteers, Medical Staff; and other independent contractors.
(b) Recommend strategies for loss prevention including, but not limited to:
  (1) Guideline development, modification and/or deletion; and
  (2) Protocol development, modification and/or deletion;
(c) Review and evaluate aggregate risk data identified through the risk identification system;
(d) Monitor Medical Peer Review activities;
(e) Review and evaluate individual occurrences and sentinel events identified through the risk identification system and conduct root cause analysis of those events;

(f) Review the facts and potential risk issues identified through claims and litigation for Medical Peer Review and process improvement opportunities;
(g) Review potential risk issues from a general communication directed to the committee;
(h) Identify trends, practice patterns, processes and systems of potential risk exposure;
(i) Refer identified issues to the appropriate department chairman and/or Hospital or Medical Staff committee;
(j) Instruct the risk manager, associated risk management personnel and/or Department of Risk Management to conduct an Investigation of identified risk exposure and reports of dissatisfaction pursuant to the authority of this Committee on its behalf, with the risk manager to report his/her findings to the designated risk management committee for the purpose of carrying out committee functions;
(k) Report committee findings, conclusions, recommendations, actions and effectiveness of actions through the Performance Improvement and Risk Management Programs, Medical Board, and Board of Trustees,
(l) Designate ad hoc members for the purpose of executing committee activities, recommendations and duties;
(m) Maintain records and minutes of committee activities; and
(n) Maintain confidentiality.

6.2-3 MEETINGS

The Clinical Risk Review Committee shall meet every other month or more often as needed.

6.3 CREDENTIALS COMMITTEE

Service on the Credentials Committee shall be considered the primary Medical Staff obligation of each member, and other Medical Staff duties of an administrative nature shall not interfere. All new members of the Credentials Committee, either prior to beginning to serve or while serving on the committee, are strongly encouraged to obtain specific education and training regarding the credentialing process provided by the Hospital.

6.3-1 COMPOSITION

The Credentials Committee shall be composed of a minimum of the following:
(a) A Chair;
(b) At least four members of the Active Medical Staff from the major clinical specialties;

(c) Hospital President or designee, without vote;
(d) Medical Staff Credentialing personnel, as staff, and without vote; and
(e) At least one past Medical Staff President, with vote.

6.3-2 RESPONSIBILITIES AND FUNCTIONS

The Credentials Committee shall:
(a) Coordinate the credentialing and delineation of privileges process for Practitioners and other individuals with clinical privileges;
(b) Recommend policies, procedures, protocols and forms for appointment and reappointment and the granting of clinical privileges;
(c) Review the recommendations of the Department chairman regarding appointment, reappointment and clinical privileges delineation;
(d) Approve qualifications for granting privileges;
(e) Make recommendations for clinical privileges;
(f) In the course of appointment, reappointment processing and as otherwise requested, investigate, review and report matters regarding clinical or ethical

conduct of any Practitioners and report findings to the Medical Board as requested;

(g) Make recommendations to the Medical Board concerning appointments, re-appointments, Department affiliation and clinical privileges on all applicants to the Medical Staff;

(h) Review and recommend, as questions arise, criteria for new clinical privileges and for privileges that involve different specialties;

(i) Recommend, upon request from Administration, whether new procedures or services should be offered to Patient at the Hospital;

(j) Assist Department chairmen in resolving problems with Practitioners as requested;

(k) Keep records and minutes of all committee meeting activities; and

(l) Observe the confidentiality policies of the Medical Staff.

6.3-3 MEETINGS

The Credentials Committee shall meet at least every other month or more often as needed.

6.4 CLINICAL INFORMATION COMMITTEE

6.4-1 COMPOSITION

(a) A Chair;

(b) At least four members of the Active Medical Staff from the major clinical; specialties.

(c) Manager of Health Information Management;

(d) Administrative Director of Patient Care Services;

(e) Ancillary Department representatives as appropriate;

(f) Director of Information Services;

(g) Director of Care Transition;

(h) Lead of Clinical Documentation Specialist;

(i) Director of Quality Management;

(j) Chief Medical Officer;

(k) Director of Patient Access Services; and

(l) Director of Privacy and Compliance.

6.4-2 RESPONSIBILITIES AND FUNCTIONS

(a) Coordinate the analysis of timeliness, completion, and clinical pertinence (quality of documentation) of clinical information quarterly.

(b) Provide service line information regarding the quality of clinical information to process improvement committees and Medical Staff departments quarterly.

(c) Be responsible for the development, review, revision and/or deletion of clinical information policies:

- retention
- access
- documentation

(d) Enforce record completion requirements.

(e) Approve additions, deletions or revisions of medical record forms as recommended by the Forms Committee.

(f) Review case management data for opportunities for improvement and take action when appropriate.

(g) Review Clinical Documentation data for opportunities for improvement and take actions when appropriate

(h) Review Electronic Health Record data for opportunities for improvement and take actions when appropriate

(i) Report the Committee findings, conclusions, and recommendations to the Medical Board and/or Performance Improvement Council as appropriate.

(j) Keep records and minutes of all committee meeting activities.
(k) Observe confidentiality policies.

6.4-3 MEETINGS

The Clinical Information Committee will meet at least quarterly or more often as needed.

6.5 CLINICAL PRACTICE COMMITTEE

6.5-1 COMPOSITION

(a) Co- Chairs, one of whom is a Medical Staff member from Infection Control and one of whom is a Medical Staff member from Medicine;
(b) Staff representatives from each of the following medical specialties: Cardiology, Emergency Medicine, Family Practice, Hematology/Oncology, OB/GYN, Pediatrics, Pulmonologist, Psychiatry, and Surgery;
(c) Administrative Director of Patient Care Services;
(d) Director of Pharmacy;
(e) Director of Laboratory Services; and
(f) Representative from Infection Control.

6.5-2 FUNCTIONS

(a) Reviews findings of the Infection Control program and approves goals and initiatives;
(b) Annually reviews successes and opportunities for improvement, anti-microbial susceptibilities and resistance trends, and approves revisions;
(c) Reports committee findings, conclusions and recommendations to the Performance Improvement Council and other committees/departments as appropriate;
(d) Develops and maintain drug formulary;
(e) Evaluates requests for additions and deletions to the formulary;
(f) Approves policies regarding administration, selection, procurement, distribution and use of drugs;
(g) Review adverse drug reactions and interactions;
(h) Reviews reports on the activities of the Medication Use Subcommittee regarding opportunities to improve medication administration, trends in actual and near miss medication events and actions for improvement;
(i) Submits Med Use Subcommittee finds, conclusions and recommendations quarterly to the Patient Safety Clinical Review Committee;
(j) Review Drug Utilization data for the opportunities for improvement and take action when appropriate;
(j) Maintains records and minutes of all committee meeting activities; and
(k) Maintains confidentiality.

6.5-3 MEETINGS

The Infection Control committee shall meet quarterly or more often as needed.

6.6 HEALTH AND REHABILITATION COMMITTEE

6.6-1 COMPOSITION

(a) A Chair;
(b) Physician member of the Department of Psychiatry (who may also serve as the Chair;
(c) Medical Staff Officer;
(d) Hospital President or designee; and
(e) Department Chair and/or Vice Chair shall be asked to participate in any meeting at which a member of their Department is involved;
(f) Other participants, upon invitation by the chairman, who may be requested to

service as resources for specific issues.

The Chairman, or his designee, may act on behalf of the Committee in carrying out the responsibilities and the functions of the Committee. The Chairman, or his designee shall report to the Committee at its next meeting (or earlier if deemed necessary) of any action taken or recommendation made. Any acts of the Chairman shall be considered to be an act of the full Committee.

6.6-2 RESPONSIBILITIES AND FUNCTIONS

The duties of the Physician Health and Rehabilitation Committee shall include, but are not be limited to, the following:

(a) Receive and consider information received by self-referral or referral by other staff of the organization related to the health or well-being of Medical Staff members or Allied Health Practitioners, conducting Investigation and seeking corroboration to evaluate the credibility of a complaint, allegation or concern received by medical or other staff of the organization;

(b) Provide advice and assistance to the Practitioner in question, make recommendations regarding referral of the affected Practitioner to the appropriate professional internal or external resource for diagnosis and treatment of the condition or concern;

(c) Make recommendations to the Medical Board, including recommendations for leave of absence, regarding a Practitioner who has demonstrated health problems and/or impairment (which includes disruptive behavior), and make recommendations regarding the status of a Practitioner who has requested reinstatement following Leave of Absence for health and/or impairment;

(d) Oversee the monitoring of Practitioners with health and/or impairment problems and the safety of Patients until the rehabilitation or any disciplinary process is complete in accord with approved policies and procedures;

(e) Receive periodic progress reports from treating or monitoring entities;

(f) Make recommendations to the Medical Board regarding policies and procedures which establish the mechanisms and guidelines concerning submission of reports regarding the health or well-being of a Practitioner, types of health and/or impairment issues to be considered, the Investigation process, intervention, monitoring, reinstatement, referrals, and record keeping processes;

(g) Maintain all activities in a confidential manner, except as limited by law, ethical obligation, or when the safety of a Patient is threatened. The decision to disclose will be made by the Hospital President in consultation with the Medical Staff President who will also make the decision as to who will disclose the information and as to whom the information can be disclosed;

(h) Provide education to the Members of the Medical Staff and other staff of the organization about Practitioner health, well-being and impairment; about recognition and appropriate responses to different levels and kinds of distress and impairment; and about appropriate resources for prevention, treatment and rehabilitation;

(i) Report to the Medical Board if a Practitioner may be providing unsafe treatment; and

(j) Keep records and minutes of all committee meeting activities.

6.6-3 MEETINGS

The Physician Health and Rehabilitation Committee shall meet on an as-needed basis.

6.7 NOMINATING COMMITTEE

6.7-1 COMPOSITION

(a) Medical Staff President-Elect, serving as Chair;

(b) Two members from the Medical Board; and

(c) Two at large members from the Medical Staff.

6.7-2 RESPONSIBILITIES AND FUNCTIONS

(a) Identify nominees for election to general Staff offices in accordance with the Bylaws and this Manual.
(b) Consult with members of the Medical Staff or of the appropriate constituent group, as appropriate, and the Hospital President concerning the qualifications and acceptability of prospective nominees.

6.7-3 MEETINGS

The Nominating Committee will meet at least annually.

6.8 PROFESSIONAL ACTIVITIES COMMITTEE

6.8-1 COMPOSITION

(a) Past Medical Staff President as Chair;
(b) Current Medical Staff President;
(c) Current President-Elect of the Medical Staff;
(d) Member of Board of Trustees appointed by the Board of Trustees Chair;
(e) Department Chairs shall be asked to participate on an ad hoc basis t at which a member of their Department is involved;
(f) Chief Medical Officer; and
(g) Other participants, upon invitation by the Chair, may be requested to serve as resources for specific issues.

6.8-2 RESPONSIBILITIES AND FUNCTIONS

(a) Investigate matters of professional and ethical conduct;
(b) Investigate questions of competency in regard to behavior and citizenship of Practitioners within the Hospital setting.

6.8-3 MEETINGS

The Professional Activities Committee will meet on an as-needed basis.

6.9 CLINICAL QUALITY AND PATIENT SAFETY COMMITTEE

Clinical Quality and Patient Safety Committee is formed to identify and analyze opportunities for improvement in quality, service, and cost of patient care and community processes across the continuum. There is at least one process improvement committee in each organization. Physician membership shall be as appointed by the Medical Staff President. The Committee shall meet as often as necessary to carry out the tasks and responsibilities identified / assigned.

6.9-1 AUTHORITY

The Clinical Quality and Patient Safety Committee has the authority to manage the following aspects independently within the following framework:

(a) Decision making regarding the clinical process or processes it is responsible for, if the decision does not have the potential to affect any other clinical process within the organization.
(b) Each member of the Clinical Quality and Patient Safety Committee will have one vote.
(c) Decisions involving the professional scope of practice as identified by state licensing boards will be made by that profession.

6.9-2 RESPONSIBILITY

The Clinical Quality and Patient Safety Committee has the responsibility to:

(a) Include such ad hoc members as are necessary.
(b) Plan for smooth implementation regarding the changes to the clinical process.
(c) Communicate the changes, with prospective start dates, to all involved parties

(includes Departments, both Medical Staff and Hospital).
(d) Report actions and follow-up to the Medical Board.
(e) Refer identified peer review issues to the appropriate Department.
(f) For changes affecting more than one area or Hospital-wide issues, refer the issue to the appropriate committee(s) for coordination or oversight.
(g) Report back to represented Departments and sections, the results of review, subsequent actions and improvements regarding processes.

6.9-3 FUNCTIONS

The functions of the Clinical Quality and Patient Safety Committee include:

(a) Conduct Patient focused process review by service line
(b) Consider data from the following sources for opportunities for improvement in the Quality, Cost or Service of identified process:
  (1) Clinical Outcomes
  (2) Comparative and/or benchmark data
  (3) Operative, invasive and non-invasive procedures
  (4) Processes related to the use of blood and blood products
  (5) Processes related to medication use
  (6) Infection surveillance, prevention and control
  (7) Risk and safety management
  (8) Resource utilization
  (9) Patient / Family education
  (10) Medical record review
  (11) Monitoring and evaluation of important aspects for all Departments involved in service line.
  (12) Critical pathway/protocol evaluation
  (13) Customer Satisfaction
(c) Continually attempt to improve care delivery based on data analysis.
(d) Report back to represented Departments, the results of review, subsequent actions and improvements regarding processes
(e) Recommend needed educational programs to the Medical Board as identified through quality activities.
(f) Refer identified peer review issues to the appropriate Department
(g) Develop policies and procedures that result from process improvement activities
(h) Comply with regulatory / accreditation requirements where applicable
(i) Keep records and minutes of committee meeting activities
(j) Observe confidentiality policies.

6.9-4 CANCER SUBCOMMITTEE

The Cancer Subcommittee is a standing subcommittee of the Clinical Quality and Patient Safety Committee. The Cancer Subcommittee composition, duties, responsibilities, requirements, and meeting frequency fulfills the standards set forth in the current edition of the Commission on Cancer (“CoC”) Program Standards. The Cancer Subcommittee is responsible and accountable for all cancer program activities at the Hospital. Each Required member of the committee must attend 50% of meetings annually. All Physicians on the committee are currently board certified or in the process of certification. The Cancer Subcommittee will meet at least once each calendar quarter. The Cancer Subcommittee will follow all of the committee’s Policies/Procedures.

6.10 MEDICAL ETHICS COMMITTEE

The role of the Medical Ethics Committee is to provide education on important ethical issues in healthcare to caregivers, care recipients, and the community. In addition, the Medical Ethics Committee serves as a forum for health care professionals to participate in the discussion and resolution of ethical issues that arise in the daily provision of medical care.

6.10-1 COMPOSITION

(a) Chair;
(b) At least four members of the Medical Staff from the major clinical specialties;
(c) Ancillary Department representatives as appropriate;
(d) Community member(s) appointed by the President of the Medical Staff as a voting member.

6.10-2 RESPONSIBILITIES AND FUNCTIONS

(a) Provide Hospital employees and Medical Staff members with a forum for addressing ethical medical issues;
(b) Provide educational support to the Medical Staff, Hospital staff and members of the community regarding important ethical issues;
(c) Perform studies at the direction of the Medical Board to assess the effectiveness of ethical considerations in the clinical decision-making process;
(d) Develop policies and incorporate legal requirements regarding Patient rights and responsibilities into appropriate policies and develop an effective communication plan;
(e) Serve as a forum for consultation by a Patient or Patient's designated representative when ethical issues arise during the Patient's care in accordance with written policy;
(f) Report to the Medical Board and back to represented Departments, the results of review, subsequent actions and improvement regarding processes;
(g) Comply with regulatory/accreditation requirements where applicable;
(h) Keep records and minutes of all committee meeting activities; and
(i) Observe the confidentiality policies of the Medical Staff.

6.10-3 MEETINGS

The Medical Ethics Committee shall meet quarterly or more often as needed.

6.11 INSTITUTIONAL REVIEW BOARD

The Hospital utilizes the Texas Health Resources Institutional Review Board (IRB) to carry out the functions associated with review of any research protocols and activities to be conducted on the Hospital Campus. The Medical Board reviews and recommends to the Board of Trustees, research activities to be conducted at the Hospital. The Board of Trustees has final authority over research activities conducted at the Hospital. Research protocols may be carried out at the Hospital only if approved both by the IRB and the Board of Trustees.

QPC approved: 6/30/2020; 9/30/2020; 11/30/2021