MEDICAL STAFF BYLAWS

Texas Health Harris Methodist Hospital Alliance

Effective date: 04/01/2024

PREAMBLE

Whereas, the Physicians and other licensed independent Practitioners who are appointed to the Medical Staff at Texas Health Harris Methodist Hospital Alliance ("Hospital") are organized to provide leadership for the Medical Staff and accountable to the Board of Trustees as required by legal and accreditation requirements.

Whereas, the Board of Trustees of Texas Health Harris Methodist Hospital Alliance intends to utilize an operating model for the hospital referred to as "co-management" which uses a shared-governance leadership structure with the medical staff organization;

Whereas, the physicians and other licensed independent practitioners who are appointed to the Medical Staff at Texas Health Harris Methodist Hospital Alliance will be organized to provide leadership for the Medical Staff and also serve as the clinical arm of the shared-governance leadership structure of Hospital; and

Therefore, these Medical Staff Bylaws set out:

- The organization and structure, rights, and obligations of the Medical Staff of Hospital and its Members, and the relationship of the Medical Staff and its Members to the Board of Trustees;
- the Medical Staff's responsibility for the oversight, review, and appraisal of the quality of the professional services provided by Members of the Medical Staff and others with Clinical Privileges;
- the mechanism by which Medical Staff membership and Clinical Privileges are granted, limited, and terminated; and
- the Medical Staff's accountability to the Board of Trustees.

DEFINITIONS

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

Advanced Practice Provider ("APP") is an individual, other than a Practitioner, who provides a "medical level of care" (as that term is used by the Centers for Medicare & Medicaid Services) or performs surgical tasks consistent with granted Clinical Privileges, but who may be required by law and/or the Hospital to exercise some or all of those Clinical Privileges under the direction of, or in collaboration with, a Supervising/Collaborating Physician pursuant to a written supervision/collaborative agreement. Prescriptive authority is outlined separately from Clinical Privileges for APPs; and, therefore, APPs are deemed to have prescriptive authority within the Hospital only if specified on the relevant delineation of Privileges (approved APPs include Physician Assistants ("PA") and Advanced Practice Registered Nurse ("APRN"). APRNs include Certified Nurse Anesthetists, Certified Nurse Midwives, and/or Clinical Nurse Specialist ("CNS") [TX BON 221.2]).

Allied Health Professional ("AHP") is an individual who is permitted by law or the Hospital to function only under the direction of a Supervising/Collaborating Physician pursuant to an established supervision or sponsorship relationship and consistent with a defined Scope of Service. Allied Health Professionals do not provide a "medical level of care" (as that term is used by the Centers for Medicare & Medicaid Services) and are not Practitioners nor APPs as defined in these Bylaws.

Article: An article in these Bylaws.

Board of Trustees: The governing body of Hospital has the ultimate responsibility and authority for the operation of the Hospital as required by legal and accreditation requirements and may delegate its authority to a committee.

Bylaws or **Medical Staff Bylaws**: These Medical Staff Bylaws of the Medical Staff of Hospital.

Chair of the Board of Trustees: The individual elected by Hospital Board of Trustees who is responsible for presiding over the Hospital Board of Trustees. Unless otherwise provided in these Bylaws, any reference to the Chair of the Board of Trustees shall include their designee.

Chief Quality & Medical Officer ("CQMO"): The individual appointed by the Hospital President to provide strategic, long-term direction for the Hospital's clinical quality, patient safety, and risk management programs, and build support and involvement with the Medical Staff. Unless otherwise provided in these Bylaws, any reference to the Hospital CQMO shall include their designee.

Clinical Council: A committee of Medical Staff members from a specific service line responsible for the overall management of the service line and Medical Peer Review, as further described in Article 5.

Clinical Council Physician Co-Chair: The physician Member of the Medical Staff serving as co-chair of the Clinical Council, as further described in Article 6.

Clinical Privileges: Permission granted to Practitioners and certain Advanced Practice Providers to provide patient care, treatment, and services, including access to Hospital equipment, facilities, and personnel.

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

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

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

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

FPPE: Focused Professional Practice Evaluation of a Practitioner, as referenced in Article 9 and/or in Medical Staff policy.

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

Hospital: Texas Health Harris Methodist Hospital Alliance

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

Investigation: An investigation as defined in Section 12.4.

Leadership Council: The medical executive committee of the Medical Staff and clinical arm of the shared governance co-management environment as detailed in Article 5.

Leadership Council Physician Co-Chair: The physician Member of the Medical Staff serving as co-chair of the Leadership Council and responsible for the organization and conduct of the Medical Staff, as further described in Article 6. The Leadership Council Physician Co-Chair may also be referred to as the Chief of Staff.

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

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

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

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

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

Member: A Practitioner (herein defined as Physician, Dentist, Oral Maxillofacial Surgeon, or Podiatrist) who has been appointed to the Medical Staff in accordance with these Bylaws.

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

OPPE: Ongoing Professional Practice Evaluation of a Practitioner, as referenced in Section 2.5.3, Article 9, and Medical Staff policy.

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

Patient Contacts: Patient care activities in the Hospital or one of its affiliated outpatient centers, carried out by the Member (or APP under the delegation, direction, and/or supervision of a Member) as detailed below pursuant to a Member's Clinical Privileges, defined as:

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

Any of the above activities when carried out by an APP under the direct or indirect supervision of the Member will be attributed to the Member.

A Patient Contact does not include referrals solely for outpatient diagnostic procedures (e.g., a referral for lab or imaging services).

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

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

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

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

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

Quality Assurance and Performance Improvement ("QAPI"): The Hospital's written plan for performance improvement activities including, but not limited to, those conducted through Medical Peer Review.

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

Service Line: A grouping of Members of the Medical Staff from multiple clinical specialties organized around a disease, organ system, clinical procedure/intervention, or patient population, who come together on a regular basis to conduct Medical Peer Review related to the Service Line and discuss issues in a collaborative multi-specialty environment, as further detailed in Article 5.

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

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

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

System: Texas Health Resources ("THR"), the sole corporate member of Hospital.

Task Force: A committee of Members of the Medical Staff chartered by the Leadership Council or a Clinical Council, in accordance with Section 5.5, to accomplish a specific task. A task force should be of finite duration and disband upon accomplishment of its stated goal.

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

1. MEDICAL STAFF STRUCTURE, FUNCTION, AND PURPOSES

1.1. STRUCTURE AND FUNCTIONS

1.1.1. The Medical Staff is structured through the use of Medical Staff categories and Service Lines as set out in Articles 3 and 5.[2] Performance of the functions of self-governance and other Medical Staff responsibilities are accomplished primarily by the voting Members of the Active Staff serving as the "Organized Medical Staff" as defined by The Joint Commission, the Leadership Council and the Clinical Councils, and other committees of the Medical Staff, as detailed in these Bylaws in Articles 5 and 6, the Rules and Regulations, the Manuals, and the Medical Staff policies.[3]

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

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

[2] Joint Commission Accreditation Standards for Hospitals, MS.01.01.01 EP 12.
[3] Department of State Health Services, Hospital Licensing Standards, 25 Tex. Admin. Code Sec. 133.41(k)(3)(C).
[4] MS.03.01.01.

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

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

1.2. PURPOSES AND OBLIGATIONS

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

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

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

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

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

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

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

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

1.2.1.8. Review and evaluate the qualifications of APPs (and where applicable, AHPs), permissible Clinical Privileges and scope of practice, and appropriate level of delegation, direction, and/or supervision, and make recommendations to the Board of Trustees as set forth in Hospital policy.

2. MEDICAL STAFF MEMBERSHIP

2.1. GENERAL

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

[5] MS.01.01.01 EP 1.
[6] MS.01.01.01 EP 4; see also Medicare Conditions of Participation, 42 C.F.R. Sec. 482.11(a).
[7] 42 C.F.R. Sec. 482.12(a)(5), 482.22(b); 25 Tex. Admin. Code Sec. 133.41(k)(2).
[8] 25 Tex. Admin. Code Sec. 133.41(f)(4)(E), 133.41(k)(1); 42 C.F.R. Sec. 482.22(a).

have been appointed to the Medical Staff and/or who have been granted Clinical Privileges in accordance with these Bylaws may admit and treat patients in the Hospital.

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

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

2.1.4. Resources. In making decisions regarding appointment to the Medical Staff, the number of Practitioners necessary for a specialty or required for Hospital services and specialties of current Members, the availability of Hospital services, the needs of the community served by the Hospital, and the Hospital's strategic plan may be considered by the Board of Trustees.

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

2.2. GENERAL CRITERIA AND QUALIFICATIONS[11]

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

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

2.2.3. Lack of Exclusion. Each Practitioner and APP must not be excluded from participation in the Medicare, Medicaid, TRICARE, or any other federal or state governmental health care program or convicted of fraud or abuse under the Medicare, Medicaid, or other federal or state governmental health care program.

2.2.4. Professional Liability Insurance. Each Practitioner must maintain professional liability insurance in the form and amounts required by the Board of Trustees applicable to the Practitioner's practice, including the use of any APPs or other health care professionals not employed by the Hospital. Evidence of coverage must be submitted: (a) at the time of application to the Medical Staff; (b) no later than the last day of coverage for the policy currently in effect or within one business day of receipt of documentation

[9] 42 C.F.R. Sec. 482.22(a)(2).
[10] MS.06.01.07 EP 3; 25 Tex. Admin. Code Sec. 133 41(f)(4)(F)(i)(III).
[11] MS.01.01.01 EP 13; 42 C.F.R. Sec. 482.12(a)(6)-(a)(7), 482.22(c)(4); 25 Tex. Admin. Code Sec. 133.41(f)(4)(E)(i), 133.41(k)(3)(D).
[12] 42 C.F.R. Sec. 482.11(c); MS.06.01.03 EP 6.

of coverage from the insurance carrier, whichever occurs first; and (c) within five days of a request from Medical Staff Services.

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

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

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

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

2.2.6.3. Any Practitioner requesting Medical Staff membership and/or to exercise Clinical Privileges after reaching the age of 70 years shall be referred to the Medical Staff Aging Practitioner policy. Referral to this policy is also required for APPs after reaching the age of 70 years.

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

2.2.8. Proximity. Each Practitioner with Clinical Privileges must remain within sufficient proximity to the Hospital to provide call coverage and continuous care for the Practitioner's patients in the Hospital and to fulfill Medical Staff responsibilities.

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

2.2.10. Board Certification and Residency Training.[16]

2.2.10.1. Each Physician Practitioner must be currently certified by the specialty board appropriate to the Clinical Privileges being requested, either by the American Board of Medical Specialties ("ABMS"), the American Bureau of Osteopathic Specialists ("BOS")[17], or the Royal College of Physicians and Surgeons of Canada and must maintain that certification during membership on the Medical Staff. Physicians who are graduates of foreign schools of medicine, other than accredited Canadian schools of medicine, must have satisfactorily completed the examination of the

[13] 42 C.F.R. Sec. 482.12(a)(6); MS.06.01.03, MS.06.01.05.
[14] MS.06.01.05 EP 2, 6.
[15] 42 C.F.R. Sec. 482.12(a)(6).
[16] 42 C.F.R. Sec. 482.12(a)(6); see also MS.06.01.05 EP 2.

Educational Council of Foreign Medical Graduates ("ECFMG"). Physicians trained outside the United States must also meet all the residency requirements in this section. The requirement that the residency program be approved by the American Bureau of Osteopathic Specialists or Accreditation Council of Graduate Medical Education ("ACGME") will be waived only if the Physician is ABMS or BOS board eligible or certified appropriate to the Physician's specialty.

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

2.2.10.3. Exceptions to Board Certification. Exceptions to the board certification requirements in Sections 2.2.10.1 – 2.2.10.2 may be recommended by the Leadership Council and approved by the Board of Trustees in the case of practitioners who (a) are current members of a medical staff at a THR wholly-controlled hospital or a University of Texas Southwestern Medical Center affiliated hospital, and (b) are able to demonstrate training, experience, and current competency equivalent to that required for board certification and the member is otherwise in good standing as a member of such medical staff, to include without limitation a satisfactory quality record as evidenced in performance review records and fulfillment of all other requirements appropriate to the member's membership level; demonstrate current competence, adherence to the ethics of their profession, good reputation, physical and mental health status (subject to any necessary reasonable accommodation to the extent required by law), the ability to work with others (staff members, members of other health care disciplines, Hospital management and employees, visitors, patients, and the community in general).

2.2.11. Oral Maxillofacial Surgeon.

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

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

2.2.12. Podiatrist.

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

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

2.2.13. Failure to Achieve or Maintain Board Certification. Failure of a Physician, Oral Maxillofacial Surgeon, or Podiatrist to achieve board certification within the first two testing cycles of initial appointment as provided above, or failure to maintain certification, shall constitute an automatic resignation from the

Medical Staff and shall not entitle the Physician, Oral Maxillofacial Surgeon, or Podiatrist to any procedural rights of review under these Bylaws or otherwise. The Leadership Council may consider individual cases to waive board certification requirements based on extenuating circumstances.

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

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

2.2.16. Lack of Criminal History. Practitioner may not have been convicted of, pled guilty, or pled *nolo contendere* to any felony reasonably related to the Practitioner's qualifications, competence, functions, or duties as a medical professional or offenses involving an act of violence, child abuse, sexual offense, or relating to other moral turpitude. Practitioners with prior military service may not have been court-martialed or received any military discharge under other than honorable conditions for specific actions during their service. Other criminal offenses may be considered in evaluating a Practitioner's qualifications.

2.2.17. Coverage. The Practitioner must provide written confirmation of arrangements for appropriate alternative medical coverage by a Member for patients for whom the Practitioner is or will become responsible should the Practitioner be unavailable. The Member who has agreed to cover for the Practitioner must have at least the same Clinical Privileges as the Practitioner and meet the proximity requirements delineated in Section 2.2.8 when providing coverage. At its discretion, the Leadership Council may grant an exception to coverage.

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

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

2.3. DUTIES AND OBLIGATIONS

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

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

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

2.3.3. Abide by these Bylaws, the Rules and Regulations, all Manuals and Medical Staff policies, the Medical Staff Code of Conduct and corporate compliance program and other Hospital policies, and legal and accreditation requirements, including without limitation, education directed at supporting THR's goal of maintaining patient safety and high-quality care, and maintain credentialing as determined by Medical Staff policy.

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

2.3.4.1. One Business Day After Receipt of Notice

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

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

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

2.3.4.2. Five Business Days After Receipt of Notice

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

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

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

2.3.4.2.4. Leave of absence ("LOA"), whether voluntary or involuntary, from another hospital or health care entity;

2.3.4.2.5. Filing of any report concerning the Member with the NPDB;

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

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

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

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

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

2.3.4.2.11. Any conviction, guilty plea or deferred adjudication, *nolo contendere* plea, filing of formal charges for a felony or misdemeanor (including Driving Under the Influence or Public Intoxication), other than minor traffic violations, any court-martial, or any discharge from military service under other than honorable conditions.

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

2.3.6. Perform in a professional and cooperative manner the responsibilities and assignments associated with membership, including Hospital and Medical Staff committee assignments, and timely payment of any medical staff dues and/or credentialing fees;

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

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

2.3.9. Participate in emergency services call coverage as required by the Member's Service Line and Staff category, subject to the ultimate authority of the Board of Trustees following consultation with the Leadership Council, as set forth elsewhere in these Bylaws, Rules and Regulations, and Hospital and Medical Staff and Service Line policies;

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

2.3.11. Discharge such other reasonable responsibilities and obligations as may be established by the Leadership Council or the Board of Trustees; and

2.3.12. Maintain accurate and current contact information with Medical Staff Services, including a preferred email address used regularly by the practitioner, all office addresses and home address, as well as all phone numbers including offices, home, and mobile telephone.

2.3.12.1. Email addresses. Maintain on file with Medical Staff Services and regularly monitor a single, current e-mail address that will be the primary mechanism used to communicate all Medical Staff and peer review information to the Practitioner and, in addition, may be shared with others and used by the Hospital, System, members of the Medical Staffs and other privileged Practitioners and their representatives, to communicate with the individual.

2.4. TERM OF APPOINTMENT

2.4.1. Duration. The term of appointment shall be for a period of up to three years from the appointment date and may be for a period of less than three years.[17] A term of less than three years is not an Adverse Recommendation or Action and shall not entitle the Practitioner to any procedural rights of review under these Bylaws or otherwise.

[17] 42 C.F.R. Sec. 482.22(a)(1); 25 Tex. Admin. Code Sec. 133.41(k)(1)(B); MS.06.01.07 EP 9.

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

2.5. PROCESS FOR APPOINTMENT[18]

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

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

2.5.2.1. Signifies the Practitioner will abide by the Medical Staff Bylaws, Rules and Regulations, and Medical Staff policies, as well as Hospital policies;[19]

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

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

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

2.5.2.5. Authorizes the release of information by the Hospital, any Medical Staff committees, and by third parties, including medical records regarding any of the Practitioner's patients and the Practitioner, as well as Medical Peer Review data, relating to the Practitioner's professional qualifications, and any other information related to the application for appointment and/or Clinical Privileges, provided such information is provided in good faith;

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

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

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

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

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

2.5.3.1. A Complete Application means:

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

2.5.3.1.2. All questions on the application form have been answered to the satisfaction of the Credentialing Committee, and all supplemental information as requested has been provided (e.g., malpractice claims, copies of licenses, DEA certificate, etc.);

2.5.3.1.3. All reference requests, required documentation, requests for additional information/ clarification forwarded to the applicant and/or other parties, and any other documents/ verifications solicited by the Hospital and the Credentialing Committee have been received;

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

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

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

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

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

2.5.3.2.1. What information is needed and from whom;

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

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

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

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

2.5.4. Review by Credentials Committee

2.5.4.1. Once an application is a Complete Application, Medical Staff Services will forward the application and any supporting documentation to the Credentials Committee. The Credentials Committee shall have thirty (30) days to review the application. The Credentials Committee may conduct a personal interview with the Practitioner.

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

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

2.5.5. Review by Leadership Council.

2.5.5.1. The Leadership Council shall review the application and the recommendation of the Credentials Committee within 30 days of receipt. The Leadership Council may conduct a personal interview with the Practitioner.

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

2.5.5.3. If the recommendation of the Leadership Council is an Adverse Recommendation or Action, the Hospital President, CQMO, or their designee shall provide the Practitioner with Special Notice of the recommendation as provided in Article 10, and all further procedures shall be as set forth in that Article.

2.5.5.4. If the recommendation of the Leadership Council is not an Adverse Recommendation or Action, it shall be forwarded with any supporting documentation to the Board of Trustees for review.

2.5.6. Review by Board of Trustees.

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

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

2.5.6.3. If the recommendation of the Board of Trustees is an Adverse Recommendation or Action, the Hospital President, CQMO, or their designee shall provide the Practitioner with Special Notice of

the recommendation as provided in Article 10 and all further procedures shall be as set forth in that Article.[20]

2.5.6.4. If the recommendation of the Board of Trustees is not an Adverse Recommendation or Action, it shall be the final decision of the Board of Trustees. The Hospital President, CQMO or their designee shall notify the Practitioner in writing within 20 days of the decision.[21]

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

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

2.6. PROCESS FOR REAPPOINTMENT[22]

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

2.6.1.1. If a Member fails to submit a timely Complete Application without good cause, as determined by the Leadership Council subject to the approval of the Board of Trustees, Medical Staff membership and all Clinical Privileges shall expire at the end of the current term of appointment.

2.6.1.2. The schedule for reappointment shall be established by Medical Staff Services, subject to the approval of the Leadership Council.

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

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

2.6.3.1. The results of any FPPE and OPPE, information generated by Medical Peer Review or other medical staff professional conduct processes, and when available, relevant Practitioner-specific data as compared to aggregate data, morbidity and mortality data, clinical outcomes, efficiencies, and patient satisfaction;

2.6.3.2. Compliance with the duties and obligations of Medical Staff membership;

2.6.3.3. Usage of the Hospital, fulfillment of Medical Staff assignments, and fulfillment of other activities related to the Member's professional services and contributions;

2.6.3.4. Results of the NPDB query; and

2.6.3.5. Any other information required by legal or accreditation standards, policy, or the Leadership Council and the Board of Trustees.

[20] MS.06.01.09 EP 4, 5.
[21] 25 Tex. Admin. Code Sec. 133.41(f)(4)(F)(i)(VIII).
[22] MS.01.01.01. EP 27; 25 Tex. Admin. Code Sec. 133.41(k)(1)(A).

2.7. WITHDRAWAL OF COMPLETE APPLICATION OR CERTAIN REQUESTS

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

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

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

2.8. LEAVE OF ABSENCE

2.8.1. Mandatory. Any Member who will not be engaged in the Member's customary or usual professional practice for longer than 60 consecutive days must take a LOA in accordance with this section. A LOA is not a surrender or relinquishment of Clinical Privileges.

2.8.2. Types of Leave of Absence.

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

2.8.2.2. Parental Leave of Absence. A Member may request and be granted a LOA of up to 90 days after the birth or adoption of a child. Parental LOAs are eligible for an expedited reinstatement approval process.

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

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

2.8.2.5. Personal Leave of Absence. A Member may request and be granted a LOA for personal reasons (e.g., to pursue a volunteer endeavor such as contributing work to "Doctors Without Borders/USA") or family reasons (e.g., to serve as a caregiver in scenarios other than Parental LOAs).

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

2.8.3. Process for Requesting Leave of Absence. A LOA must be requested in writing in advance specifying the type of leave requested and the requested duration. The written request must be submitted to the Chief of Staff by delivery to Medical Staff Services. Following recommendation by the Leadership Council, the Board of Trustees may grant a Practitioner a LOA under Section 2.8. See Section 2.8.2.6 if the Leadership Council finds the Practitioner was unable to request a LOA.

2.8.4. Duration of LOA and Extension. A LOA shall not exceed one year or the Practitioner's remaining appointment period, whichever is shorter, unless an extension is granted. A Military LOA shall be for the period of deployment. An extension may be requested by the Practitioner under the same process as for the initial period of LOA. See Section 2.8.6 if reappointment is due during LOA or period of requested extension.

2.8.5. Status of Practitioner While on LOA.

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

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

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

2.8.6. Leave of Absence and Reappointment.

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

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

2.8.7. Requesting Reinstatement.

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

2.8.7.2. The Practitioner must also:

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

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

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

2.8.8. Reinstatement Procedures.

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

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

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

2.8.8.2.2. In the case of any Medical LOA or other reinstatement request the Credentials Committee deems appropriate, the Credentials Committee shall refer to the request with its recommendation to the Leadership Council.

2.8.8.3. Leadership Council. At its next meeting, the Leadership Council shall review the reinstatement request and the recommendation of the Credentials Committee. The Leadership Council may conduct a personal interview with the Practitioner. The Leadership Council shall issue a written recommendation to the Board of Trustees as to whether reinstatement should be granted and any conditions or limitations that should apply. If reinstatement is not recommended or any conditions or limitations are recommended, a statement of the reasons for such shall be included.

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

2.8.8.3.2. If the recommendation of the Leadership Council is not an Adverse Recommendation of Action, it shall be forwarded with any supporting documentation to the Board of Trustees for review.

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

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

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

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

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

2.9. RESIGNATION

2.9.1. Request and Obligations. A Member may submit a resignation of Medical Staff membership and Clinical Privileges at any time to the Leadership Council through Medical Staff Services. The resignation will not be effective until the Member has: (a) completed all outstanding medical records, (b) completed emergency services call coverage as required by the Service Line, and (c) received the Board of Trustees' approval of the resignation.

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

2.10. LIMITATIONS ON REAPPLICATION

2.10.1. Three Year Prohibition.

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

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

2.10.2. Effect of Withdrawal of Application.

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

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

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

2.11. WAIVER OF REQUIREMENTS

The Board of Trustees, following consultation with the Leadership Council, may waive a qualification for Medical Staff membership, Clinical Privileges, and/or a Staff category, but only on a finding that the waiver is in the best interests of the Hospital and the community it serves. Failure to waive a requirement for a particular Practitioner does not entitle the Practitioner to any procedural rights of review under these Bylaws or otherwise.

2.12. MISREPRESENTATION, MISSTATEMENT OR OMISSION

A significant or material misrepresentation, misstatement, or omission from an application for appointment, reappointment and/or Clinical Privileges, whether intentional or not, shall result in automatic withdrawal of the application from further processing. If the application has already been processed and Medical Staff membership and/or Clinical Privileges have been granted, discovery of the significant or material misrepresentation, misstatement, or omission shall result in automatic termination of Medical Staff membership and all Clinical Privileges. The determination of what constitutes a "significant or material" misrepresentation, misstatement, or omission shall be made by the Leadership Council, subject to the approval of the Board of Trustees, and shall involve information related to competence or professional conduct, and/or the assessment of the qualifications of Medical Staff membership and/or Clinical Privileges. Material omissions or misstatements may also disqualify an applicant from future consideration.

2.13. ORGANIZED HEALTH CARE ARRANGEMENT

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

3. CATEGORIES OF MEDICAL STAFF MEMBERSHIP[23]

3.1. CATEGORIES

The categories of Medical Staff membership are: Active, Courtesy, Community, Telemedicine, and Emeritus. Each Member of the Medical Staff must be assigned to a specific Staff category, as well as a Service Line (see Article 5).

3.2. ACTIVE STAFF

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

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

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

3.2.1.2. Actively and regularly provide patient care services to patients in the Hospital, with at least 36 Patient Contacts over a 36-month term of appointment (or an average of at least 1 patient contact per month over a shorter appointment) for those with Clinical Privileges; and

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

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

3.2.2.1. Vote on Medical Staff and Clinical Council matters, and any committees to which assigned as a voting member;

3.2.2.2. Hold office within the Medical Staff organization, if qualified;

3.2.2.3. Serve as a member and/or chair of the Leadership Council or a Clinical Council, chair or member of any standing or other committees of the Medical Staff, including subcommittees, task forces, or workgroups thereof, or a committee of the Hospital; and

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

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

3.2.3.1. Hold appropriate Clinical Privileges;

3.2.3.2. Provide emergency services call coverage as required by the Member's Service Line and Staff category, subject to the ultimate authority of the Board of Trustees following consultation with the Leadership Council; and

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

3.2.4. Failure to Meet Patient Contacts. In the event a Member up for reappointment to the Active Staff category has contacts less than the specified amount during the preceding appointment period, such Member shall be eligible for the Active category if the Member had no issues of quality of care and significant involvement, as determined by the Leadership Council in its sole discretion, either through Medical Staff leadership or Medical Staff committee involvement. A reappointment of up to one (1) year may be granted under this circumstance in the event the Member does not meet the contact requirement.

3.3. COURTESY STAFF

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

3.3.1.1. Continuously meet the qualifications for Medical Staff membership in Article 2 and for assignment to the appropriate Service Line.

3.3.1.2. Are members of the active staff of an acute care hospital accredited by The Joint Commission or Det Norske Veritas which will provide Medical Peer Review data (quality review, evaluation, and monitoring activities like Active Staff at THR) to the Hospital if requested for purposes of evaluating competence and professional conduct; and

3.3.1.3. Provide consultation for a specialty not available from Members on the Active Staff (or provide services in a hospital-based specialty but not meet Active Staff patient contact requirements). A Courtesy Staff Member will not be required to become an Active Staff Member because of call

coverage contacts alone if providing consultation for a specialty not available from Members on the Active Staff; and

3.3.1.4. Maintain their Patient Contacts to not more than 36 for each 36-month term of appointment (or not more than an average of one (1) per month over a shorter appointment).

3.3.2. Rights and Prerogatives. Members of the Courtesy Staff:

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

3.3.2.2. May attend committee meetings by invitation.

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

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

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

3.3.3.3. Hold appropriate Clinical Privileges, exercising admitting privileges only if granted, and if providing call coverage, only during periods of that coverage; and

3.3.3.4. Provide complete written OPPE data from another acute care hospital accredited by The Joint Commission or Det Norske Veritas to the Leadership Council or its designee at least every 12 months if the Member does not have sufficient Patient Contacts at the Hospital for the performance of OPPE. Failure to provide the required OPPE data shall be grounds for automatic action as provided in Article 11.

3.3.4. Exceeding Patient Contacts. This maximum number shall not include patient contacts that occur when the Courtesy Staff Member is providing call coverage for an Active Staff Member.

3.3.5. Insufficient Patient Contacts. In special circumstances and to best meet the needs of the Medical Staff or Hospital, the Leadership Council may accept evidence of satisfactory patient care activity at another health care facility in lieu of the contact requirement. In the event a Member of the Courtesy Staff does not meet the minimum number of contacts during an appointment period, such Member may be reappointed by the Leadership Council in its sole discretion. Only a single one-year reappointment shall be granted under this circumstance in the event the Member does not meet the contact requirement.

3.4. COMMUNITY STAFF

3.4.1. Qualifications. Community Staff membership shall consist of only office/clinic-based Practitioners who:

3.4.1.1. Continuously meet the qualifications for Medical Staff membership in Article 2, except for the DEA registration requirement, and for assignment to the appropriate Service Line;

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

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

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

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

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

3.4.2.3. May attend Medical Staff meetings, including educational programs, with or without vote as indicated in the invitationor appointment; and

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

3.5. TELEMEDICINE STAFF

3.5.1. Qualifications. The Telemedicine Staff category shall consist of Medical Staff Members who are providing patient care services remotely using a telemedicine medium or communication system, according to commonly accepted standards, for the purposes of evaluation, diagnosis, consultation, or treatment that requires the use of advanced telecommunications technology. A Member of the Telemedicine Staff may be either an in-state physician or an out-of-state physician and must satisfy all requirements of the Texas Medical Board for the practice of telemedicine, including licensure requirements.

3.5.2. Responsibilities. A Member of the Telemedicine Staff shall:

3.5.2.1. Actively participate in the quality evaluation and monitoring activities required of Medical Staff members;

3.5.2.2. Discharge the responsibilities set forth in these Bylaws, Medical Staff Policies, Procedures, Rules and Regulations, and applicable Hospital policies and procedures;

3.5.2.3. Retain responsibility within the Member's area of professional competence for the continuous care and supervision of each patient for whom the Member is responsible for providing services, or arrange a suitable alternative as applicable in accordance with these Bylaws, Medical Staff Policies, Procedures, Rules and Regulations, and applicable Hospital policies and procedures;

3.5.2.4. Report any changes in health status to the Leadership Council immediately;

3.5.2.5. Discharge such other staff functions as may be required from time to time by the Leadership Council or a Co-Chair of the Clinical Council for the Service Line in which the Member is assigned;

3.5.2.6. Is not required to participate in the emergency services call program and is exempt from the Proximity requirement as outlined in 2.2.8;

3.5.2.7. May not hold a Medical Staff leadership position; and

3.5.2.8. Shall not admit or discharge patients to/from the Hospital.

3.5.3. Limitations:

3.5.3.1. An out-of-state telemedicine licensee's clinical practice shall be limited exclusively to the interpretation of diagnostic testing and reporting results to a physician fully licensed and located in Texas or for the follow-up of patients where the majority of patient care was rendered in another state, and the license holder shall practice medicine in a manner so as to comply with all other statutes and laws governing the practice of medicine in the state of Texas.

3.5.3.2. Unless a person holds a current full license to practice medicine in Texas, a person holding an out-of-state telemedicine license shall not be authorized to physically practice medicine in the state of Texas.

3.5.4. Credentialing. The Board of Trustees, following consultation with the Leadership Council, may authorize a written agreement with a distant site hospital or a telemedicine entity, which agreement allows reliance on the credentialing and privileging decisions of that distant site; provided that, the process meets the applicable legal and accreditation requirements. Practitioners holding telemedicine Clinical Privileges only shall be subject to FPPE/OPPE.

3.6. EMERITUS STATUS

Emeritus status is an honorary recognition available to Practitioners who were Members of the Active Staff, retired in Good Standing and are no longer engaged in professional practice, and who maintain a good reputation in the community served by the Hospital. Emeritus status is extended by invitation only and entirely discretionary. Practitioners with Emeritus status may attend Medical Staff meetings by invitation without vote and any educational programs of the Medical Staff. These practitioners are not eligible for Medical Staff membership or Clinical Privileges. As Emeritus status is discretionary, the Leadership Council may terminate the status at any time on prior Special Notice to the Practitioner. Termination is subject to the approval of the Board of Trustees.

3.7. CHANGES IN STAFF CATEGORY

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

4. CLINICAL PRIVILEGES

4.1. EXERCISE OF CLINICAL PRIVILEGES

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

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

4.2. DELINEATION OF CLINICAL PRIVILEGES

4.2.1. Development. The Medical Staff, through the Credentials Committee and Leadership Council, and following consultation with the appropriate Clinical Council Co-Chair(s), shall be responsible to develop and recommend to the Board of Trustees for approval a listing of Clinical Privileges that will be available and offered at the Hospital. The list of Clinical Privileges shall take into consideration the needs of the community and the Members of the Medical Staff, the adequacy of resources, equipment, and personnel of the Hospital to support the Clinical Privileges, and the cost to the Hospital of offering the particular Clinical Privileges.[24]

[24] MS.06.01.01.

4.2.2. Criteria and Other Requirements.[25] The Leadership Council, in consultation with the Credentials Committee and the appropriate Clinical Council Co-Chair(s), shall also develop and approve criteria, including, but not limited to, minimum threshold criteria and other requirements for the granting of the approved list of Clinical Privileges, which shall also be subject to the approval of the Board of Trustees. This process shall also apply to Clinical Privileges offered in more than one Service Line. Criteria for clinical privileges shall be in addition to the general criteria and qualifications in Section 2.2, unless otherwise provided on the delineation of privileges.[26]

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

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

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

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

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

4.3. PROCESS FOR GRANTING AND RENEWAL[27]

4.3.1. Application.

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

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

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

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

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

[27] MS.01.01.01 EP 14; 42 C.F.R. Sec. 482.22(c)(6).

4.3.2. Criteria.[28] The determination of whether to grant Clinical Privileges shall be based on:

4.3.2.1. The Practitioner's education, training, experience, current competence, clinical judgment, health status and ability to perform the requested Clinical Privileges, peer recommendations when required, and other relevant information;[29]

4.3.2.2. Information regarding previously successful or currently pending challenges to or restrictions on any licensure or registration or the voluntary relinquishment of such licensure or registration;[30]

4.3.2.3. Information regarding voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, denial, or loss of Clinical Privileges at another health care entity;[31]

4.3.2.4. Information regarding professional liability claims and suits either pending or closed, regardless of the outcome;[32] and

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

4.3.3. Process.[33]

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

4.3.3.2. The renewal process shall include any information relevant to the Practitioner's competence and professional conduct, including without limitation, consideration of information generated pursuant to Medical Peer Review, specifically OPPE[34] pursuant to the QAPI, relevant Practitioner-specific data as compared to aggregate data and morbidity and mortality data when available, and if needed, information from other health care entities.[35]

4.3.4. Term.

4.3.4.1. Clinical Privileges may be granted for a period of up to three years and may be for a period of less than three years.[36] A term of less than three years is not an Adverse Recommendation or Action and shall not entitle the Practitioner to any procedural rights of review under these Bylaws or otherwise.

4.3.4.2. Any initial grant of Clinical Privileges shall be subject to FPPE as set out in written policy.[37] The term of the initial FPPE may be extended, not to exceed a total of three years if the initial FPPE has not been satisfactorily completed or the Practitioner did not have a sufficient number of cases at the Hospital for completion of the initial FPPE.

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

[28] 42 C.F.R. Sec. 482.22(c)(4), 482.22(c)(6); 25 Tex. Admin. Code Sec. 133.41(k)(3)(E).
[29] MS.06.01.05 EP 2.
[30] MS.06.01.05 EP 9.
[31] MS.06.01.05 EP 9.
[32] MS.06.01.05 EP 9.
[33] MS.01.01.01 EP 26; MS.06.01.03 EP 4; 25 Tex. Admin. Code Sec. 133.41(k)(3)(E).
[34] MS.08.01.03.
[35] MS.06.01.05 EP 9.
[36] MS.06.01.07 EP 9; 25 Tex. Admin. Code Sec. 133.41(k)(1)(B); 42, C.F.R. Sec. 482.22(a)(1).
[37] MS.08.01.01 EP 1.

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

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

4.3.7.1. The application shall state in detail the specific changes in Clinical Privileges desired and the Practitioner's recent training and experience which justify the change in Clinical Privileges. If a decrease in Clinical Privileges is requested, the application will state the reason for the requested decrease. The application regarding the request for change in Clinical Privileges will be processed in the same manner as an application for initial Clinical Privileges.

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

4.4. EXCLUSIVE PROFESSIONAL SERVICES ARRANGEMENTS

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

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

4.5. TEMPORARY CLINICAL PRIVILEGES[38]

4.5.1. Criteria. Temporary Clinical Privileges may be granted only to Practitioners with a pending application for initial appointment or to fulfill an important patient care, treatment, and service need, as detailed below.[39] In granting temporary Clinical Privileges, special requirements may be imposed to monitor and assess the quality of care rendered by the Practitioner exercising such privileges. Temporary privileges may be granted by the Hospital President, CQMO, or their designee with the recommendation of the Chief of Staff.[40]

4.5.1.1. Practitioners Applying to the Medical Staff. The credentialing process must include:

4.5.1.1.1. primary source verification of the applicant's current state professional licensure(s),

4.5.1.1.2. relevant training and current competence at time of granting privileges,

4.5.1.1.3. ability to perform the privileges requested,

4.5.1.1.4. a query and evaluation of the NPDB information,

[38] MS.06.01.13.
[39] MS.06.01.13 EP 1, 3.
[40] MS.06.01.13 EP 4 -5.

4.5.1.1.5. no current or previously successful challenge to licensure or controlled substances registration,

4.5.1.1.6. no record of involuntary termination of medical staff membership at another health care entity, and

4.5.1.1.7. no record of involuntary limitation, reduction, denial or loss of clinical privileges at another health care entity.[41]

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

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

4.5.1.2.2. The credentialing process must include primary source verification of the Practitioner's current state professional licensure and current competence, criminal background check, current malpractice insurance verification, and a query and evaluation of the NPDB information.[42]

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

4.5.1.2.4. Such Clinical Privileges shall be restricted to the treatment of not more than four patients in any one year by any Practitioner, after which such Practitioner shall require approval of the Hospital President, CQMO, or their designee and Chief of Staff to attend additional patients.

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

4.5.3. Termination of Temporary Clinical Privileges. The Hospital President, CQMO, or their designee may, after consultation with the Chief of Staff, terminate any or all of a Practitioner's temporary Clinical Privileges. If failure to act may result in imminent danger to the health of an individual, the termination (or a suspension) may be affected by any person entitled to impose summary Corrective Actions under Article 9. Temporary Clinical Privileges shall automatically terminate on issuance of an Adverse Recommendation or Action or on issuance of a final decision by the Board of Trustees. They shall be automatically terminated on issuance of an unfavorable recommendation by the Credentials Committee or automatically modified to conform to the Credentials Committee's recommendation that the Practitioner be granted Clinical Privileges which are different from the temporary Clinical Privileges. In the event of termination, the Practitioner's patients then in the Hospital shall be assisted to select another Practitioner by the Chief of Staff.

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

[41] MS.06.01.13 EP 3.
[42] MS.06.01.13 EP 2.

4.6. EMERGENCY CARE Provided by a Medical Staff Member (someone on staff performing outside their normal scope)

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

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

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

4.7. PRIVILEGES TO PERFORM HISTORY AND PHYSICAL EXAMINATION[43]

4.7.1. General. Clinical Privileges for performing a medical H&P shall be delineated. The medical H&P shall be performed by a Physician, Oral and Maxillofacial Surgeon, or Advanced Practice Provider with appropriate Clinical Privileges in accordance with the Rules and Regulations.

4.7.2. Time Requirements.

4.7.2.1. The medical H&P must be completed and included in the medical record no later than 24 hours after the patient's admission to the Hospital and prior to surgery or any procedure requiring anesthesia, except in emergencies which preclude such documentation. See Rules and Regulations on documentation requirements in emergencies.

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

4.7.3. Dentists and Podiatrists.

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

4.7.3.2. Dentists and Podiatrists are responsible to secure a Physician Member to manage and coordinate their patients' medical condition during hospitalization and meet any requirements in the Rules and Regulations.[44]

[43] MS.01.01.01 EP 16; 42 C.F.R. Sec. 482.22(c)(5); 25 Tex. Admin. Code Sec. 133.41(k)(3)(F).
[44] 42 C.F.R. Sec. 482.12(c)(4).

4.8. TEMPORARY DISASTER PRIVILEGES

4.8.1. Authority. If the Hospital's Emergency Medical Plan has been activated, any Member or other Practitioner with Clinical Privileges, to the degree permitted by professional license, shall be permitted to and be assisted by Hospital personnel in doing everything possible to save the life of a patient or to save the patient from serious harm. Additionally, temporary disaster privileges may be granted to Practitioners who are not Members of the Staff by the Hospital President, CQMO, Chief of Staff, or their designees, as provided in Hospital policy.[45]

4.8.2. Process. The process for granting temporary disaster privileges shall include the basic steps of photo identification and primary source verification, including licensure. The Medical Staff oversees the professional performance of volunteer practitioners by direct observation, mentoring, and/or clinical record review of volunteer staff in accordance with legal and accreditation requirements.[46]

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

4.9. ADVANCED PRACTICE PROVIDERS and ALLIED HEALTH PROFESSIONALS

4.9.1. General. Certain individuals may be granted Clinical Privileges to provide health care in the Hospital as APPs or AHPs.[47] The process for reviewing applicants and granting Clinical Privileges to an APP shall be set out in Hospital policy. Any grant of Clinical Privileges shall be in accordance with, and shall be subject to, any required Practitioner delegation, direction and/or supervision as set out in Hospital policy following consultation and recommendation by the Leadership Council. APPs and AHPs are not eligible for Medical Staff membership or any of the procedural rights of review afforded to Practitioners under these Bylaws or otherwise. Any review rights shall be limited to those set out in the Hospital policy.

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

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

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[45] EM.02.02.13 EP 2.

[46] EM.02.02.13; EP 5-6.

[47] Clinical privileges are required by The Joint Commission for APRNs and PAs who practice within the hospital. HR.01.02.05 EP 10-11 (EPs allow use of medical staff process or an "equivalent process" to credential and privilege, but CMS does not accept equivalent process – telephone call with The Joint Commission July 31, 2012). The CMS Conditions of Participation require clinical privileges for any practitioner providing a "medical level of care" but also if performing surgery. The Joint Commission Booster Pak 2011 and telephone call with The Joint Commission July 31, 2012; 42 C.F.R. Sec. 482.51(a)(4). The accompanying Interpretive Guidelines provide that the hospital "must specify the surgical privileges for each practitioner that performs surgical tasks. This would include practitioners such as MD/DO, dentists, oral surgeons, podiatrists, RN first assistants, nurse practitioners, surgical physician assistants, surgical technicians, etc." CMS State Operations Manual.

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

5. ORGANIZATION OF THE MEDICAL STAFF[48]

5.1. SERVICE LINES (see Appendix A)

5.2. ASSIGNMENT TO SERVICE LINE

5.2.1. Each Member of the Medical Staff and other Practitioner and APP with Clinical Privileges will be assigned to the appropriate Service Line in which the Member (or Practitioner or APP) has Clinical Privileges and be accountable to the Clinical Council of the applicable Service Line, as well as the Leadership Council, as set forth below.

6. MEDICAL STAFF COMMITTEES[49]

6.1. GENERAL (see Appendix B for additional committee information)

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

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

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

6.1.4. Members and Attendance. The Members of Medical Staff committees shall be appointed by the Chief of Staff and the chairs shall be Members of the Active Staff, unless otherwise provided in these Bylaws. The Hospital President, CQMO, and Chief Nursing Officer may attend any Leadership Council or other Medical Staff committee meeting, whether standing, ad hoc, special, or a task force, including a meeting in executive session.[50]

6.1.5. Joint System Committees. With the approval of the Leadership Council and Board of Trustees, the System may establish a joint System medical peer review committee with the System and this THR hospital, and other THR hospitals, to conduct specific aspects of medical peer review as set out in the committee's written charter. The written charter shall set out the composition, responsibilities, and reporting requirements of the committee. At least a majority of the voting members of the committee must be Active Staff Members of THR hospitals, and the committee shall report to the Leadership Council and the Board of Trustees or designated committee. A joint System medical peer review committee shall be established and operate as a medical peer review committee/medical committee/professional review body with the associated confidentiality and immunity provisions consistent with Section 12 of these Bylaws. Use of a joint System medical peer review committee shall not require an amendment of the Bylaws.

[48] MS.01.01.01 EP 12; 42 C.F.R. Sec. 482.22(c)(3).
[49] 42 C.F.R. Sec. 482.22(c)(3); MS.01.01.01 EP 12.
[50] MS.02.01.01 EP 2 (the standard references the CEO or his or her designee).

6.2. LEADERSHIP COUNCIL[51]

6.2.1. General. The Leadership Council shall serve as the governing committee of the Medical Staff. By approval of these Bylaws, the Medical Staff delegates and authorizes the Leadership Council to represent and act on its behalf on all matters and in between meetings of the Medical Staff, subject to any limitations imposed by these Bylaws and in a manner consistent with these Bylaws.

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

6.2.2.1. Making recommendations to the Board of Trustees as to:

6.2.2.1.1. the Medical Staff structure,

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

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

6.2.2.1.4. the delineation of Clinical Privileges for eligible Advanced Practice Providers,

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

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

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

6.2.2.1.8. the results of its review and actions on reports from the Clinical Councils and other committees or assigned groups.

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

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

6.2.2.4. Coordinating the activities of the Service Lines, Medical Staff committees, and other groups within the Medical Staff organization;

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

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

6.2.2.7. Determining reasonable emergency services call coverage responsibilities and schedules and ensuring that the Service Lines provide for timely and adequate call coverage for the Hospital's

[51] MS.01.01.01 EP 20-23, MS.02.01.01.

emergency department for each of the specialty areas within the Service Lines as directed by the Board of Trustees;

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

6.2.2.9. Assessing the amount of Medical Staff dues, if applicable, payable by Members, subject to the approval of the Board of Trustees.

6.2.3. Composition.

6.2.3.1. Medical Staff Members. The Leadership Council shall have as voting members the elected officers of the Medical Staff and at least 5 but not more than 9 Members of the Active Staff.

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

6.2.3.1.2. All disciplines and specialties from the Active Staff categories are eligible for membership on the Leadership Council.[52] A majority of the voting members of the Leadership Council must be Physicians.[53]

6.2.3.1.3. Members shall be elected by the voting Members of the Medical Staff from a ballot of qualified candidates, either at a Medical Staff meeting or by mail ballot using the procedures in Article 8. The candidates shall be proposed by an ad hoc nominating committee comprised of the Hospital President, the Leadership Council Physician Co-Chair, and a Clinical Council Physician Co-Chair selected by the Hospital President.

6.2.3.1.4. Leadership Council members may not hold a similar position at another health care entity during service on the Leadership Council.

6.2.3.2. Hospital Members. The Leadership Council shall also include as voting members: Hospital President, CQMO, Chief Nursing Officer, Chief Financial Officer, and Chief Nursing Officer. Non-voting members shall include: Director of Community Integration, Support Services Director, Ancillary Services Director, and Human Resources Director. The Hospital President may invite other Hospital staff, including Medical Staff Services, to attend meetings as support and resources for the Leadership Council.

6.2.3.3. Chairs. The Chief of Staff and the Hospital President shall serve as co-chairs of the Leadership Council, and both shall be voting members. (See Section 7.2 on appointment of the Chief of Staff.)

6.2.3.4. Terms. Membership terms shall be three (3) years and staggered. Members may serve consecutive terms. A majority of the voting members of the Leadership Council must be physicians.

6.2.3.5. Medical Peer Review Duties. When the Leadership Council is performing Medical Peer Review functions, attendance shall be limited to Organized Medical Staff Members, Hospital President, CQMO, Chief Financial Officer, and Chief Nursing Officer, unless other members are invited by a Leadership Council Co-Chair.

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

6.2.3.6. Removal of Members. The procedures for removal of the Leadership Council Physician Co-Chair are set out in Section 7.2. Any other Medical Staff Member of the Leadership Council may be removed for cause on two-thirds (2/3) vote of the Leadership Council or for cause on two-thirds (2/3) vote of the Board of Trustees. Only the Board of Trustees may remove the Hospital President, CQMO, or Chief Nursing Officer, and only the Hospital President may remove another member appointed under Section 6.2.3.2.

6.2.4. Meetings and Reporting.

6.2.4.1. The Leadership Council shall meet at least ten (10) times each year monthly and otherwise on the call of a Leadership Council Co-Chair.

6.2.4.2. For a quorum, at least two-thirds (2/3) of the voting members of the Leadership Council and the Hospital President must be present in person, or by teleconference, videoconference, or other appropriate means by which all participants can hear each other.

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

6.2.4.4. The Leadership Council shall report to the Board of Trustees after each meeting.

6.3. CLINICAL COUNCILS

6.3.1. Duties. There is a Clinical Council for each of the Service Lines. The Clinical Councils support the Leadership Council in achieving agreed-upon goals and standards of patient care and are responsible for overall management and outcomes of the specialties within the respective Service Line. The Clinical Councils' duties include the following:

6.3.1.1. Developing, implementing and regularly updating patient care (clinical) protocols, pathways and guidelines for the delivery of population management services within the Service Line;

6.3.1.2. Overseeing all aspects of case management activities for Service Line patients including (i) discharge planning; (ii) appointment scheduling; (iii) development of patient educational materials and discharge instructions; and (iv) ordering of appropriate services and supplies upon discharge;

6.3.1.3. Providing for timely and adequate specialty call coverage for the Hospital's emergency department for each of the specialty areas within the Service Line, subject to the approval of the Leadership Council;

6.3.1.4. Implementing FPPE and OPPE, including ongoing monitoring of patient, physician and staff satisfaction within the Service Line, and, as needed, developing, implementing and managing programs and plans for improvement and other Medical Peer Review activities within the Service Line; and

6.3.1.5. Developing and annually updating best practice standards for the Service Line, including performance-based benchmarks and monitoring systems, and developing, implementing and monitoring programs and plans to reduce adverse events, including medication errors, within the Service Line.

6.3.2. Composition.

6.3.2.1. Medical Staff Members. Each Clinical Council shall have at least six (6) but not more than ten (10) Members of the Organized Medical Staff from the Service Line as voting members. The members shall be appointed by the Leadership Council on the basis of the following behavioral and technical competencies: accountability, aspiration and passion for leadership, conflict management, engaged in Hospital's vision, integrity, judgment, legal/ethical/political awareness, skillful communication, and trust and respect. Clinical Council members may not hold a similar position at another hospital or health care entity during service on the Clinical Council and may not serve simultaneously on the Leadership Council.

6.3.2.2. Hospital Members. The Clinical Council shall also include as voting members: a Clinical Council Executive Co-Chair, a representative from Finance, and a representative from Nursing, all appointed by the Hospital President.

6.3.2.3. Chairs. The Clinical Council members shall elect a Physician Co-Chair from among their members. The Clinical Council Physician Co-Chair and the Clinical Council Executive Co-Chair shall serve as Co-Chairs of the Clinical Council, and both shall be voting members.

6.3.2.4. Terms. Membership terms shall be staggered three (3) year terms. Members may serve consecutive terms.

6.3.2.5. Medical Peer Review Duties. When the Clinical Council is performing Medical Peer Review functions, attendance shall be limited to Organized Medical Staff Members and the Clinical Council Executive Co-Chair, unless other members are invited by a Co-Chair.

6.3.3. Meetings and Reporting. The Clinical Councils shall meet at least monthly and otherwise on the call of a Co-Chair. For a quorum, at least two-thirds (2/3) of the Council members and the Clinical Council Executive Co-Chair or his designee must be present in person, or by teleconference, videoconference or other appropriate means by which all participants can hear each other. Affirmative action shall require majority vote of the members present, as defined above, in the presence of a quorum. The Clinical Councils shall report to the Leadership Council.

6.4. CREDENTIALS COMMITTEE

6.4.1. Duties. The Credentials Committee shall:

6.4.1.1. Coordinate the credentialing and privileging process for Practitioners and APPs/AHPs in accordance with the Bylaws;

6.4.1.2. Review the applications for appointment, reappointment, and/or Clinical Privileges;

6.4.1.3. Make recommendations to the Leadership Council regarding appointment, reappointment, and/or Clinical Privileges, including Staff category and Service Line assignment; and

6.4.1.4. Make recommendations to the Leadership Council for criteria for Clinical Privileges.

6.4.2. Composition. See Appendix B

6.4.3. Meetings; Quorum. The Credentials Committee shall meet monthly to review applications for appointment and reappointment and requests for new privileges or a change in privileges or medical staff category and make recommendations to the Leadership Council. For a quorum, at least one-half (1/2) of the voting Members of the Credentials Committee must be present in person, or by teleconference, videoconference or other appropriate means by which all participants can hear each other.

6.5. ADDITIONAL COMMITTEES AND TASK FORCES

6.5.1. Other standing committees of the Leadership Council or a Clinical Council may be established in writing by the Leadership Council or by a Clinical Council with the approval of the Leadership Council.

6.5.2. The Leadership Council and the Clinical Councils have the authority to form special and ad hoc committees and task forces to assist in the performance of authorized functions. Any such formation shall be reflected in writing with a statement of the purpose of the committee or task force.

6.5.3. The Hospital President, CQMO, and CNO may attend any Leadership Council, Clinical Council or other committee meeting, whether standing, ad hoc, special, or a task force, including a meeting in executive session.

7. LEADERSHIP OF THE MEDICAL STAFF

7.1. GENERAL [54]

The responsibility for the organization and conduct of the business of the Medical Staff shall rest with a Physician Member who shall serve as the Chief Officer of the Medical Staff and Leadership Council Physician Co-Chair.[55] Each Service Line shall have a Clinical Council Physician Co-Chair who is responsible for the organization and conduct of the Service Line and who shall co-chair the Clinical Council.

7.2. LEADERSHIP COUNCIL PHYSICIAN CO-CHAIR

7.2.1 Qualifications. The Leadership Council Physician Co-Chair must be a physician Member of the Organized Medical Staff who has demonstrated competencies in the following areas: accountability, aspiration and passion for leadership, conflict management, engaged in the organization's vision, integrity, judgment, legal/ethical/political awareness, skillful communication, and trust and respect. They must be a Member in good standing and may not have been subject to corrective action at this Hospital at any time. The Leadership Council Physician Co-Chair may not hold a similar position at another hospital or health care entity during their service in this position.

7.2.2 Duties. The duties of the Leadership Council Co-Chair shall include the following:

7.2.2.1 Serve as the chief officer of the Medical Staff, and represent and act as a spokesperson for the Medical Staff to the Hospital, the Board of Trustees and the community;
7.2.2.2 Serve as a voting member of and co-chair the Leadership Council;
7.2.2.3 Serve as an Ex-officio, non-voting member of the Clinical Councils, all special and ad hoc committees of the Leadership Council and Clinical Councils, task forces, and all other Medical Staff committees;
7.2.2.4 Call, preside at, and be responsible for the agenda of all regular and special meetings of the Medical Staff;
7.2.2.5 Enforce the Medical Staff Bylaws, Rules and Regulations, any Manuals, and Medical Staff policies, as well as Hospital policies applicable to Practitioners;
7.2.2.6 Implement and interpret the policies of the Board of Trustees to the Medical Staff and report to the Board of Trustees regarding patient care, Medical Peer Review and other activities affecting the Medical Staff;
7.2.2.7 Interact with the Hospital President, CQMO, and other members of Hospital administration and the Board of Trustees on matters of mutual concern affecting the Hospital; and
7.2.2.8 Perform those duties specifically listed in these Bylaws and as may be delegated by the Leadership Council or the Board of Trustees.

7.2.3 Appointment. The Leadership Council Physician Co-Chair shall be appointed by the Hospital President from the physician members of the Leadership Council, following consultation with the Leadership Council.

7.2.4 Term. The term of office shall be three years and begin on January 1, ending on December 31 of the third year.

7.2.5 Resignation or Removal.

7.2.5.1 The Leadership Council Physician Co-Chair may resign from their position at any time on written notice to the Leadership Council.
7.2.5.2 The Leadership Council Physician Co-Chair may be removed from office by a two-thirds vote of the Members of the Organized Medical Staff present at a special called meeting for that purpose with a quorum of the personal presence of at least two-thirds of the members. To schedule the special

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

meeting, there must be a written petition signed by at least 33% of the members of the Organized Medical Staff. The only individuals permitted to attend the special meeting are the Hospital President, who shall serve as the presiding officer, the members of the Organized Medical Staff, and a representative of the Medical Staff Services Office who shall take minutes.

7.2.5.3 The Leadership Council Physician Co-Chair may also be removed by a two-thirds vote of the Leadership Council with the approval of the Board of Trustees, or by the Board of Trustees.

7.2.5.4 Removal shall be automatic if the Leadership Council Physician Co-Chair is no longer a Member in good standing, or holds a similar position at another hospital or health care entity during his service in this position.

7.2.6 Vacancy. In the event of a vacancy in the position of Leadership Council Physician Co-Chair, the Leadership Council shall appoint a new member to the position to serve the remainder of the term.

7.3 CLINICAL COUNCIL PHYSICIAN CO-CHAIR

7.3.1 Qualifications. The Clinical Council Physician Co-Chair must be a Member of the Organized Medical Staff who has demonstrated competencies in the following areas: accountability, aspiration and passion for leadership, conflict management, engaged in the organization's vision, integrity, judgment, legal/ethical/political awareness, skillful communication, and trust and respect. They must be a Member in good standing and may not have been subject to corrective action at this Hospital at any time. They must also be board certified by the specialty board appropriate to their specialty and clinical privileges.[56] The Clinical Council Physician Co-Chair may not hold a similar position or serve as a medical staff officer at another hospital or health care entity during their service in this position.

7.3.2 Duties. The duties of the Clinical Council Physician Co-Chair shall include the following:

7.3.2.1 Serve with the Clinical Council Executive Co-Chair as Co-Chair of the Clinical Council, jointly responsible to call, preside at and be responsible for the agenda of meetings of the Clinical Council;

7.3.2.2 Account with the Clinical Council Executive Co-Chair to the Leadership Council for clinically related and administratively related activities within the Service Line;[57]

7.3.2.3 Serve as a voting member of the Clinical Council;

7.3.2.4 Maintain continuing surveillance of the professional performance of Practitioners and others with clinical privileges in the Service Line and report regularly thereon to the Leadership Council;[58]

7.3.2.5 Transmit to the appropriate authorities, as required by Articles 2, 4 and 7, recommendations of the Clinical Council concerning appointment and Staff category, reappointment, delineation of clinical privileges, and corrective action with respect to Practitioners applying to or assigned to the Service Line;[59]

7.3.2.6 Appoint with the Clinical Council Executive Co-Chair such standing, special or ad hoc committees or task forces as are necessary to conduct the functions of the Clinical Council as set out in these Bylaws and designate a chair for each;

7.3.2.7 Implement within the Service Line and Clinical Council actions delegated by the Leadership Council and integrate the Service Line into the primary functions of the Hospital and coordinate and integrate inter-Service Line and intra-Service Line services;[60]

7.3.2.8 Work with the Clinical Council Executive Co-Chair to prepare annual reports pertaining to the Service Line and Clinical Council as may be required by the Leadership Council or the Board of Trustees;

7.3.2.9 Assess and/or recommend to the Leadership Council off-site sources for needed patient care, treatment and services not provided by the Service Line or the Hospital;[61]

[56] MS.01.01.01 EP 36.
[57] MS.01.01.01 EP 36.
[58] MS.01.01.01 EP 36.
[59] MS.01.01.01 EP 36.
[60] MS.01.01.01 EP 36.
[61] MS.01.01.01 EP 36.

7.3.2.10 Provide or ensure the orientation and continuing education for all persons in the Service Line;[62]

7.3.2.11 Develop and implement policies and procedures that guide and support the provision of care, treatment, and service within the Service Line;[63]

7.3.2.12 Make recommendation on a sufficient number of qualified and competent persons to provide care, treatment, and service in the Service Line[64] and make recommendations for space and other resources needed by the Service Line;[65]

7.3.2.13 Recommend to the Leadership Council the criteria for clinical privileges that are relevant to the care provided within the Service Line;[66]

7.3.2.14 Determine qualifications and competence of Service Line personnel who are not Practitioners and who provide patient care, treatment, and services;[67]

7.3.2.15 Continuously assess and improve the quality of care, treatment, and services in accordance with the Hospital's Performance Improvement Plan and maintain quality control program, as appropriate;[68] and

7.3.2.16 Perform such other matters as may be requested from time to time by the Leadership Council or the Board of Trustees that are commensurate with the office.

7.3.3 Appointment. The Clinical Council Physician Co-Chair shall be elected by the Clinical Council members on the basis of the following behavioral and technical competencies: accountability, aspiration and passion for leadership, conflict management, engaged in the organization's vision, integrity, judgment, legal/ethical/political awareness, skillful communication, and trust and respect.

7.3.4 Term. The term of office shall be three years and begin on January 1, ending on December 31 of the third following year.

7.3.5 Resignation and Removal.

7.3.5.1 The Clinical Council Physician Co-Chair may resign from their position at any time on written notice to the Leadership Council.

7.3.5.2 The Clinical Council Physician Co-Chair may be removed from office by a two-thirds vote of the Members of the Organized Medical Staff assigned to the Service Line and present at a special called meeting for that purpose, with a quorum of the personal presence of at least two-thirds of the members. To schedule the special meeting, there must be a written petition signed by at least 33% of the members of those Organized Medical Staff. The only individuals permitted to attend the special meeting are the Leadership Council Co-Chairs, one of whom shall serve as the presiding officer, the members of the Organized Medical Staff assigned to the Service Line, and a representative of the Medical Staff Services Office who shall take minutes.

7.3.5.3 The Clinical Council Physician Co-Chair may also be removed by: (i) a two-thirds vote of the Clinical Council with the approval of the Leadership Council; (ii) a two-thirds vote of the Leadership Council with the approval of the Board of Trustees, or (iii) by the Board of Trustees following consultation with the Leadership Council.

7.3.5.4 Removal shall be automatic if the Clinical Council Physician Co-Chair is no longer a Member in good standing, or holds a similar position at another hospital or health care entity during their service in this position.

7.3.6 Vacancy. In the event of a vacancy in the position of Clinical Council Physician Co-Chair, the same procedures for election under Section 7.3.3 shall be followed and the new co-chair shall serve the remainder of the term.

[62] MS.01.01.01 EP 36.
[63] MS.01.01.01 EP 36.
[64] MS.01.01.01 EP 36.
[65] MS.01.01.01 EP 36.
[66] MS.01.01.01 EP 36.
[67] MS.01.01.01 EP 36.
[68] MS.01.01.01 EP 36.

7.4 CLINICAL COUNCIL PHYSICIAN VICE CHAIR

The Leadership Council, in consultation with the Leadership Council Physician Co-Chair, shall appoint a Clinical Council Physician Vice Chair from the members of the Clinical Council to perform the duties of the Clinical Council Physician Co-Chair in their absence. The Vice Chair may attend meetings of the Clinical Council but may not vote unless they are participating in the absence of the Physician Co-Chair. The Vice Chair shall be subject to the qualifications, duties, term, removal and resignation, and vacancy provisions above in Section 7.3.

8. MEETINGS

8.1. MEDICAL STAFF

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

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

8.2. COMMITTEE

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

8.3. ATTENDANCE REQUIREMENTS

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

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

8.4. NOTICE OF MEETINGS

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

8.5. QUORUM AND VOTING

8.5.1. Quorum. Unless these Bylaws provide otherwise, the personal presence of at least 10% of the voting Members of the Medical Staff, Council, or committee at a meeting shall constitute a quorum.

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

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

8.6. MAIL/FACSIMILE/ELECTRONIC BALLOTS

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

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

8.6.3. Return. Mail/facsimile/electronic ballots shall allow at least 14 days from the date of delivery for return. Affirmative action shall require the majority vote of those ballots that are returned. Return may be by mail, facsimile, electronic transmission, or hand delivery by the required date. Language asserting that a Member who does not return a ballot cannot be automatically assumed as an affirmative or "yes" vote. Unless otherwise provided in these Bylaws, a mail/facsimile/electronic ballot vote requires voting by at least 20% of the Members who are sent a ballot.

9. MEDICAL PEER REVIEW AND CORRECTIVE ACTION

9.1. GENERAL

9.1.1. Process. Medical Peer Review is conducted on an ongoing basis, with primary responsibility for implementation of the QAPI pertinent to the Medical Staff and others with Clinical Privileges placed on the Clinical Councils with oversight by the Leadership Council.

9.1.2. Objectives. The Medical Staff's objectives regarding ongoing implementation of the QAPI are to:

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

9.1.2.2. Evaluate FPPE and OPPE information, competence and professional conduct of Members and others with Clinical Privileges.

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

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

9.1.2.5. Evaluate the effectiveness of improvement efforts and actions and communicate the findings to the appropriate individuals and committees, including to the Board of Trustees through the Leadership Council.

9.1.3. OPPE/FPPE. In addition to evaluating the results of OPPE, reported concerns regarding the competence or professional conduct of Members or others with Clinical Privileges are evaluated by the Clinical Councils, with referral to the Leadership Council, if indicated.[69] Members may be placed under FPPE or may be requested to participate in performance improvement activities as described in Section 9.2.2 for the purpose of obtaining additional information or to modify practice, in accordance with the Medical Staff *Peer Review Policy.* Neither FPPE nor performance improvement activities entitle the Practitioner to procedural rights of review under the Bylaws or otherwise. See Section 12.4.2 on when FPPE constitutes Investigation.

9.1.4. Use in Reappointment. Information generated pursuant to Medical Peer Review, specifically the ongoing implementation of the QAPI and the results of FPPE and OPPE, is also used in the reappointment process.[70]

9.1.5. Collegial Intervention. 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 is encouraged. The goal of these efforts is to arrive at voluntary, responsive actions by the Practitioner to resolve questions that have been raised. Collegial efforts may include, but are not limited to counseling, sharing of comparative data, monitoring, performance improvement plans, and additional training or education. 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. The relevant Medical Staff leader(s) (includes officers, Council 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.

9.2. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

9.2.1. Authority. As a part of the Medical Peer Review process, the Clinical Councils may review a Practitioner's medical records at any time. If indicated, the Clinical Councils may utilize QAPI interventions to implement practice changes with the Practitioner on a voluntary basis in accordance with the Medical Staff *Peer Review Policy*. These actions are not considered Corrective action under these Bylaws and, as the Practitioner's compliance is not mandatory, do not entitle the Practitioner to procedural rights of review under these Bylaws or otherwise. See Section 10.1.3.

9.2.2. Actions in Absence of Review. This section does not preclude a member of the Leadership Council, a Clinical Council Physician Co-Chair, or the CQMO on behalf of the Leadership Council, from conferring with or counseling any Practitioner in the absence of a review when indicated. Voluntary or collegial efforts are not required prior to initiating Corrective Action.

9.3. SPECIAL REQUIREMENTS

9.3.1. Meeting. Whenever a suspected deviation from acceptable standard clinical or professional practice and/or professional conduct is identified, the Chief of Staff, a Clinical Council Physician Co-Chair, or the CQMO may require the Practitioner to confer with the Leadership Council, the Board of Trustees, or another standing Medical Staff committee or special committee, task force or ad hoc committee thereof appointed to consider the matter.

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

[69] MS.09.01.01.
[70] MS.08.01.03.

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

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

9.3.2. Provide Information. Whenever a suspected deviation from acceptable standard clinical or professional practice and/or professional conduct is identified, the Chief of Staff, a Clinical Council Physician Co-Chair, or the CQMO may require the Practitioner to provide requested information to the Leadership Council or the Clinical Council, or the Board of Trustees, or a standing committee or subcommittee, task force, or ad hoc committee thereof appointed to consider the matter.

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

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

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

9.3.3. Educational Program. Whenever an in-house educational program is recommended because of Medical Peer Review activities, the Practitioner whose performance has prompted the program and a Leadership Council Co-Chair or Clinical Council Co-Chair shall agree upon an acceptable program date within 30 days of the recommendation.

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

9.3.3.2. Failure of the Practitioner to attend shall be reported to the Leadership Council for consideration for possible Corrective Action.

9.4. REQUESTING CORRECTIVE ACTION[71]

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

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

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

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

9.4.1.4. Failure of the Practitioner to effect voluntary practice changes requested by the Leadership Council or the Clinical Council or comply with other actions imposed pursuant to Section 9.2.

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

9.4.2.1. If the Chief of Staff in consultation with the Hospital President, CQMO, or their designee *determines* that the matter may be resolved without the necessity of initiating an Investigation for purposes of possible Corrective Action, they may attempt to do so subject to the approval of the Leadership Council.

9.4.2.2. The Leadership Council shall review the request at its next regular meeting or a special called meeting. If the Leadership Council decides to initiate an Investigation for purposes of possible Corrective Action, such shall be documented in the minutes of the Leadership Council meeting. The Leadership Council also may refer the request to another committee, as not being appropriate for Corrective Action at this time, and request that the committee report back to the Leadership Council.

9.4.2.3. The Investigation may be conducted by the Leadership Council itself, a Clinical Council, or an ad hoc committee appointed by the Leadership Council Co-Chairs within 15 days of initiation of the Investigation (hereinafter referred to as the "Investigating Committee").

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

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

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

9.5. PROCEDURES FOR INVESTIGATION

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

9.5.2. Time. The Investigation shall be completed within 60 days of the Leadership Council's decision to initiate the Investigation, unless the Leadership Council Co-Chairs grant an extension for good cause.

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

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

9.5.4.1. If the opportunity for a meeting is afforded, the Investigating Committee shall provide Special Notice to the Practitioner at least seven days prior to the meeting. The notice shall advise the Practitioner of the place, time, and date of the meeting and the basis for the request for Corrective Action, with a general listing of the medical records or events that are the subject of the Investigation.

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

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

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

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

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

9.6. RECOMMENDATION FOR CORRECTIVE ACTION

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

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

9.6.2.1. Denying the request for Corrective Action;

9.6.2.2. Issuing a letter of reprimand or admonition;

9.6.2.3. Placing the Practitioner on probation[72] for a stated period of time;

9.6.2.4. Imposing a consultation, monitoring or supervision requirement;

9.6.2.5. Requiring additional education, training, or experience;

9.6.2.6. Requiring treatment, rehabilitation, or counseling;

9.6.2.7. Restricting, limiting, suspending, or terminating one or more Clinical Privileges;

9.6.2.8. Changing Medical Staff category or Medical Staff prerogatives; and/or

9.6.2.9. Suspending or terminating Medical Staff membership; or

9.6.2.10. Defer action for a reasonable time period when circumstances warrant, not to exceed ninety (90) days.

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

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

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

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

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

9.7. SUMMARY CORRECTIVE ACTION [73]

9.7.1. Grounds. The Hospital President, with the concurrence of the Leadership Council Physician Co-Chair or a Clinical Council Physician Co-Chair has the authority to suspend or restrict all or any portion of a Practitioner's Clinical Privileges, effectively immediately, whenever there is reasonable belief that failure to take such action may result in imminent danger to the health and/or safety of any individual.[74]

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

9.7.1.2. If necessary, the Leadership Council Physician Co-Chair or a Clinical Council Physician Co-Chair or their designee shall assist any patients of the Practitioner who are hospitalized at the time of the summary Corrective Action to secure alternate coverage from another Member of the Medical Staff.

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

9.7.2. Reporting. The individual imposing the summary Corrective Action shall report the action immediately to the Leadership Council, and the action shall remain in effect unless modified by the Hospital President, CQMO, or their designee or the Leadership Council.

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

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

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

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

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

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

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

[73] MS.01.01.01 EP 29, 32.

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

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

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

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

9.7.6.1. If the Board of Trustees affirms the recommendation of the Leadership Council, the Hospital President, CQMO, or their designee shall provide the Practitioner with Special Notice of the final decision of the Board of Trustees pursuant to this section within five days of the decision.

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

9.7.7. Adverse Recommendation and Right to Hearing.

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

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

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

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

9.7.8.2. If a summary Corrective Action is rescinded by final decision of the Board of Trustees, while the Practitioner's files will retain a record of the actions taken, the summary Corrective Action is considered not to have occurred, and the Hospital shall not disclose the rescinded action to a third party unless required to do so by law.

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

9.8. TEMPORARY ACTION[75]

9.8.1. Grounds. The Hospital President, CQMO, or their designee, with the concurrence of the Leadership Council Physician Co-Chair or a Clinical Council Physician Co-Chair, may impose a temporary suspension or restriction of, or condition on, the Clinical Privileges of a Practitioner. The temporary

[75] 42 U.S.C. Sec. 11112(c)(1)(B).

action may not to exceed 14 days, during which time a review or evaluation is conducted to determine the need for further action.

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

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

9.9. VOLUNTARY AGREEMENT

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

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

10. **PROCEDURAL RIGHTS OF REVIEW**[76]

10.1. ENTITLEMENT TO PROCEDURAL RIGHTS OF REVIEW[77]

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

10.1.1.1. The Leadership Council takes an Adverse Recommendation or Action;

10.1.1.2. An Adverse Recommendation or Action is taken by the Board of Trustees following a recommendation or action by the Leadership Council that was not an Adverse Recommendation or Action; or

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

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

10.1.2. Adverse Recommendation or Action Defined (Grounds for Procedural Rights of Review). Subject to the provisions in Section 10.1.3 or as otherwise provided in these Bylaws, only the following actions or

[76] MS.01.01.01 EP 34.

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

recommendations when taken provided in Section 10.1.1 constitute an Adverse Recommendation or Action entitling a Practitioner to procedural rights of review under these Bylaws:

10.1.2.1. Denial of appointment to the Medical Staff;

10.1.2.2. Denial of reappointment to the Medical Staff;

10.1.2.3. Termination or revocation of appointment to the Medical Staff;

10.1.2.4. Denial of requested Clinical Privileges;

10.1.2.5. Termination or revocation of Clinical Privileges;

10.1.2.6. Suspension of Clinical Privileges, other than a temporary action pursuant to Section 9.8;

10.1.2.7. An observation or proctor requirement if the observer or proctor's approval is required for the Practitioner to exercise Clinical Privileges or a proctor or supervisor requirement if the proctor or supervisor is required to be present or approve for the Practitioner to exercise Clinical Privileges for more than 30 days based on competence or professional conduct;

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

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

10.1.2.10. Any other restriction or limitation of Clinical Privileges based on competence or professional conduct if such action, when final, would be reportable to the NPDB.

10.1.3. Not Grounds for Procedural Rights of Review.[78] None of the following recommendations or actions, nor any others so referenced in the Bylaws, shall constitute an Adverse Recommendation or Action or entitle the Practitioner to the procedural rights of review in these Bylaws or otherwise. The Practitioner is entitled to submit a written explanation or rebuttal regarding the recommendation or action which shall be placed in the Practitioner's file.

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

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

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

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

[78] 42 USC Sec. 11112(c)(1)(A).

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

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

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

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

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

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

10.1.3.11. Denial of a request for LOA or for an extension of a LOA;

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

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

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

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

10.1.3.16. Failure to grant, terminate, or limit temporary Clinical Privileges;

10.1.3.17. Removal or limitation of emergency services call coverage obligations;

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

10.1.3.19. Expiration of membership and privileges because of failure to apply for reappointment within the allowable time period under these Bylaws; and

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

10.1.4. Actions Pursuant to Contract.[79]

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

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

10.2. NOTICE OF ADVERSE RECOMMENDATION OR ACTION[80]

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

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

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

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

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

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

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

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

10.2.2. Waiver.

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

10.2.2.2. The Adverse Recommendation or Action shall become effective immediately, subject to review and approval by the Board of Trustees at its next regular meeting. The Hospital President, CQMO,

[79] Id.

[80] 42 U.S.C. Sec. 11112(b)(1).

or their designee shall provide the Practitioner with Special Notice of the Board of Trustees' final decision within 10 days of the decision.

10.3. REQUEST AND PREHEARING PROCEDURES[81]

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

10.3.2. Notice of Scheduling.[82] Following receipt of a proper request for a hearing, the Hospital President, CQMO, or their designee shall schedule the hearing as provided below and provide Special Notice to the Practitioner of:

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

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

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

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

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

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

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

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

[81] MS.01.01.01 EP 34.
[82] 42 USC Sec. 11112(b)(2).

10.3.6.1. A copy of the expert's curriculum vitae;

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

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

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

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

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

10.3.8. Exchange of Exhibits.

10.3.8.1. At least 15 days prior to the start of the hearing, the Leadership Council or Board of Trustees, whichever recommended the Adverse Recommendation or Action, and the Practitioner must each provide the other with a list of the documents intended to be presented during the hearing and with a copy of the documents, unless they have been previously provided. Any objections to these documents must be made by Special Notice to the Presiding Officer at least seven days prior to the start of the hearing. The ruling on the objections, if any, shall be by the Presiding Officer at a pre-hearing conference and if not, at the start of the hearing.

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

10.4. HEARING COMMITTEE[83]

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

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

10.4.1.2. A System medical peer review committee; or

10.4.1.3. An independent hearing officer who is not a member of the Medical Staff.

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

When considering selection of a hearing officer in lieu of an ad hoc committee, the Hospital President, CQMO, or their designee may consider circumstances, such as the complexity of the issues and availability of Members to serve on a committee.

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

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

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

10.4.3.2. Have a conflict of interest;

10.4.3.3. Be a direct economic competitor of the Practitioner; or

10.4.3.4. Be professionally associated with or related to the Practitioner.

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

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

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

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

10.4.5. Limitations on Contact.

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

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

10.5. REPRESENTATIVE

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

10.6. PRESIDING OFFICER

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

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

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

10.7. RIGHTS OF THE PARTIES[84]

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

10.7.1. Be present at the hearing;

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

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

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

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

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

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

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

[84] 42 USC Sec. 11112(b)(3)(C).

10.8. RECORD OF HEARING

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

10.9. ATTENDANCE AT HEARING

10.9.1 Practitioner.[85] The personal attendance of the Practitioner for whom the hearing is scheduled is required. If the Practitioner does not testify in the Practitioner's own behalf, the Practitioner may be called and examined by the Representative and/or the Hearing Committee. Failure of the Practitioner to be present during the hearing without good cause, as determined by the Presiding Officer, shall constitute a waiver of the Practitioner's right to a hearing and any further procedural rights of review under these Bylaws or otherwise.

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

10.10. HEARING PROCEDURES AND BURDEN OF PROOF

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

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

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

10.10.2.2. That the Practitioner possesses the necessary qualifications and competence for the Clinical Privileges and/or membership on the Medical Staff.

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

10.10.3. Recess and Completion Deadline. The Presiding Officer may, at the Presiding Officer's sole discretion and without Special Notice to the parties, recess the hearing for the convenience of the participants or for the purpose of requesting that the parties obtain additional evidence or present additional witnesses. Once the hearing is started, it must be completed within 60 days.

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

10.10.5. Written Statements. Both the Practitioner and the Representative shall have the right to submit to the Hearing Committee for consideration a written statement on any matter(s) pertinent to the Adverse

[85] 42 USC Sec. 11112(b)(3)B).

Recommendation or Action at the close of the hearing or by a later time and date designated by the Presiding Officer.

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

10.11. DELIBERATIONS AND REPORT

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

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

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

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

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

10.12. CONSIDERATION BY LEADERSHIP COUNCIL OR BOARD OF TRUSTEES

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

10.12.2. Adverse Recommendation or Action Initiated by Leadership Council

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

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

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

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

10.12.3. Adverse Recommendation or Action Initiated by Board of Trustees.

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

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

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

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

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

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

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

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

10.13. REQUEST AND GROUNDS FOR APPEAL

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

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

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

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

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

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

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

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

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

10.13.3.1. The Adverse Recommendation or Action was not made in the reasonable belief that it will further quality health care[86];

10.13.3.2. There was not a reasonable effort to obtain the facts of the matter in issuing the Adverse Recommendation or Action[87];

10.13.3.3. There was not a reasonable belief that the Adverse Recommendation or Action was warranted by the known facts[88];

10.13.3.4. The Adverse Recommendation or Action was arbitrary or capricious [89]

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

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

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

10.14. APPELLATE REVIEW PANEL

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

[86] 42 U.S.C. Sec. 11112(a).

[87] Id.

[88] Id.

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

10.15. APPELLATE REVIEW PROCEDURES

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

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

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

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

10.16. FINAL DECISION BY BOARD OF TRUSTEES

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

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

10.16.3. Notice to Practitioner. The Hospital President, CQMO, or their designee shall provide the Practitioner with Special Notice of the Board of Trustees' final decision within 10 days of the decision, with a statement of the basis for the decision. A copy shall also be sent to the Leadership Council.

10.17. MEDIATION

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

10.17.2. Request. The Eligible Practitioner must submit a request for mediation by Special Notice to the Hospital President, CQMO, or their designee within 14 days of: (a) receipt of the notice of an Adverse

Recommendation or Action as required by Section 10.2; or (b) the 90th day from the Credentials Committee's *[or Leadership Council as applicable]* receipt of a Complete Application. If a request for mediation and a request for hearing have been submitted in response to notice of an Adverse Recommendation or Action, the mediation shall be conducted first and the timelines for scheduling the hearing temporarily suspended until the mediation is completed.

10.17.3. Conditions of Mediation.

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

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

10.17.3.3. The mediation shall occur either at the Hospital, the mediator's office, or other mutually agreeable location and shall be limited to a full day of mediation, unless otherwise agreed by the Eligible Practitioner and Hospital President, CQMO, or their designee.

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

10.17.4. Agreement. Any agreement reached at mediation is "proposed" and must be approved by the Board to be final and binding.

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

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

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

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

10.18. MISCELLANEOUS

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

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

11. **AUTOMATIC ACTION**[90]

11.1. GENERAL

11.1.1. Defined. On notice to the Hospital of occurrence of any of the following, automatic action as detailed below shall result, in addition to any other automatic actions set out elsewhere in these Bylaws. An automatic action is not considered an Adverse Recommendation or Action *or* Corrective Action, does not entitle the Practitioner to any procedural rights of review under these Bylaws or otherwise, and does not require any action by the Leadership Council or the Board of Trustees. The occurrence of automatic action does not prevent the imposition of Corrective Action for the same or related grounds pursuant to the procedures in Article 9.

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

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

11.2. TYPES OF AUTOMATIC ACTION

11.2.1. License.

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

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

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

[90] MS.01.01.01 EP 28, 31.

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

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

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

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

11.2.6. Medical Records. Using the procedures in the Rules and Regulations, a Practitioner's Clinical Privileges shall be automatically suspended for delinquency in completion of medical records ("delinquency" is defined as medical records that are incomplete 15 days or more after patient discharge from the Hospital). The Practitioner's Clinical Privileges shall be automatically terminated along with Medical Staff membership if the Practitioner remains on automatic suspension for more than 90 consecutive days. Automatic suspension and termination provisions may also be used, as detailed in the Rules and Regulations, for failure to comply with other medical record documentation requirements.

11.2.7. Board Certification. Except as provided below, if the Practitioner fails to secure or maintain board certification (including recertification if available) or maintain board eligibility as required by these Bylaws, the Practitioner's Clinical Privileges and Medical Staff membership shall be automatically terminated. If a member of the Medical Staff who was board certified on the Effective Date (see Section 2.2.10.1) failed to secure re-certification, that member shall be exempted from automatic termination to obtain re-certification only if, on the date the board certification expired, the member is scheduled for the next re-certification examination. This exemption shall end on the date the results of the re-certification examination are available.

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

11.2.9. Providing Information. Failure of a Practitioner to provide information for which the Practitioner has received Special Notice in accordance with Section 9.3.2.1 shall result in an automatic suspension of Clinical Privileges. The Practitioner shall be given Special Notice of the automatic suspension and a final opportunity to provide the requested information as provided in Section 9.3.2.2. Failure to provide the requested information as provided in Section 9.3.2.2 will result in an automatic termination of the Practitioner's Clinical Privileges and Medical Staff membership. Failure to comply with requested health status examination and/or

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

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

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

11.2.12. Mandated Policies. Failure of a Practitioner to comply with Hospital or Medical Staff policies that mandate certain training such as EHR training or Highly Reliable Organization ("HRO") Education or vaccines or immunizations shall result in automatic suspensions or terminations of Clinical Privileges as provided in those policies.

12. MEDICAL PEER REVIEW CONFIDENTIALITY AND IMMUNITY

12.1. MEDICAL PEER REVIEW

12.1.1. Medical Peer Review Committee Status. The Leadership Council, the Clinical Councils, all Medical Staff, and Service Line *[if applicable]* committees (whether standing, special, ad hoc, subcommittee, joint committee, task force, Hearing Committee, or Appellate Review Body), as well as the Medical Staff when meeting as a whole, any joint System medical peer review committee, shall be constituted and operate as a "medical peer review committee," "medical committee," and "professional review body," as such terms are defined by Texas and/or federal law,[91] and are authorized by the Board of Trustees through these Bylaws to engage in Medical Peer Review as defined below. This provision shall also apply to any Hospital or other committees engaged in Medical Peer Review at the Hospital, including the Board of Trustees and its committees.

12.1.2. Medical Peer Review Defined. "Medical Peer Review"[92] means the evaluation of medical and health care services, including the evaluation of the qualifications and professional conduct of Members, Practitioners, and other individuals holding or applying for Clinical Privileges, and of patient care, treatment, and services provided by them. The term includes but is not limited to:

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

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

12.1.2.3. Any evaluation of the merits of a complaint relating to Members, Practitioners or others with Clinical Privileges and issuance of a recommendation or action in that regard;

12.1.2.4. Any evaluation of the accuracy of a diagnosis or quality of the patient care, treatment, or services provided by one of the above individuals or other health care professionals within the Hospital, including but not limited to implementation of the Hospital's QAPI and the review of patient care, treatment, or services by another Practitioner, whether or not a member of the Medical Staff, or another individual with Clinical Privileges;

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

12.1.2.5. A report made to an individual or a committee engaged in Medical Peer Review or to a licensing agency;

12.1.2.6. Implementation of the duties of a committee engaged in Medical Peer Review by a member, agent, or employee of the committee; and

12.1.2.7. "Medical peer review" as defined in the Texas Medical Practice Act and "professional review activity" as defined by the federal Health Care Quality Improvement Act.[93]

12.1.3. Agents and Members. The Hospital President, CQMO, or their designee, other members of Hospital Administration, Medical Staff Services staff, and all other Hospital departments supporting Medical Peer Review activities shall be considered agents of the Medical Staff, Clinical Council, and Service Line *[if applicable]* committees and the Medical Staff and Board of Trustees as applicable when performing authorized functions and responsibilities.

12.1.3.1. Practitioners, whether or not members of the Medical Staff, and others including outside peer reviewers who are requested by the Leadership Council or another Medical Staff committee, a Clinical Council or a committee thereof, or a special or ad hoc committee or task force thereof, or by the Medical Staff or the Board of Trustees to review the patient care, treatment, or services of another Practitioner or individual with Clinical Privileges, or who do so as an authorized function of the requesting committee, Clinical Council, task force, Medical Staff, or Board of Trustees, shall be considered agents thereof when performing such review in good faith.

12.1.3.2. Any good faith action by an agent or member of the Leadership Council or another Medical Staff committee, a Clinical Council or committee thereof, or special or ad hoc committee or task force thereof, or of the Medical Staff or the Board of Trustees, when performing authorized functions and responsibilities shall be considered an action taken on behalf of the committee, Clinical Council, task force, Medical Staff, or Board of Trustees as applicable, not an action taken in the agent or member's individual capacity. This shall include, but not limited to, actions by the Medical Staff, Clinical Council, and Service Line *[if applicable]* officers, the CQMO, and other Practitioners serving in medical staff leadership and/or administrative positions, and the Hospital President, CQMO, or their designee.

12.2. CONFIDENTIALITY

12.2.1. General. All records and proceedings of the Medical Staff, the Leadership Council, the Clinical Councils, Service Lines *[if applicable]*, and any committees (whether standing, special, ad hoc, subcommittees, joint committees, or task forces, including a Hearing Committee or Appellate Review Panel under Article 10) thereof, and the Board of Trustees, including but not limited to any minutes of meetings, disclosures, discussion, statements, communications to or from third parties, reviews under Section 12.1.3.1, actions, or recommendations in the course of Medical Peer Review, shall be privileged and confidential to the fullest extent permitted by Texas and federal law. They shall be subject to disclosure only in accordance with written Hospital policies, unless otherwise required by Texas or federal law, and shall be privileged to the fullest extent permitted by Texas and federal law.

12.2.2. Obligation to Maintain Confidentiality. All Members and others holding Clinical Privileges, as well as those applying for such status, and all other individuals participating in, providing information to, or attending meetings of those groups listed in Section 12.1.1 are required to maintain the records and proceedings related to any Medical Peer Review activities as confidential, subject to disclosure only in accordance with Hospital policies, unless otherwise required by Texas and/or federal law.

[93] Tex. Occ. Code Sec. 151.002(7)-(8); 42 U.S.C. Sec. 11151(10).

12.2.3. Waiver. The privilege of confidentiality as to the records and proceedings of those groups listed in Section 12.1.1 may only be waived on the written consent of the chair of the committee, Clinical Council, or task force, and the Hospital President, CQMO, or their designee.

12.2.4. Minutes. Minutes of all meetings of those groups listed in Section 12.1.1, except for the Board of Trustees, shall be prepared by Medical Staff Services as agents thereof, and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer of the meeting and forwarded to the Leadership Council.

12.2.5. Maintenance and Access. All minutes under Section 12.2.4 will be maintained by the Hospital as records and proceedings of a "medical peer review committee," "medical committee," and "professional review body," as such terms are defined under Texas and/or federal law, in a confidential manner to provide maximum protection under the law. They are the property of the Hospital and except for Board of Trustees' minutes, are maintained by Medical Staff Services.

12.2.5.1. They will be available for inspection by the Leadership Council, the Hospital President, CQMO, or their designee, the Board of Trustees, and any employees and agents of the Hospital whose authorized functions necessitate access.

12.2.5.2. A member of the Leadership Council, a Clinical Council member, and other committee or task force members may also inspect the records and proceedings of their committee or task force which were generated during their service as a member, if the member is currently a Member of the Medical Staff.

12.2.5.3. Access is also permitted pursuant to Hospital policy and as required by Texas or federal law, accreditation requirements, or third-party contract of the Hospital.

12.2.5.4. Access of a Practitioner to records and proceedings shall be only as required by law, written Medical Staff policy, or as approved by the Hospital President, CQMO, or their designee.

12.3. IMMUNITY FROM LIABILITY

12.3.1. Immunity. The Medical Staff and its Members, the Board of Trustees, the Hospital, and any committees, representatives, agents, employees, or members thereof, and third parties as defined below, will have immunity as provided in Section 2.5.2.6. This immunity shall be to the fullest extent permitted by Texas and federal law and shall include any immunity for any permissive and mandatory reporting provided for by Texas or federal law.

12.3.2. Third Parties. The reference above to third parties shall mean all individuals and entities, including without limitation their representatives, medical staffs, trustees, directors, officers, and employees, who provide information, whether orally or in writing, to the Hospital or the Medical Staff, concerning any matter that might directly or indirectly affect a Practitioner's exercise of Clinical Privileges or Medical Staff membership, or relating to the Practitioner's qualifications for appointment or reappointment to the Medical Staff or practice at the Hospital.

12.3.3. Authorization and Release of Liability. All applicants for appointment to the Medical Staff, reappointment, and/or Clinical Privileges shall execute a release of liability consistent with the immunity and release of liability provisions in these Bylaws and an authorization for the Hospital, the Medical Staff, and third parties to disclose confidential information as necessary for Medical Peer Review in the course of application and at all times thereafter. The effectiveness of the immunity provisions of these Bylaws, however, is not contingent on execution of these authorizations and releases. The immunity provisions in these Bylaws and any releases of liability shall be in addition to and not in limitation of any immunity afforded by Texas or federal law.

12.4. MANDATORY REPORTING AND INVESTIGATION DEFINED

12.4.1. Duty. The Hospital President, CQMO, or their designee, in consultation with the Chief of Staff, shall be responsible to comply with any mandatory reporting requirements of the Hospital under Texas and federal law pertaining to Medical Staff membership or Clinical Privileges.[94] Nothing in this section or the other provisions of the Bylaws shall prevent an individual Member or member of the Board of Trustees from making any other report to Texas or federal agencies as permitted or required by law.

12.4.2. Investigation Defined. An "Investigation" for purposes of mandatory reporting requirements is only:

12.4.2.1. An investigation affirmatively initiated by the Leadership Council following receipt of a request for possible Corrective Action as set forth in Section 9.4.2, based on competence or professional conduct;

12.4.2.2. That period of time following issuance of an Adverse Recommendation or Action (defined in Article 10) based on competence or professional conduct during appointment, reappointment, Clinical Privileges, or Corrective Action under Article 9; or

12.4.2.3. That period of time following issuance of summary Corrective Action under Section 9.7.

FPPE for identified concerns is not considered an Investigation unless it is imposed specifically as a precursor to Corrective Action.

12.4.3. Duration. An Investigation continues until issuance of a final decision by the Board of Trustees, acceptance of a resignation from the Practitioner by the Board of Trustees, or withdrawal of the application from processing. Any other use of the term "investigation" in these Bylaws, Rules and Regulations, any Manuals, or Medical Staff policies does not constitute an Investigation.

12.4.4. Summary Corrective Action. Summary Corrective Action pursuant to Section 9.7 is considered a "professional review action," as that term is defined in the Health Care Quality Improvement Act, when affirmed by the Leadership Council. For purposes of mandatory reporting, the professional review action is considered to have taken effect on the date it was imposed by the individual pursuant to Section 9.7.1.[95]

12.4.5. Automatic Termination of Clinical Privileges. An automatic termination or expiration of a Practitioner's clinical privileges while the Practitioner is under Investigation does not subject the Practitioner to mandatory reporting for a surrender of privileges while under Investigation, since the privileges were not surrendered voluntarily. Examples include, but are not limited to, expiration of temporary clinical privileges, automatic termination pursuant to a contract for professional services, or automatic termination pursuant to Article 2.

13. CONFLICT OF INTEREST AND HOSPITAL CONFLICT MANAGEMENT

13.1. Conflict of Interest – Medical Peer Review.

13.1.1. Disclosure. Whenever a Practitioner is participating in Medical Peer Review and/or performing a function for the Medical Staff, the Leadership Council or a Clinical Council, Service Line *[if applicable]*, or a committee or task force thereof, or the Hospital, and the Practitioner interests could be reasonably interpreted as being in conflict with the interests of the Medical Staff, Leadership Council, Clinical Council, Service Line *[if applicable]*, or other committee, Hospital, or individual under review, the Practitioner shall disclose those interests and the potential for conflict to the appropriate decision makers prior to such participation. The chair may require the Practitioner to refrain from any participation in decisions that may be affected by or affect the Practitioner's interests.

[94] 25 Tex. Admin. Code Sec. 133.41(f)(4)(H).
[95] NPDB Guidebook, E-36 (2015).

13.1.2. Individual Peer Review. A Practitioner shall not be eligible to be present during or participate in any meeting, discussion, or deliberation of the Leadership Council, a Clinical Council, Service Line, if applicable, or committee or task force of which they are a member regarding the Practitioner's Clinical Privileges or Medical Staff membership or any other Medical Peer Review activity involving the Practitioner, except to the extent specifically provided for in the Bylaws, Rules and Regulations, a Manual, or Policy, or when invited by the chair.

13.1.3. Involvement of Family or Business Partners. Any family members or business partners of a Practitioner shall not be eligible to participate in, or be present during, any meeting, discussion, or deliberation of the Leadership Council, a Clinical Council, or committee or task force regarding the Practitioner's Clinical Privileges or Medical Staff membership or any other Medical Peer Review activity involving the Practitioner. "Family member" shall mean a Practitioner's: (a) parents or stepparents, including spouses of the same, (b) ancestors, (c) spouse, (d) child or stepchild, grandchild, or great grandchildren, (e) siblings, whether related by whole or half blood, or (f) the spouse of an individual described in clause (d) or clause (e), and shall include adoptive relationships of the above.

13.1.4. Hospital and Texas Health System Policies. These provisions shall be in addition to any requirements of the Hospital's conflict of interest policies, as well as those of Texas Health System.

13.2. HOSPITAL CONFLICT MANAGEMENT POLICY FOR LEADERSHIP[96]

13.2.1. Notice of Different Decision. Whenever a decision of the Board of Trustees is contrary to a recommendation of the Leadership Council, the members of the Leadership Council shall be given Special Notice of the decision by the Hospital President, CQMO, or their designee.

13.2.2. Request for Appearance. Within five days of the Chief of Staff's receipt of the notice, the Leadership Council, through the Chief of Staff, may file a written request with the Hospital President, CQMO, or their designee that a designated representative or representatives of the Leadership Council be given an opportunity to appear before and/or submit a written statement to the Board of Trustees on the decision.

13.2.3. Appearance and Final Decision. If so requested, the Leadership Council representative(s) shall be given prior Special Notice of the date, time, and place for the appearance and/or submission of a written statement, which shall be established by the chair of the Board of Trustees. Depending on the nature of the issue, at the discretion of the chair of the Board of Trustees, the process may also include meetings with the Leadership Council or other involved parties and the gathering of additional information, with the overall objective of protecting the safety and quality of patient care. The Board of Trustees shall consider any information provided by the Leadership Council pursuant to this process in reaching a final decision.

13.2.4. Not Applicable to Individual Peer Review. This provision shall not apply to Medical Peer Review decisions regarding individual Practitioners, including but not limited to those pertaining to appointment, reappointment, Clinical Privileges, or Corrective Action.

14. ADOPTION AND AMENDMENT OF BYLAWS AND ANCILLARY DOCUMENTS

14.1. GENERAL

14.1.1. Bylaws.[97] The Medical Staff is responsible for adopting and amending the Bylaws, which responsibility cannot be delegated. These Bylaws shall be reviewed at least every two (2) years and otherwise at the direction of the Leadership Council or on the request of the Board of Trustees to verify compliance with legal and accreditation requirements and current Medical Staff practice and identify the need for amendments.

[96] LD.02.04.01.

[97] MS.01.01.01 EP1-2; 42 C.F.R. Sec. 482.22(c); 25 Tex. Admin. Code Sec. 133.41(f)(4)(A)-(B), Sec. 133.41(k)(3).

14.1.2. Ancillary Governance Documents. The Medical Staff shall adopt, using the procedures below, Rules and Regulations, Manuals, and Medical Staff policies as may be necessary to implement the processes and requirements set out in these Bylaws.[98] The Rules and Regulations, Manuals, and Medical Staff policies shall be reviewed at least every two (2) years and otherwise at the direction of the Leadership Council or on the request of the Board of Trustees to verify compliance with legal and accreditation requirements and current Medical Staff practice and identify the need for amendments. Any ancillary governance documents adopted pursuant to this Article shall be subject to and governed by these Bylaws. The definitions in these Bylaws shall be applicable to the Rules and Regulations, the Manuals, and Medical Staff policies, although they may include additional definitions. In the event of a conflict between the Rules and Regulations, a Manual, or a Policy and the Medical Staff Bylaws, these Bylaws shall control.

14.1.3. Hospital Bylaws. The Medical Staff Bylaws, Rules and Regulations, any Manuals, and Medical Staff policies shall not conflict with the bylaws of the Hospital adopted by the Board of Trustees. [99]

14.2. ADOPTION AND AMENDMENT OF MEDICAL STAFF BYLAWS

14.2.1. Procedure. These Bylaws may be adopted or amended at a regular meeting or a special called meeting of the Medical Staff (or by mail/facsimile/electronic ballot as provided in Article 8) by majority vote.

14.2.1.1. Notice that an adoption or amendment is being proposed shall be provided to the voting Members of the Medical Staff and copies of the proposed amendments shall be available in Medical Staff Services for review at least 10 days prior to the meeting or distribution of the mail/electronic ballot.

14.2.1.2. Adoption or amendment shall require a quorum of at least 20% of the voting Members of the Medical Staff at a meeting. If an electronic vote is used as provided in Article 8, at least 30% of the voting Members of the Medical Staff must vote. Any adoption or amendment approved by the Medical Staff shall be effective only when and if approved by the Board of Trustees.

14.2.1.3. The approved, adopted bylaws or amendments shall be distributed to the Members of the Medical Staff.

14.2.2. Initiation of Process. A motion to amend these Bylaws may be made by: the Leadership Council; the Hospital President, CQMO, or their designee; or at least 80% of the voting Members of the Medical Staff.

14.2.2.1. All requests must be in writing to the Leadership Council. The Leadership Council may refer the proposed amendment to an ad hoc Bylaws Committee for review and recommendation within a stated time period.

14.2.2.2. Upon receipt of the review and recommendation of the Bylaws Committee, if any, the Leadership Council shall consider the proposed amendment at its next regular meeting (or a special called meeting) and decide whether to present the proposed amendment for a vote at a regular or special called meeting of the Medical Staff (or by mail/electronic ballot as provided in Article 8) or not to present the amendment.

14.2.2.3. An amendment proposed directly by the Medical Staff as provided above must be presented for a vote to the Medical Staff at a meeting or by mail/electronic ballot as provided above.[100]

14.2.3. Effective Date. Except as provided in Section 14.9, these Bylaws and any amendments pursuant to this Article shall become effective only upon the date of approval by the Board of Trustees.[101] The Bylaws and any amendments shall replace and supersede all previous medical staff bylaws and be upheld by the

[98] MS.01.01.01 EP 25.
[99] MS.01.01.01 EP 4.
[100] MS.01.01.01 EP 8, 24.
[101] 25 Tex. Admin. Code Sec. 133.41(f)(4)(B), 133.41(k)(3)(A); 42 U.S.C. Sec. 482.12(a)(4), 482.22(c)(1).

Board of Trustees, unless otherwise stated in the Bylaws provision or amendment approved by the Board of Trustees.[102] The Medical Staff, individual Members of the Medical Staff, and applicants for Medical Staff membership and/or Clinical Privileges shall comply with and enforce the Medical Staff Bylaws, which shall be distributed to or made available to Members and applicants.[103]

14.3. ADOPTION AND AMENDMENT OF RULES AND REGULATIONS

14.3.1. By Leadership Council.

14.3.1.1. Regular Amendment. The Rules and Regulations may be adopted or amended at a regular meeting (or a special meeting called for such purpose) of the Leadership Council; provided that, at least 14 days prior to the meeting, the Leadership Council must notify the Medical Staff of the proposal. [104]

14.3.1.1.1. The notice shall advise the Members of the opportunity and procedures to submit written comments on the proposal to the Leadership Council for their consideration prior to voting on the proposal. Adoption or amendment shall require the affirmative vote of majority of the voting members present at a meeting of the Leadership Council at which there is a quorum.

14.3.1.1.2. The approved amendments shall be communicated to the Members of the Medical Staff. The procedures for conflict management between the Medical Staff and the Leadership Council on the approved amendment are set out below in Section 14.4.

14.3.1.2. Urgent Amendment. In cases of a documented need for an urgent amendment of the Rules and Regulations to comply with a law or regulations, the Leadership Council may provisionally adopt or amend the Rules and Regulations and forward it to the Board of Trustees for approval without prior notification of the Medical Staff as required in Section 14.3.1.1. [105]

14.3.1.2.1. In such case, the Members of the Medical Staff shall be notified of the amendment within 10 days of approval by the Leadership Council. The notice shall advise the Members of the opportunity and procedures to submit written comments on the proposal to the Leadership Council within 10 days of the notice.

14.3.1.2.2. The procedures for invoking the conflict management process are set out in Section 14.4. If the conflict management process is not invoked, no further action is required.[106]

14.3.2. By Medical Staff.

The Rules and Regulations may be adopted or amended at a regular meeting (or special meeting called for such purpose) of the Medical Staff or by mail/facsimile/electronic ballot.[107]

14.3.2.1. To be submitted for a vote, a written petition setting out the proposed amendment or changes and signed by at least 33% of the voting Members of the Medical Staff must first be filed with Medical Staff Services.

14.3.2.2. Adoption or amendment at a meeting shall require a two-thirds (2/3) affirmative vote of the voting Members of the Medical Staff present and voting at a meeting where a quorum of at least 20% of the voting Members of the Medical Staff are present; provided that, the Medical Staff has been notified of the proposal at least 20 days prior to the meeting.[108]

[102] MS.01.01.01 EP 7.
[103] MS.01.01.01 EP 5; 25 Tex. Admin. Code Sec. 133.41(k)(3).
[104] MS.01.01.01 EP 9.
[105] MS.01.01.01 EP 11.
[106] MS.01.01.01 EP 11.
[107] MS.01.01.01 EP 8.
[108] MS.01.01.01 EP 9.

14.3.2.3. The procedures for a mail/electronic ballot are set out in Section 8.7 and adoption or amendment shall require voting by at least 30% of the voting Members of the Medical Staff and a two-thirds (2/3) affirmative vote of those voting.

14.3.2.4. A copy of the proposal must also be submitted to the Leadership Council through Medical Staff Services within the same time frame, and the comments of the Leadership Council presented at the Medical Staff meeting prior to the vote or with the mail/electronic ballot.

14.4. CONFLICT MANAGEMENT PROCESS FOR LEADERSHIP COUNCIL AND MEDICAL STAFF[109]

14.4.1. Petition. In the event of disagreement between the Medical Staff and the Leadership Council on adoption or amendment of the Rules and Regulations under Section 14.3 (or of a Manual under Section 14.5 or a Medical Staff policy under Section 14.6), implementation of the following conflict management procedures may be requested by submission of a written petition signed by at least 33% of the voting Members of the Medical Staff. The petition must be submitted to Medical Staff Services within 10 days of communication of an approved amendment to the Medical Staff under Section 14.3.1.1.2 or notice to the Medical Staff of an urgent amendment under Section 14.3.1.2.1.

14.4.2. Medical Staff Representatives. The petition must identify the specific disagreement with the amendment and designate at least two voting Members of the Medical Staff who have signed the petition to serve as representatives of the Medical Staff on this disagreement.

14.4.3. Meeting. The Leadership Council shall call a special meeting of the Leadership Council, inviting at least the two representative Members identified, to discuss the disagreement or conflict. The Leadership Council, with the approval of the Hospital President, CQMO, or their designee, may use the services of a facilitator or mediator at the meeting.

14.4.4. Good Faith Efforts. The Leadership Council and the Members attending the special meeting will exchange information relevant to the issue and work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Leadership Council, and the safety and quality of patient care delivered at the Hospital.

14.4.5. Final Decision. Within five days of conclusion of the meeting, the Leadership Council will reconsider the proposed change, take a new vote on the issue at a regular or special called meeting, and provide the Medical Staff with notice of the new vote. There shall be no further right to the conflict management process once the new vote is taken.

14.5. ADOPTION AND AMENDMENT OF MANUALS

The process and procedures for adoption or amendment of a Manual shall be the same as for adoption or amendment of the Rules and Regulations under Section 14.3, including the conflict management process in Section 14.4.[110]

14.6. ADOPTION AND AMENDMENT OF MEDICAL STAFF POLICIES

14.6.1. Adoption or amendment of a Medical Staff policy may be accomplished:

14.6.1.1. On the affirmative vote of a majority of the members of the Leadership Council at a regular or special meeting of the Leadership Council at which a quorum is present; or

14.6.1.2. By the Medical Staff using the procedures in Section 14.3.[111]

[109] MS.01.01.01 EP 10.
[110] MS.01.01.01 EP 8-10.
[111] MS.01.01.01 EP 8-10.

14.6.2. On approval or adoption of a Medical Staff policy by the Leadership Council, notice of the policy shall be provided to the Medical Staff.[112] The conflict management process in Section 14.4 shall be implemented on submission of a written petition signed by at least 33% of the voting Members of the Medical Staff within 10 days of the provision of notice of the policy to the Medical Staff.[113]

14.7. APPROVAL OF ANCILLARY DOCUMENTS BY BOARD OF TRUSTEES

14.7.1. The Rules and Regulations and any Manuals, and any amendments thereto, shall be effective only on approval by the Board of Trustees.[114] Medical Staff policies shall be effective on approval by the Medical Staff or the Leadership Council in accordance with the procedures in Section 14.6; provided that, Medical Staff policies dealing with Medical Peer Review activities shall require approval by the Board of Trustees and not be effective until so approved.

14.7.2. The Medical Staff complies with and enforces the Rules and Regulations, any Manuals, and Medical Staff policies approved as provided by this Article, and the Board of Trustees upholds those documents it approves.[115]

14.8. NOTICES TO MEDICAL STAFF

Any notices to the Medical Staff required by this Article 14 shall be deemed delivered to the Practitioner on: (a) deposit with the U.S. mail, (b) facsimile transmission, or (c) electronic transmission of the notice to the most current email address on file with Medical Staff Services.

14.9. TECHNICAL AND EDITORIAL CORRECTIONS

Corrections that are strictly limited to correcting numbering, punctuation, typographical, or inadvertent errors or updating references in the Bylaws, Rules and Regulations, Manuals, or Medical Staff policies, such as titles of positions, committee names, or names of policies that do not involve a substantive change, may be made by Medical Staff Services, effective on the approval of the Chief of Staff and the Hospital President, CQMO, or their designee, without the necessity of compliance with the procedures in this Article.

14.10. PROHIBITION ON UNILATERAL AMENDMENT[116]

Except as noted under Section 14.6 for certain Medical Staff policies, neither the Medical Staff, the Leadership Council, nor the Board of Trustees may unilaterally adopt or amend the Bylaws, the Rules and Regulations, a Manual, or a policy.

This is to certify that the above and foregoing is a true and correct copy of the Hospital Medical Staff Bylaws.

DocuSigned by:
By: Stacy Cantu 035EAE3FA5464FE... Date: 4/2/2024
Stacy G. Cantu, Corporate Secretary
Texas Health Harris Methodist Hospital Alliance

Date Approved by Hospital Medical Staff: 01/19/2024
Date Approved by Hospital Quality and Performance Committee as delegated by the Hospital Board of Trustees: 03/27/2024
Effective Date: 04/01/2024

[112] MS.01.01.01 EP 9.
[113] MS.01.01.01 EP 10.
[114] 25 Tex. Admin. Code Sec. 133.41(f)(4))B); 42 C.F.R. Sec. 482.12(a)(4).
[115] MS.01.01.01 EP 5, 7.
[116] MS.01.01.03.

APPENDIX A

5.1 The Medical Staff shall have three Service Lines: Medical Services, Surgical Services, and Women and Children Services. The specialties within each Service Line shall include at least the following:

Medical Services
- Primary Care and Community Services (Family Medicine and Internal Medicine)
- Hospitalists
- Emergency Medicine
- Medicine Specialties
- Radiology

Surgical Services
- General Surgery
- Surgery Specialties
- Anesthesia
- Pathology

Women and Children Services
- Obstetrics
- Gynecology
- Pediatrics

APPENDIX B

6.5.2 Composition of the Credentials Committee: The Credentials Committee shall be composed of a minimum of the following members: *[list if applicable – if not applicable state "Not applicable"]*

The Credentials Committee shall be comprised of a representative of each Clinical Council. The Physician Co-Chair of each Clinical Council will appoint a representative to the Credentials Committee. A Physician Co-Chair of a Clinical Council may serve on the Credentials Committee. Representative from each Clinical Council should be present when voting.

Appendix C

7.3.4 Duties of Immediate Past-President *[list if applicable – if not applicable state "Not applicable"]*

Not applicable