

ARTICLE I. NAME

The name of this organization shall be CHRISTUS Mother Frances Hospital-Winnsboro Medical Staff

ARTICLE II. PURPOSE

The purposes of this organization are:

- To provide oversight for a uniform quality of care, treatment and services delivered by the practitioners who are credentialed and privileged through the medical staff process;
- To set forth the process and criteria for the credentialing, privileging and evaluation the competency of all physicians, licensed independent practitioners and allied health staff;
- To provide leadership in performance improvement activities, to improve quality of care, treatment and patient safety; and
- To establish a framework for how the Medical Staff will organize and govern its affairs.

ARTICLE III. MEDICAL STAFF MEMBERSHIP

3.1 Nature of Medical Staff Membership

Membership on the Medical Staff of CHRISTUS Mother Frances Hospital – Winnsboro is a privilege, which shall be extended only to competent professionals who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated policies of the Medical Staff and Hospital.

3.2 Qualifications for Membership

General Qualifications. Only physicians, dentists, podiatrists, and other practitioners licensed to practice in the State of Texas shall be qualified for membership on the membership on the medical staff as applicable. To be considered for medical staff membership, the applicants must possess and provide documentation of the following:

- a. Current Licensure;
- b. Current DEA and DPS licensure;
- c. Adequate experience, education and training;
- d. Current professional competence;
- e. Good judgment;
- f. Ability to perform the clinical privileges requested.

Must be of such physical and mental health status, so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care. Applicants may be asked to provide to the Medical Executive Committee (MEC) proof of their physical and/or mental health status.

Must:

- a. Adhere to the ethics of their respective professions;
- b. Be able to work cooperatively with others;

- c. Be willing to participate in and properly discharge those responsibilities determined by the medical staff.

Must maintain in force professional liability insurance that:

- a. Is not less than a minimum amount as from time to time may be jointly determined by the Board of Directors, MEC and the Medical Board; and
- b. Does not exclude from coverage any of the procedures for which the applicant is seeking privileges.

Applicants shall not be denied membership and/or clinical privileges on the basis of sex, race, creed, color or national origin, disability, or on the basis of other criteria, lacking professional justification.

Members must report any:

- a. arrests,
- b. restrictions or reprimands by the Texas Medical Board,
- c. exclusion from any state or federal governmental program, including Medicare/Medicaid or adverse action related to a Member's eligibility to participate in such governmental programs, or
- d. loss or restriction of privileges at any other facility within 30 days of such action.

Any practitioner excluded from the Medicare/Medicaid/Tricare or any government funded health care program will not be offered membership and/or clinical privileges until such sanction is clear.

Those practitioners who provide continuing care for patients must maintain an office and residence within reasonable proximity of the hospital as defined by the medical staff in the rules and regulations to permit timely, continuous patient care.

Must possess the skills and training necessary to satisfy the patient care or educational needs of the community the hospital serves.

3.3 Waiver of Qualifications

Under special circumstances, in order to serve the best interests of the hospital and medical staff, one or more of the above qualification requirements may be waived.

3.4 Conditions and Duration of Appointment

A Focused Professional Practice Evaluation (FPPE) shall be initiated for each initial applicant. Practitioners must comply with and actively participate in FPPE. The evaluation should be completed within 3-6 months of initiation of clinical activity (unless there is insufficient clinical data to assess competency). The department chair/section chief or appointed active staff member will review and approve the completed FPPE.

Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Governing Board in accordance with these Bylaws.

3.5 Responsibilities of Membership

All members of the medical staff are expected to fulfill the responsibilities of membership by:

- a. Providing patients with the quality of care meeting the professional standards of the Medical Staff of this hospital;
- b. Abiding by these bylaws and the rules and regulations of the Medical Staff;

- c. Working cooperatively with medical staff members, nurses, hospital administration and others;
- d. Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership;
- e. Abiding by applicable hospital bylaws, rules, policies and protocols;
- f. Providing medical care to patients in emergency situations wherever and whenever needed regardless of the member's category of appointment or the patient's ability to pay;
- g. Requesting consultation from other specialties as the needs of the patient require, and providing consultation to other medical staff members when requested.
- h. Self-reporting any physician health matter, including impairment or substance abuse matters;
- i. Self-reporting loss of professional liability insurance;
- j. Self-reporting any investigation, recommendation, limitation, suspension or termination regarding:
 - Privileges at any other health care facility, or
 - License to practice by any state or federal agency as required by these bylaws
- k. Actively participating in the hospital's quality improvement and utilization review activities;
- l. Performing other staff obligations as may be established from time to time by the medical staff
- m. Medical staff members may also be expected to discharge in a reasonable manner the following responsibilities:
 - Serving on medical staff committees;
 - Providing emergency department call coverage;
 - Regularly attending Medical Staff meetings and Service Committee meetings as specified in these bylaws;
 - Timely response to patients upon admission and ordering appropriate tests and basic treatments when given basic admitting privileges;
 - Assuring appropriate communication with consultants. Emergent/urgent consults shall require both a STAT physician order as well as direct physician-to-physician communication and be requested with the expectation that consultations will be seen within 24 hours, unless otherwise specified by the requesting physician.

3.6 Leave of Absence

3.6.1 Leave Status.

If a medical staff member expects to be away from practice for a period greater than thirty (30) days or for a shorter period due to a medical or surgical reason, he must submit a completed "Request for Leave of Absence" form to the chief of service. A leave of absence may not exceed one year except for military service. During the period of time of the leave, the medical staff member's clinical privileges to admit, treat, or consult are voluntarily relinquished and may not be exercised.

3.6.2 Reappointment during Leave.

If the expiration date of the practitioner's current appoint is within the period of time of the requested leave of absence, an application for reappointment will be issued and processed through the scheduled reappointment cycle. Failure to submit a completed application for reappointment will be deemed a voluntary resignation of medical staff membership and clinical privileges at the end of the practitioner's current appointment.

3.6.3 Reinstatement Following Leave.

Prior to termination of a leave the practitioner must request reinstatement by completing a "Request for Return from Leave of Absence." The request shall include evidence of continued and current competence, a summary of relevant professional activities, if any, during the leave and evidence of a good physical and mental health, which shall be reviewed by the chief of service. If a medical leave of absence has been granted the practitioner must have a "Return to Work Statement" completed by his healthcare provider for the specific medical condition that resulted in the request for leave of absence. Failure to Request Reinstatement. Failure to submit a request for reinstatement will be deemed a voluntary resignation of medical staff membership and clinical privileges at the end of the practitioner's current appointment. Termination of appointment and clinical privileges under these circumstances does not entitle the practitioner to the procedural rights afforded by the hearing and appeal process outlined in the bylaws process. If the medical staff appointment and clinical privileges expire or are resigned, the practitioner will be required to submit an application and appropriate fees which will be processed as an application for initial appointment. The medical staff member requesting reinstatement, reappointment or appointment must submit such information to the executive committee and to the board of directors.

3.7 Adverse Recommendation or Action

Any recommendation by the Medical Board regarding initial appointment, reappointment or the granting of clinical privileges that is an Adverse Recommendation or Action shall entitle the affected Practitioner or Action by the Medical Board shall also entitle the affected Member to the Procedural Rights of Review as outlined in the Fair Hearing Plan.

3.8 Resignation from the Medical Staff

A Member of the Medical Staff may submit his resignation at any time in writing to the Medical Staff Office, Hospital President, or Medical Staff President. However, his resignation cannot be accepted and will not be effective until the Member has completed all medical records, fulfilled the current month's call schedule and cooperated with the Hospital in answering all inquiries. Should the Member fail or refuse to do any of the above, the Member shall be classified as having "resigned – not in good standing."

ARTICLE IV. CATEGORIES OF THE MEDICAL STAFF

4.1 Appointments

All appointments to the medical staff shall be made by the Board of Directors after recommendation by the MEC which functions as the Credentialing Committee. The medical staff shall be divided into the following categories: Active, Affiliate, Courtesy, and Consulting.

4.2 Active Medical Staff

4.2.1 Qualifications.

The Active Medical Staff shall consist of those physicians (MD/DO), dentists (DDS/DMD), and podiatrists (DPM) who are in active practice and regularly care for patients in the hospital. Active Staff member shall be able to provide continuous care to the member's patients in the hospital.

4.2.2 Responsibilities.

Each appointee to the active Staff shall agree to assume all the functions and responsibilities of membership on the Medical Staff, including, where appropriate, emergency service care and

consultation assignments. The Active Staff shall be responsible for the transaction of all the business of the Medical Staff and for the quality of medical care and treatment in the hospital.

4.2.3 Prerogatives.

Active Staff members shall be eligible to vote, hold office and serve as chairpersons of committees.

Non-admitting Physicians. This membership may extend to certain individuals whose specialties do not by tradition admit patients, but whose services are vital to total patient care such as radiologists, pathologists or anesthesiologists.

Section 4.3 Affiliated Staff

The Affiliated Category Medical Staff shall consist of physicians, dentists and podiatrists who are not eligible for appointment to the Active or Courtesy Category. The Affiliated Category shall consist of physicians, dentists or podiatrists whose clinical privileges shall be exercised only within the non-provider based Trinity Mother Frances Clinics. The applicant for Affiliated Staff Category membership shall meet the qualifications and adhere to the conditions and duration for staff as defined in Article III, Section 2. Appointees to the Affiliated Category shall have no Hospital admitting privileges, staff committee responsibilities, may not vote and may not hold office.

Section 4.4 Courtesy Staff

4.4.1 Qualifications.

The Courtesy Staff shall consist of physicians, dentists and podiatrists who have twelve (12) or fewer patient care contacts in the hospital each year. A patient care contact shall be any of the following:

- a. Admissions;
- b. Consultation;
- c. Surgery; or
- d. Rounding on patients

4.4.2 Responsibilities.

Courtesy Staff member must arrange coverage at all times by an Active Staff member or another Courtesy Staff member in the same department when the Courtesy Staff member is not available. The covering physician must have similar training and privileges for the specialty care to be provided.

4.4.3 Limitations.

Courtesy Staff members shall not be eligible to vote or hold office.

4.4.4 Change in Category:

At the time of reappointment, if a Member of the Courtesy Staff has not had at least one (1) Patient Contact as required or has exceeded the permitted twenty-three (23) Patient Contacts, the Member shall not be eligible for reappointment to the Courtesy Staff for a period of two (2) years. The Member may request transfer to another Staff category if the Member is qualified for that category.

Section 4.5 Consulting Staff

4.5.1 Qualifications.

Consulting Medical Staff members shall be medical practitioners of recognized ability who are not members of another category of the Medical Staff and who may be called in for consultation or assistance by any member of the Medical Staff. Consulting Staff members must be in good standing on the Active Medical Staff of another hospital or engaged in clinical practice in a specialty not required to maintain specialty call coverage by the medical staff bylaws.

4.5.2 Limitations.

Consulting Staff members may only attend patients who are under the care of an Active Staff member.

ARTICLE V. PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

5.1 Application for Appointment

All applications for appointment to the Medical Staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Governing Board after recommendation by the Medical Executive Committee. The initial applicant shall submit the completed and signed application on the prescribed form with a non-refundable application fee as specified by the Hospital.

All applications shall require the following detailed information concerning the applicant's professional qualifications:

- a. The name of at least three (3) peers in the same professional discipline as the applicant who have had extensive experience in observing and working with the applicant who can provide adequate references pertaining to the applicant's professional competence and ethical character. One of the 3 references should be the residency or fellowship program director for applicants recently completing training or, the Chief of Service from a hospital affiliation where the applicant is currently clinically active. Only one of the three peer references can be a partner.
- b. Evidence of current state license, DEA, and DPS certificate (if applicable);
- c. Information as to whether the applicant's membership status and/or clinical privileges have ever been revoked, suspended, reduced or not renewed at any other hospital or institution, whether voluntarily or involuntarily; and whether any such action is currently pending;
- d. Information as to whether the applicant's membership in local, state or national medical societies, or license to practice in any profession in any jurisdiction, has ever been suspended or terminated, whether voluntarily or involuntarily; whether any such action is currently pending; including any Agreed Orders with state medical boards or medical societies.
- e. Information as to whether the applicant has ever been convicted of a felony and whether the applicant's narcotic license has ever been suspended or revoked; whether voluntarily or involuntarily; and, whether any such action is currently pending;
- f. Previously successful or currently pending challenges to any licensure or registration in any state and in any healthcare related profession (Federal/CMS, State, Drug Enforcement Administration, and DPS);
- g. Relevant practitioner-specific data as compared to aggregate data, when available;
- h. Ongoing Professional Practice Evaluation (OPPE) data, when available;
- i. Evident of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant;

- j. Current evidence of adequate professional liability insurance in the type, amount and duration prescribed by the Governing Board. This policy must provide at a minimum an individual insurance policy for the practitioner physician;
- k. Confirmation of the absence of any physical or mental condition which could affect the applicant's ability to exercise the clinical privileges requested safely and competently (regardless of how this is answered, the application will be processed in the usual manner). This documentation shall be confirmed;
- l. A request for specific clinical privileges desired by the applicant;
- m. A portion of continuing medical education hours should relate in part to the practitioner's specialty. Continuing medical education certifications and supporting documentation relating to the practitioner's specialty must be provided at the time of reappointment or annually as required by accreditation / certification programs or as specified on clinical privilege delineation forms as approved by the section or department. It shall be the responsibility of the staff member to provide certifications and support documentation of the required hours of trauma related continuing education to the Hospital on an annual basis. Failure to provide certifications and supporting documentation of continuing medical education shall result in disciplinary action up to and including loss of staff membership and privileges.
- n. Evidence of completion of EHR training by CTMFHS ConnectCARE trainer.
- o. A statement indicating that he/she has received, read, and agrees to abide by these Bylaws, the Rules and Regulations, Hospital policies and procedures, and other governing documents of the Medical Staff and the Hospital, applicable to the Medical Staff members made available to him/her.
- p. A grant of absolute immunity to and a release of the Hospital, the governing board, the Medical Staff, all peer review and medical committees, including, but not limited to the Credentialing Committee, and their members, the Hospital and Medical Staff officers and authorized records, statements, documents, recommendations or disclosures involving the practitioner that are performed, made, requested, or received by such persons without malice related to the following:
 - i. Applications for appointment, reappointment, or clinical privileges, including temporary clinical privileges;
 - ii. Periodic reappraisals undertaken for reappointment or for an increase or decrease in clinical privileges;
 - iii. Proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, or any other disciplinary sanction;
 - iv. Summary suspension;
 - v. Hearings and appellate reviews;
 - vi. Medical Care evaluations;
 - vii. Utilization reviews;
 - viii. Any other Hospital, Medical Staff, Department, Division, or committee activities;
 - ix. Matters or inquiries concerning the practitioner's professional qualifications, credentials, clinical competence, character, ethics, behavior, or ability to perform fully the essential functions of the professional services and clinical privileges requested; and
 - x. Any other matter that might directly or indirectly have an effect on the practitioner's competence, patient care, or the orderly operation of the Hospital or any other hospital or health care facility.

The practitioner acknowledges that all proceedings or information relating to the above shall be privileged to the fullest extent permitted by law and that the privilege extends to the Hospital, the governing board, the Medical Staff, all peer review committees, including, but not limited to the Hospital and Medical Staff officers and their authorized representatives, and any third parties who provided information or participated in the proceedings.

The completed application shall be submitted to the Medical Staff Central Credentialing Office. Once the Medical Staff Office has collected and verified the references and other materials deemed pertinent, the completed application and all supporting materials shall be submitted for evaluation. Primary source verifications are listed below, but may not be inclusive;

- a. Current licensure, registration and/or certification. Document and verify from primary sources the Practitioner's current licensure, registration and/or certification status.
- b. Relevant education, training and experience. Document and verify from Primary sources whenever feasible the veracity of the Practitioner's disclosures regarding relevant education, training and experience; and query the National Practitioner Data Bank.
- c. Continuing professional competence. Review of at least three (3) written 16 references from individuals in the same or similar professional discipline as the Practitioner and who are knowledgeable about the Practitioner's professional performance within the past two (2) years to attest to and confirm the Practitioner's continuing professional competence and ability to perform the privileges requested. Additional references may include peers who are either related to nor associated in practice with the Practitioner, but who are personally acquainted with the Practitioner's professional qualifications and current professional competence.
- d. Health status. Confirm absence of any substance abuse or health conditions that may adversely affect the Practitioner's ability to perform the privileges or scope of service requested from the chief of service or staff at another hospital where the Practitioner has privileges or scope of service, or by a currently licensed physician designated by the credentials Committee. Such confirmation may include a physical and/or mental health examination conducted by a health care professional of the Credentials Committee's choosing.
- e. Litigation history. Explanation of the existence of any prior or current lawsuits, settlements, or judgements, including malpractice claims.
- f. Exclusions. Confirm absence of exclusions from participation in Medicare, Medicaid, and Tricare.

By applying for appointment to the Medical Staff, each applicant thereby signifies a willingness to appear for interviews in regard to the application, pledges to provide for continuous care of said applicant's patients, pledges to inform the Hospital (this is a continuous requirement) of any changes in membership or privileges at other hospitals whether voluntarily or involuntary; sanctions or investigative proceedings by third party payors, state medical board orders, loss of medical license, DEA certificate, DPS certificate or professional liability insurance, authorizes the Hospital to consult with members of medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on the applicant's competence, character and ethical qualifications, consents to the Hospital's inspection of all records and documents that may be material to an evaluation of the applicants professional qualifications and competence to carry out the clinical privileges requested as well as of the applicant's moral and ethical qualifications for staff membership, releases from any liability all representatives of the Hospital and its medical staff for their acts performed in good faith and without

malice in connection with evaluation of the applicant and the applicant's credentials, and releases from any liability all individuals and organizations who provide information to the Hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.

The application form shall include a statement that the physician has received and been oriented to the Medical Staff Bylaws, Rules and Regulations and policies and procedures, and that the applicant agrees to abide by these; and, that the applicant agrees to be bound by the terms thereof without regard to whether or not membership and/or clinical privileges is granted in all matters relating to consideration of the application.

Each applicant for appointment or reappointment to the Medical Staff or for clinical privileges shall be obligated to supplement his/her responses to questions, or requests for information on the application form after the application has been submitted, if a response or information given was incorrect or incomplete, or is no longer correct or complete due to a change in circumstances. The applicant for appointment, reappointment, and/or the grant of clinical privileges has the burden to produce evidence necessary for appropriate evaluation of the application and failure to provide any requested information will result in a finding of incomplete application.

5.2 Appointment Process

Within ninety (90) days after receipt of the application for membership and privileges and once all information has been verified and required supporting documentation has been obtained inclusive of querying the National Practitioner's Data Bank, the Medical Executive Committee shall examine the evidence of character, professional competence, qualifications and ethical standing of the practitioner and shall determine, through information contained in references given by the practitioner and from other sources available to the committee, whether the practitioner has established and meets all of the necessary qualifications for the category of staff membership and the clinic privileges requested by the applicant for Medical Staff membership and privileges, or that the application be deferred for further consideration.

At its next regular meeting, or within thirty (30) days after receipt of the application, the Medical Executive Committee shall determine whether to recommend to the Governing Board that the practitioner be appointed to the Medical Staff, that the practitioner be rejected for Medical Staff membership, or that the application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by probationary conditions relating to such clinical privileges.

The Governing Board shall take final action on a completed application within sixty (60) days after a completed application is received with report and recommendation of the Medical Executive Committee.

The applicant shall be notified in writing of the final action taken by the Governing Board, including a reason for denial or restriction of privileges requested, not later than twenty (20) days after the date on which the final action is taken.

When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed up within ninety (90) days with a subsequent recommendation for appointment with specified clinical privileges, or for rejection for staff membership.

When the recommendation of the Medical Executive Committee is favorable to the practitioner, the application shall be promptly forwarded, together with all supporting documentation, to the Governing Board.

When the recommendation of the Medical Executive Committee is averse to the practitioner either in respect to appointment or clinical privileges, the practitioner shall promptly be notified by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the Governing Board until after the practitioner has exercised or has been deemed to have waived the right to a hearing as provided in Article IX of these Bylaws.

If, after the Medical Executive Committee has considered the report and recommendations of the Hearing Committee and the hearing record, the Medical Executive Committee's reconsideration and recommendation is favorable to the practitioner, it shall be processed in accordance with subparagraph d. of the Section 2. If such recommendation continues to be adverse, the applicant shall be promptly notified by certified mail, return receipt requested. Such recommendation and documentation shall be forwarded to the Governing Board, but the Governing Board shall not take any action thereon until after the practitioner has exercised or has been deemed to have waived the rights to an appellate review as provided in Article IX of these Bylaws.

At its next regular meeting, but not later than sixty (60) days, after receipt of a favorable recommendation, the Governing Board or its Executive Committee shall act in the matter. If the Governing Board's decision is adverse to the practitioner in respect to either appointment or clinical privileges, the applicant shall be promptly notified of such adverse decision, within twenty (20) days, along with the reason for denial or restriction of privileges, by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the practitioner has exercised or has been deemed to have waived the rights under Article IX of the Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

At its next regular meeting, but not later than sixty (60) days, after all of the Practitioner's rights under Article IX have been exhausted or waived, the Governing Board or its duly authorized committee shall act in the matter. The Governing Board's decision shall be conclusive, except that the Governing Board may defer final determination by referring the matter for further reconsideration. Any such referral shall state the reasons therefore, shall set a time limit within which a subsequent recommendation and new evidence in the matter, if any, the Governing Board shall make a decision either to appoint the practitioner to the staff or to reject the practitioner for staff membership. All decisions to appoint shall include a delineation of the clinical privileges, which the practitioner may exercise.

Whenever the Governing Board's decision will be contrary to the recommendation of the Medical Executive Committee, the Governing Board shall submit the matter to a joint committee composed of an equal number of members from the Governing Board and Medical Executive Committee for review and recommendation and shall consider such recommendation before making its decision final.

When the Governing Board's decision is final, it shall send notice promptly of such decision through the administrator or the secretary of the medical staff, to the chairperson of the Medical Executive Committee, and of the department concerned, and by certified mail, return receipt requested, to the practitioner.

5.3 Reappointment Process

An application for reappointment to the Medical Staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Governing Board.

The Medical Executive Committee shall review the completed application and make a recommendation that the practitioner be reappointed to the Medical Staff with the requested clinical privileges or rejected

for Medical Staff membership and privileges, or that the application be deferred for other consideration. The reason for any change in staff status or clinical privileges shall be documented.

Each recommendation concerning the reappointment of a medical staff member and the clinical privileges to be granted upon reappointment shall be based upon the individual's current competency for requested clinical privileges, current licensure, DEA & DPS number (if applicable), professional liability insurance renewal, verification of hospital affiliations, changes in membership or privileges at other hospitals whether voluntarily or involuntary; challenges to any licensure or registration; voluntary or involuntary relinquishment of any license or registration; voluntary and involuntary limitation, reduction or loss of clinical privileges; Agreed Orders with state medical boards or medical societies, any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant for reappointment; sanctions or investigative proceedings by third party payors, loss of professional liability insurance, documentation of the practitioner's health status, professional performance, judgment, and clinical technical skills, as indicated through results of Ongoing Professional Practice Evaluation (OPPE) when available (FPPE or OPPE data from other hospitals may be used, or two (2) peer recommendations from peers in the same professional discipline when sufficient practitioner specific data is not available, evidence of required participation in medical staff review, receipt of continuing medical education inclusive of one (1) CME hour of risk management education, an appraisal by the chairperson of the department or section chief of the applicable service, compliance with Medical Staff Bylaws and Rules and Regulations and policies and procedures of the Medical Staff, use of the Hospital's facilities for patients, relations with other practitioners and general attitude toward patients, the Hospital and the public.

The Medical Executive Committee shall review the Hospital personnel information form and other relevant information available to the reappointment of the staff member, and recommend to the Governing Board that appointment be either renewed, renewed with modified staff category, department and section affiliation and/or clinical privileges, or terminated. The reason for change in staff status or clinical privileges shall be documented.

The staff member seeking reappointment shall, if requested by the Medical Executive Committee as part of the reappointment appraisal, be willing to undergo physical or psychiatric examination. Refusal by the staff member to undergo such examination shall be cause to initiate the termination of staff membership.

Thereafter, the procedure provided in 5.2 of this Article V, relating to recommendations on applications for initial appointment shall be followed.

ARTICLE VI: EXPEDITED PROCESS FOR GRANTING PRIVILEGES (Board Credentials Sub-Committee)

6.1 Expedited Governing Body (Board Sub-Committee)

6.1.1 Composition: This committee shall consist of at least two (2) voting members of the Governing Body.

6.1.2 Duties: The Board Subcommittee shall receive and act on behalf of the Board regarding positive recommendations from the Medical Executive Committee concerning appointments, reappointments, or renewal or modification of clinical privileges.

6.1.3 Meetings: This meeting shall convene as soon after every Medical Executive Committee as possible.

6.1.4 Eligibility:

- a. If any of the following has occurred, the applicant will be ineligible for the expedited process:
 - The applicant submits an incomplete application,
 - The Medical Executive Committee makes a final recommendation that is adverse or has limitations.
- b. If any of the following has occurred, the applicant will be evaluated on a case-by-case basis and usually results in ineligibility for this process:
 - There is a current challenge or a previously successful challenge to licensure or registration.
 - The applicant has received an involuntary termination of medical staff membership at another hospital
 - The applicant has received involuntary limitation, reduction, denial or loss of clinical privileges
 - The Hospital determines that there has been either an unusual pattern of or an excessive number of professional liability actions resulting in a final judgment against the applicant.

6.1.5 Ratification: The Governing Body shall ratify the decision(s) made by this Board Subcommittee.

ARTICLE VII CLINICAL PRIVILEGES

7.1 General

A Practitioner must hold setting and/or specialty specific clinical privileges granted in accordance with these Bylaws to provide any health care service in the Hospital. The granting of clinical privileges shall be based on an assessment of current clinical competence, licensure, education, training of the Practitioner, peer recommendations when required, and the Practitioner's documentation of compliance with any criteria established by the Medical Board with the approval of the Board of Directors, or by the Board of Directors following consultation with the Medical Board. Renewal of clinical privileges shall include consideration of Practitioner-specific data from the Hospital's Medical Peer Review activities, the Hospital's performance improvement plan on the Practitioner's professional performance and clinical and technical skills. If the Member has limited Patient Contacts at the time of reappointment, the Member shall be responsible to provide sufficient documentation of appropriate clinical performance from other health care facilities so as to enable adequate evaluation by the Medical Board and the Board of Directors.

7.2 Non-Physician Members

Requests for clinical privileges from oral surgeons, dentists and podiatrists are processed in the same manner as for physicians. Active staff podiatrist may admit a patient as long as a physician Member of the Medical Staff is consulted when the podiatric patient is admitted. Oral surgeons and dentists must have a co-admitter Member of the Medical Staff. All non-physician members, whether they admit or co-admit, must have a Physician member of the Medical Staff perform a history and physical examination on the patient as provided in the Rules and Regulations, and must determine the risk and effect of any proposed surgical or special procedure on the total health status of the patient. The physician Member is responsible

for the care of any medical problem that may be present at admission or that may arise during hospitalization.

7.3 Temporary Privileges

7.3.1 There are two circumstances in which temporary privileges may be granted:

- a. To fulfill an important patient care, treatment, and/or service need.
- b. When a new applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Staff Executive Committee and the governing body.

Each circumstance has different criteria for granting temporary privileges. Refer to Credentials and Peer Review Manual for details.

To Fulfill an Important Care Need

The following criteria must be met in order to grant temporary privileges to meet an important care need:

- The individual must have a current license to practice in the State in which privileges are sought.
- The individual must have current competence to perform the privileges requested. Evidence of current competence can be demonstrated by meeting the following:
 - Graduate of an approved residency program in the area in which privileges are being requested, and evidence of recent relevant (past 2 years) education, training, and experience in the area of privileges being requested.
 - Additional criteria (if any) for the specific privileges requested.

New Applicant Awaiting Review

The following criteria must be met in order to grant temporary privileges to a new applicant awaiting review and approval of the Medical Staff Executive Committee and the governing body:

- Current license to practice in the State in which application to medical staff membership is sought
- Evidence of recent relevant (past two years) training or experience
- Evidence of current competence
- Ability to perform the privileges requested
- A query and evaluation of National Practitioner Data Bank (NPDB) information
- A complete application
- No current or previously successful challenge to licensure or registration
- No subjection to involuntary termination of medical staff membership at another organization
- No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges.

Temporary privileges are granted by the Chief Executive Officer or authorized designee based upon the recommendation of the Chief of Staff or authorized designee. Individuals granted temporary privileges may be subject to proctoring requirements as noted in the bylaws or rules and regulations.

Temporary privileges shall be granted for a time period not to exceed 120 days. Temporary privileges may be revoked at any time in accordance with attendant processes outlined in the Bylaws. Revocation of temporary privileges does not afford the affected individual the hearing and appeals rights noted in the bylaws.

7.4 Emergency Privileges

An “emergency” for purposes of this Section is defined as any condition that could result in serious or permanent harm 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 harm or danger. In an emergency involving a particular patient, a Member may exercise emergency privileges to provide necessary care, services, and treatment within the scope of the Member’s license using all necessary Hospital facilities, including calling for consultation if necessary or desirable, regardless of the Member’s status on the Medical Staff or the type of clinical privileges. When the emergency no longer exists, the privileges automatically terminate and the Member must apply for clinical privileges to treat the patient further. Unless the Member is authorized to continue to care for the patient, the President of the Medical Staff shall have the patient assigned to the appropriate member of the medical staff.

Section 7.5 Disaster Privileges

Disaster privileges may only be granted to a licensed independent practitioner (LIP) when the following two criteria have been met:

1. The organization’s emergency management plan has been formally activated, and;
2. The organization is unable to meet immediate patient needs.

Granting of disaster privileges must be authorized by the Chief of Staff, or the Disaster Medical Director, or authorized designee. Disaster privileges will be granted on a case by case basis.

An individual who presents as a volunteer LIP should be directed to the medical staff pool or other area as designated by the emergency management Command Center.

A volunteer LIP must present a valid government issued photo identification issued by a state or federal agency (e.g. driver’s license or passport). In addition, the volunteer LIP must provide at least one of the following:

- A current hospital picture identification card that clearly identifies the individual’s professional designation
- A current license to practice
- Primary source verification of licensure
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organization or group (s).
- Identification indicating that the individual has been granted authority to render patient care; treatment, or services in disaster circumstances (such as authority having been granted by a federal, state, or municipal entity).
- Identification by a current member of the organization or medical staff who possesses personal knowledge regarding the individual’s ability to act as a LIP during a disaster.

As soon as the immediate situation is under control, the organization should obtain primary source verification of the volunteer LIP's license. Primary source verification must be completed within 72 hours from the time the volunteer LIP presented to the organization. In extraordinary circumstances (e.g. no means of communication or a lack of resources), verification may exceed 72 hours, but must be completed as soon as possible. If primary source exceeds 72 hours, the organization will document all of the following:

- Reason(s) it could not be performed within 72 hours of the practitioner's arrival
- Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment and services
- Evidence of the hospital's attempt to perform primary source verification as soon as possible.

Primary source is the entity or agency that has the legal authority to issue the credential in question. If the entity or agency has designated another entity or agency to community information about the status of a staff member's credential, then the other entity or agency may be considered the primary source.

If the volunteer LIP is not providing care, treatment, or service which required the granting of disaster privileges, then primary source verification is not required.

The Medical Staff Office, or other designee, shall be responsible for securing primary source verification on all volunteer practitioners.

Volunteer LIP's will be identified by a name badge or tag provided by the organization. The badge / tag will list the name and professional designation of the volunteer (e.g. John Smith MD) as well as the notation that the individual is a volunteer. The volunteer LIP will be required to wear the badge / tag on his or her person while performing in that role / capacity.

Volunteer LIP's will be assigned to a member of the medical staff who is a peer in the volunteer's area of practice and experience. The medical staff member will serve as a mentor and resource for the volunteer practitioner. The medical staff member will be responsible for overseeing the professional performance of the volunteer. LIP. This may be accomplished by;

- Direct observation
- Clinical review of care documented in the patient's medical record.

Volunteer LIP's will cease providing care, treatment, or service if any one of the following criteria is met:

1. Implementation of the emergency management plan ceases.
2. The capability of the organization's staff becomes adequate to meet patient care needs.
3. A decision is made that the professional practice of the volunteer LIP does not meet professional standards.

Section 7.6 Telemedicine Privileges.

Telemedicine is the provision of clinical services to patients by practitioners from a distance via electronic communication. Practitioners providing only telemedicine services to the Hospital from a distant site will not be appointed to the medical staff but must be granted privileges at this Hospital. The medical staff may recommend privileges to the governing body through one of the following mechanisms:

- a. The Hospital uses the credentialing and privileging decision made by the distant-site to make a final privileging decision. For the medical staff to rely upon the credentialing and privileging

decisions made by the distant-site hospital when making recommendation on privileges for the individual distant-site physicians and practitioners providing such services, the Hospital's governing body ensures, through its written agreement with the distant-site hospital, that all of the following provisions are met:

1. The distant site providing the telemedicine services is a Medicare-participating and Joint Commission-accredited hospital or ambulatory care organization,
 2. The individual distant-site physician or practitioner is privileged at the distant-site providing the telemedicine services for those services to be provided at the originating site, and the distant site provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or ambulatory care organization,
 3. The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the Hospital whose patients are receiving the telemedicine services is located,
 4. Provide proof of malpractice insurance in the type, amount and duration required by the Hospital, and
 5. With respect to a distant-site physician or practitioner, who holds current privileges at the hospital whose patients are receiving the telemedicine services (originating site), the hospital has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site hospital such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum this information must include all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided by the distant-site physician or practitioner to the hospital's patients; and all complaints the hospital has received about the distant-site physician or practitioner.
- b. The originating site privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission-accredited organization. Once the medical staff makes its recommendation regarding the privileging of the telemedicine provider, it then must go through the remainder of the credentialing process for a decision regarding approval by the Board.
 - c. The Hospital fully privileges and credentials the practitioner.
 - d. The Distant Site will attest that it has privileged the practitioner and the practitioner is licensed in Texas.
 - e. The services of the Distant Site practitioners shall be subject to Focused and Ongoing Professional Practice Evaluations, these Bylaws, Rules and Regulations and Hospital policies. Once there is approval of a recommendation for privileges from the medical staff, the governing body shall decide whether to grant privileges through the usual credentialing process.

A Tele-Medicine (only) practitioner credentialing file will consist of all components of that of a practitioner requesting medical staff membership with the exception of these items; TB Immunization record. Background, and Case logs.

ARTICLE VIII ALLIED HEALTH PROFESSIONALS

8.1 Allied Health Professionals

The Allied Health Professionals (AHP) shall consist of independently licensed non-physician health care professionals who regularly care for patients in the hospital. Allied Health Professionals who are employed by the hospital will be evaluated for employment through the Human Resource (HR) process.

All Allied Health Professional will be credentialed by through the credentialing process. Such AHPs are eligible for practice privileges if they:

- a. Hold a license, certificate or other legal credential a. in a category of AHPs which the board of directors has identified as eligible to apply for practice privileges;
- b. Document their experience, background, training, demonstrated ability, judgment, and physical and mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency established by the hospital, and that they are qualified to exercise practice privileges within the hospital; and
- c. Are determined, on the basis of documented references to adhere strictly to the ethics of their respective professionals; to work cooperatively with others in the hospital setting; and to be willing to commit to and regularly assist the hospital in fulfilling its obligations related to patient care, within the areas of their professional competence and credentials.
- d. The board of directors upon recommendation of the MEC shall review and identify the categories of AHPs, based upon occupation or profession, which shall be eligible to apply for practice privileges in the hospital. For each eligible AHP category, the board of directors upon recommendation of the executive committee shall identify the practice privileges and prerogatives that may be granted to qualified AHPs in that category.
- e. Ah AHP must apply and qualify for practice privileges, and practitioners who desire to supervise or direct AHPs who provide dependent services must apply and qualify for privileges to supervise approved AHPs.
- f. The privileges and responsibilities connected with an AHPs providing patient care services within the hospital are detailed in the medical staff rules and regulations regarding AHPs.
- g. AHPs may attend medical staff committees as ex-officio non-voting members. They may also attend M&M meetings and receive continuing education credit.
- h. AHPs who are employed by the hospital are governed by their terms of employment and are not subject to medical staff correction action set forth in Article VIII. AHPs are afforded access to the fair hearing and appeal processes.

8.2 Procedural Review and Notice

Modification of Revocation of Privileges. The privileges of an AHP may be modified or revoked provided the same fair hearing and appeal process as other privileged providers is followed.

Appeal of Decision. The AHP shall have thirty (30) days following receipt of notice of the proposed modification or revocation of privileges to submit a request for appeal of the decision. The request shall be in writing addressed to the CEO.

Review Committee/Review Officer. If the AHP requests an appeal with the thirty (30) day time period, the Chief of Staff shall appoint a Review Officer and/or a Review Committee of one to three members of the Medical Staff to review the modification or revocation of privileges.

The Review Committee may include an AHP with privileges at the Hospital. The Review Committee shall not include any member of the Medical Staff who participated in the initiation, investigation or recommendation to modify or revoke the AHP's privileges.

A Review Officer may or may not be a member of the Medical Staff, but shall be an individual not in direct economic competition with the AHP, and may not have advised the Chief of Staff or the Administrator regarding the adverse recommendation or action. A Review Officer may or may not be an

attorney at law. When a Review Officer is appointed in addition to a Review Committee, the Review Officer shall act as the presiding officer of the review, provide advice and counsel to the Review Committee, and attend and participate in deliberations, but may not vote.

Notice of Review. The Administrator shall give the AHP written notice, by certified mail, return receipt requested, of the place, time and date of the review, which date shall be at least fifteen (15) days after the date of such notice; the notice shall include a list of the members of the Review Committee.

Review Process

- a. The Review Committee shall conduct the review in the form of a dialogue and inquiry review format, not as an adversarial hearing.
- b. The Review Committee shall present a written report, including a recommendation regarding the modification or revocation of the AHP's privileges, to the Medical Staff. The Medical Staff shall, within thirty (30) days of the date of the review, forward the Review Committee's report to the Board of Directors along with (1) a recommendation in support of the Review Committee's findings, (2) a statement of disagreement with the Review Committee's findings, or (3) no comment.
- c. The Board of Directors shall review the findings of the Review Committee and the Recommendation of the Medical Staff, if any, and shall, within thirty (30) days of the receipt of the report and recommendation, make a final decision regarding the modification or revocation of the AHP's privileges. The AHP shall have no further rights to appeal the Board's decision.

Failure to Appeal. In the event the AHP does not appeal the CEO's decision within the time and in the manner described, the AHP shall be deemed to have waived any right to an appeal and to have accepted the modification or revocation of privileges.

Effect of this Section. This Section does not grant the AHP the right to a hearing under the Article IX of these Bylaws and does not affect the at-will employment status of an AHP employed by the Hospital or by a member of the Medical Staff. This Section does not apply to an automatic suspension. An AHP whose privileges are terminated pursuant to the termination of the AHP's sponsorship or employment by a member of the Medical Staff is not entitled to the rights of review provided by this section.

Nursing Peer Review. The review process provided for in this Section is not intended to and does not preclude or replace any nursing peer review required for APRNs, including CRNAs, under Chapter 303 of the Texas Occupations Code and the applicable regulations of the Board of Nursing.

ARTICLE IX. CORRECTION ACTION

9.1 Procedure

Whenever the activities or professional conduct of any practitioner with clinical privileges or AHP are considered to be lower than the standards or aims of the medical staff or to be disruptive to the operations of the hospital, correction action against such practitioner may be requested by any officer of the medical staff, by the Chief of any service, by the Chairman of any standing committee of the medical staff, by the CEO or governing body. All requests for corrective action shall be in writing, shall be made to the Executive Committee, and shall be supported by preference to the specific activities or conduct which constitutes the grounds for the request.

Whenever the corrective action could be a reduction or suspension of clinical privileges, the executive committee of the medical staff shall immediately appoint an ad hoc committee of three or more members of the medical staff to investigate the matter.

Within thirty (30) days after the executive committee's receipt of the request for corrective action, the ad hoc committee shall make a report of its investigation to the executive committee. Prior to the making of such report, the practitioner against whom corrective action has been requested shall have an opportunity for an interview with the ad hoc investigating committee. At such interview, he shall be informed of the general nature of the charges against him, and shall be invited to discuss, explain or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these bylaws with respect to hearings, shall apply thereto. A record of such interview shall be made by the ad hoc committee and included with its report to the executive committee. Following receipt of a report from an ad hoc committee following the ad hoc committee's investigation of a request for corrective action involving reduction or suspension of clinical privileges, the executive committee shall take action upon the request. If the corrective action could involve a reduction or suspension of clinical privileges, or a suspension or expulsion from the medical staff, the affected practitioner shall be permitted to make an appearance before the executive committee prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature and none of the procedural rules provided in these bylaws with respect to hearings shall apply thereto. A record of such appearance shall be made by the executive committee.

The action of the executive committee on a request for corrective action may be to reject or modify the request for corrective action, to issue a warning, a letter of admonition, or a letter of reprimand, to impose terms of probation on a requirement for consultation, to recommend reduction suspension or revocation of clinical privileges, to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained, or to recommend that the practitioner's staff membership be suspended or revoked.

Any recommendation by the executive committee for reduction, suspension, or revocation of clinical privileges or for suspension or expulsion from the medical staff shall entitle the affected practitioner to the procedural rights provided in Article X of these bylaws.

The Chairman of the executive committee shall promptly notify the CEO in writing of all requests for corrective action received by the executive committee and shall continue to keep the CEO fully informed of all action taken in connection therewith. After the executive committee has made its recommendation in the matter, the procedure to be followed shall be as provided in the applicable section of Article IX hereof.

9.2 Summary Suspension

Any one of the following:

- a. Chief of the medical staff and one or more other members of the executive committee;
- b. One or more members of the executive committee,
- c. CEO and one or more members of the executive committee of either the medical staff or the governing body.

Shall have the authority, whenever failure to take such action, may in his/her opinion, result in an imminent danger to the health or safety of any individual may summarily suspend all or any portion of the

clinical privileges of a practitioner or AHP. Such summary suspension shall become effective immediately upon imposition.

Investigation

Within not more than fourteen (14) days of the imposition of a summary suspension, the Medical Executive Committee shall investigate the grounds for the summary suspension and issue a recommendation as to whether corrective action is warranted. The Medical Executive Committee shall not be limited to the examination of any particular event or incident and may review events or incidents occurring within the Hospital or outside the Hospital. Outside consultants and third parties may be utilized. If the summary suspension was imposed within thirty (30) days of a recommendation of the Medical Executive committee for corrective action following an investigation based on the same or similar grounds as the summary suspension, there shall be no requirement for further investigation by the Medical Executive Committee.

The executive committee may recommend modification, continuance or termination of the terms of the summary suspension. If, as a result of such investigation, the executive committee does not recommend immediate termination of the summary suspension, the affected practitioner shall, also in accordance with Article X be entitled to request a fair hearing by the governing body, but the terms of the summary suspension as sustained or as modified by the executive committee shall remain in effect pending a final decision thereon by the governing body.

Immediately upon the imposition of a summary suspension, the Chief of Staff shall have authority to provide for alternative medical coverage for the patient(s) of the suspended practitioner still in the hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative practitioner.

9.3 Automatic Suspension

Automatic Suspension will occur under the following circumstances:

Licensure.

If a Practitioner's license, certification or registration to practice in Texas lapses, the Practitioner's clinical privileges shall be suspended until the deficiency is corrected. If, within 90 days following the lapse, the Practitioner does not demonstrate the license, certification or registration has been renewed, the Practitioner's clinical privileges shall be automatically revoked.

DEA Certificate and DPS Registration.

If a Practitioner's DEA certificate or DPS registration lapses, that Practitioner shall be immediately and automatically divested, of his or her clinical privileges to prescribe controlled substances. If said certificate or registration lapses and is required for medical practice, the Practitioner's clinical privileges will be suspended unless the Practitioner provides documentation from the DEA or DPS demonstrating that the expiration date of the DEA certificate or DPS registration has been extended. If, within 90 days following the lapse, the Practitioner does not demonstrate the DEA certificate or DPS registration has been renewed, the Practitioner's clinical privileges shall be automatically revoked.

Professional Liability Insurance.

If a Practitioner fails to maintain professional liability insurance as set forth in these Bylaws, the Practitioner's clinical privileges will be suspended until the deficiency is corrected. If within nine (90)

days following the deficiency, the Practitioner does not provide evidence of required professional liability insurance, the Practitioner's clinical privileges may be automatically revoked.

Falsification.

If an applicant of the Medical Staff falsifies an application for appointment, reappointment, or clinical privileges, the applicant will be immediately suspended; if upon investigation the falsification is confirmed, the suspension will become permanent.

Repetitious Infractions.

If a Practitioner has been subject to at least three (3) administrative suspensions under this Section 3 within any consecutive twenty-four (24) month period, the Practitioner's clinical privileges may be immediately suspended by the Medical Executive Committee until the underlying action or failure to act giving rise to the administrative suspensions is addressed. If the underlying act or failure to act is not so addressed, the suspension will become permanent.

Reappointment.

If a practitioner fails to return his/her reappointment packet prior to deadline, the practitioner's clinical privileges will be suspended until the reappointment is approved by the Board of Directors. If within ninety (90) days following reappointment expiration date, the practitioner has not complied, the Practitioner's clinical privileges may be automatically revoked.

Electronic Health Record (EHR) Training.

If a practitioner fails to successfully complete ConnectCARE training his/her clinical privileges shall be suspended until such time as training is complete and documentation of completion is received in the Medical Staff Office.

A temporary suspension in the form of withdrawal of a practitioner's admitting and clinical privileges shall be imposed automatically after warning of delinquency for failure to complete medical records within the time specified in Rules and Regulations, ~~Section B, No. 17 of these Bylaws~~. The suspension will be effective until medical records are completed.

Action by the State Board of Medical Examiners revoking or suspending a practitioner's license, or placing said practitioner on probation, shall automatically suspend all of the practitioner's privileges. If placed on probation, the practitioner's hospital standing shall be evaluated by the Medical Executive Committee of the Medical Staff and appropriate action shall be taken.

It shall be the duty of the ~~President of the Medical~~ Chief of Staff to cooperate with the Administrator in enforcing all automatic suspensions.

Exclusions.

Any practitioner excluded from participation in Medicare, Medicaid and/or Tricare or any government funded healthcare program will be suspended immediately.

Felony.

If a Practitioner is convicted of a felony, the Practitioner's scope of practice or scope of service shall be automatically revoked upon the Hospital receiving actual notice of the conviction.

Flu Vaccination. Failure to provide annual documentation of flu vaccination or a medical or religious waiver in a form acceptable to Hospital shall result in an automatic administrative suspension until such time as such documentation is provided to Hospital.

ARTICLE X HEARING AND APPELLATE REVIEW PROCEDURE

10.1 Notice of Adverse Recommendation or Decision

The CEO shall give to any affected practitioner who is entitled to a hearing or to an appellate review prompt written notice by certified mail, return receipt requested, of an adverse recommendation or decision stating all of the following:

- a. That a professional review action has been proposed to be taken against the practitioner.
- b. The reasons for the proposed action
- c. That the practitioner has the right to request a hearing on the proposed action
- d. Any time limit of not less than thirty (30) days within in which to request a hearing
- e. A summary of the practitioner's rights in the hearing.

10.2 Request for Hearing

Upon receipt of a notice of proposed professional review action, the affected practitioner may request a hearing. Said request shall be made by written notice by certified mail, return receipt requested to the CEO within thirty (30) days of the date the practitioner received the notice of adverse recommendation or decision.

The failure of a practitioner to request a hearing to which he is entitled by these bylaws within the time and manner herein provided shall be deemed a waiver of the practitioner's right to such hearing and to any appellate review to which the practitioner might otherwise have been entitled on the matter. When the waived hearing relates to an adverse recommendation of the executive committee of the medical staff or of a hearing committee appointed by the governing body, the same shall thereupon become and remain effective against the practitioner pending the governing body's decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the governing body, the same shall thereupon become and remain effective against the practitioner in the same manner as a final decision of the governing body provided for in these Bylaws. In either of such events, the CEO shall promptly notify the affected practitioner of his status by certified mail, return receipt requested.

10.3 Notice of Hearing

Within thirty (30) days after receipt of a request for hearing from a practitioner entitle to the same, the executive committee or the governing body, whichever is appropriate shall schedule and arrange for such a hearing and shall, through the CEO, notify the practitioner of the time, place and date so scheduled, by certified mail, return receipt requested. The hearing date shall be not less than thirty (30) days, from the date of receipt of the request for hearing; provided, however, that a hearing for a practitioner who is under suspension which is then in effect, shall be held as soon as arrangements therefore, may reasonably be made, upon written request of the practitioner involved. The notice of the hearing may be supplemented at a later date.

The notice of hearing shall state in concise language the acts or omissions with which the practitioner is charged, a list of specific or representative charts being questioned, a roster of witnessed who have previously provided evidence or who may be called to provide evidence in the hearing, and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision. The

practitioner shall also be provided a summary of the practitioner's rights in the hearing as described in these Bylaws.

10.4 Composition of Hearing Committee

When a hearing relates to an adverse recommendation of the Medical Executive Committee, such hearing shall be conducted by an Ad Hoc Hearing Committee of no less than two (2) nor more than four (4) members of the Medical Staff appointed by the Chief of Staff in consultation with the Medical Executive Committee and one of the members so appointed shall be designated as Chairperson. Appointees shall not be in direct competition with the physician involved. No staff member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this Hearing Committee.

When a hearing relates to an adverse decision of the Board of Directors that is contrary to the recommendation of the Medical Executive Committee, the Board of Directors shall appoint a Hearing Committee to conduct such hearing and shall designate one of the members of this Committee as Chairperson. The appointed Chairperson shall not be in direct competition with the physician involved. At least one representative from the Medical Staff, not in direct competition with the physician involved, shall be included on this Committee when feasible.

10.5 Conduct of Hearing

There shall be at least a majority of the members of the Hearing Committee present when the hearing takes place, and no member may vote by proxy.

An accurate record of the hearing must be kept.

The mechanism shall be established by the Ad Hoc Hearing Committee, and may be accomplished by the use of a court reported, electric recording unit, transcription or by the taking of adequate minutes.

The personal presence of the practitioner for whom the hearing has been scheduled shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived rights in the same as provided in Section 2 of this Article X and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in said Section 2.

Postponement of hearings beyond the time set forth in these Bylaws shall be made only with the approval of the Ad Hoc Hearing Committee. Granting of such postponements shall be for good cause shown and in the sole discretion of the Hearing Committee.

The Affected Practitioner shall be entitled to be accompanied and/or represented at the hearing by an attorney or other person of the practitioner's choice.

Either a Hearing Office, if one is appointed, or the Chairperson of the Hearing Committee or designee, shall preside over the hearing and determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of existence of any common law or statutory rule, which make evidence inadmissible over objection in civil or criminal actions. The

practitioner for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record.

The Medical Executive Committee, when its action has prompted the hearing, shall appoint one of its members, some other Medical Staff member or its attorney to represent it at the hearing, to present the facts in support of its adverse recommendation, and to examine witnesses. The Board of Directors, when its action has prompted the hearing, shall appoint one of its members or its attorney to represent it at the hearing, to present the facts in support of its adverse decision and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision, but the Affected Practitioner shall thereafter be responsible for supporting the practitioner's challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable, or capricious.

The Affected Practitioner and Hearing Committee shall have the following rights to call and examine witnesses, to introduce written evidence, to cross-examine any witness on any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence. If the practitioner does not testify in the practitioner's own behalf, the practitioner may be called and examined as if under cross-examination. The practitioner may submit a written statement at the close of the hearing.

The Hearing Committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the Affected Practitioner for whom the hearing was convened.

Within a reasonable time, not to exceed thirty (30) days after final adjournment of the hearing, the Hearing Committee shall make a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the Medical Executive Committee or to the Board of Directors, whichever appointed it and the Affected Practitioner. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Medical Executive Committee or decision of the Board of Directors. Thereafter, the procedure to be followed shall be as provided in Article V of these Bylaws. The Affected Practitioner has the right to the record of the proceedings, copies of which may be obtained by the practitioner upon payment of reasonable charges associated with the preparation thereof.

10.6 Appeal to the Governing Body

Within thirty (30) days after receipt of a notice by an Affected Practitioner of an adverse recommendation or decision made or adhered to after a hearing as above provided, the practitioner may, by written notice to the Board of Directors delivered through the Administrator or his designed by certified mail, return receipt requested, request an appellate review by the Board of Directors. Such notice may request that the appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the practitioner's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.

If such appellate review is not requested within fifteen (15) days, the Affected Practitioner shall be deemed to have waived the right to the same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in 10.2 of this Article X.

Within thirty (30) days after receipt of such notice of request for appellate review, the Board of Directors shall schedule a date for such review, including a time and place for oral argument if such has been requested, and shall, through the Administrator or his designee, by written notice sent by certified mail, return receipt requested, notify the Affected Practitioner of the same. The date of the appellate review shall not be less than thirty (30) days, nor more than sixty (60) days, from the date of the receipt of the notice of request for appellate review, except that when the practitioner requesting the review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than fifteen (15) days from the date of receipt of such notice.

The appellate review shall be conducted by the Board of Directors or by a duly appointed appellate review committee of the Board of Directors of not less than three (3) members. To the extent possible based on the availability of Board members, no member of the appellate review committee will have been a member of the initial peer review hearing panel or a member of the Medical Executive Committee making an adverse determination that is subject to the appeal.

The Affected Practitioner shall have access to the report and record and transcription, (if any) of the Ad Hoc Hearing Committee and all other material favorable or unfavorable, that was considered in making the adverse recommendation or decision against the practitioner. The Affected Practitioner shall have thirty (30) days to submit a written statement in the practitioner's own behalf, in which those factual and procedural matters with which the Affected Practitioner disagrees, and subsequent reasons for such disagreement, shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Board of Directors through the Administrator or his designee by certified mail, return receipt requested, at least fifteen (15) days prior to the scheduled date for the appellate review. A similar statement may be submitted by the Medical Executive Committee of the Medical Staff or by the Chairperson of the Hearing Committee appointed by the Board of Directors and if submitted, the Administrator or his designee shall provide a copy thereof to the practitioner at least ten (10) days prior to the date of such appellate review by certified mail, return receipt requested.

The Board of Directors or its appointed review committee shall act as an appellate body. The Chairperson of the appellate review body shall be the Presiding Officer. The Chairperson will determine the order of procedure during the review, make all required rulings, and maintain decorum. The Board of Directors shall review the record created in the proceedings, and shall consider the written statements submitted pursuant to subparagraph e. of this Section 6, for the purpose of determining whether the adverse recommendation or decision against the Affected Practitioner was justified and was not arbitrary or capricious. If an oral argument is requested as part of the review procedure, the Affected Practitioner shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to the practitioner by any member of the appellate review body. The Medical Executive Committee or the Board of Directors, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to said practitioner by any member of the appellate review body.

New or additional matters not raised during the original hearing or in the Hearing Committee Report, nor otherwise reflected in the record, shall only introduced at the appellate review under unusual circumstances, and the Board of Directors or the committee thereof appointed to conduct the appellate review shall in its sole discretion determine whether such new matters shall be accepted.

If the appellate review is conducted by the Board of Directors, it may affirm, modify or reverse its prior decision, or in its discretion, refer the matter to the Medical Executive Committee of the Medical Staff for further review and recommendation within thirty (30) days. Such referral may include a request that the Medical Executive Committee of the Medical Staff arrange for a further hearing to resolve specified disputed issues.

If the appellate review is conducted by a committee of the Board of Directors, such committee shall, within seven (7) days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Board of Directors affirm, modify or reverse its prior decision, or refer the matter to the Executive Committee for further review and recommendation within thirty (30) days. Such referral may include a request that the Medical Executive Committee of the Medical Staff arrange for a further hearing to resolve disputed issues. Within fifteen (15) days after receipt of such recommendation after referral, the committee shall make its recommendation to the Board of Directors as above provided. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 6 have been completed or waived. Where permitted by the Hospital Bylaws, all action required of the Board of Directors may be taken by a committee of the Board of Directors duly authorized to act.

10.7 Final Decision by Board of Directors

Within thirty (30) days after the conclusion of the appellate review, the Board of Directors shall make its final decision in the matter and shall send notice thereof to the Medical Executive Committee and, through the Administrator or his designee, to the Affected Practitioner, by certified mail, return receipt requested. If this decision is in accordance with the Medical Executive Committee's last recommendation in the matter, it shall be immediately effective and final, and shall not be subject to further hearing or appellate review. If this decision is contrary to the Medical Executive Committee's last such recommendation, the Board of Directors shall refer the matter to a joint committee composed of an equal number of members from the Board of Directors and Medical Executive Committee for further review and recommendation within fifteen (15) days, and shall include in such notice of its decision a statement that a final decision will not be made until the Committee's recommendation has been received.

Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the Medical Executive Committee of the Medical Staff, or by the Board of Directors, or by duly authorized committee of the Board of Directors, or by both.

If at any time after receipt of special notice of an adverse recommendation, action or result, a practitioner fails to make a required request or appearance or otherwise fails to comply or to proceed with the matter, the practitioner shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights to which he might otherwise have been entitled under the Medical Staff Bylaws then in effect with respect to the matter involved.

10.8 Reporting

In accordance with Texas Occupations Code Section 160.003, if a determination is made that a practitioner in Texas poses a continuing threat to the public welfare through the practice of medicine, the person or committee must report relevant information in writing to the Texas Medical Board, or appropriate Board. This report must include:

1. The name of the practitioner;
2. A description of the acts or omissions or other reasons for the action or, if known, for the surrender; and
3. Such other information respecting the circumstances of the action or surrender, as deemed appropriate.

In accordance with 42 U.S.C. Sections 11133, 11134, 11131, and Texas Occupations Code Section 160.002, to prevent loss of immunity from civil damages afforded by statute, the following professional review actions must be reported by the Hospital's authorized representative to the National Practitioners Data Bank and to the Texas Medical Board or appropriate Board:

1. Action that adversely affects the clinical privileges of a practitioner for a period longer than 30 days; or
2. Acceptance of the surrender of clinical privileges of a practitioner (while the practitioner is under an investigation by the entity relating to possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding).

This duty may not be nullified through contract.

To avoid being subject to a civil monetary penalty, the Hospital must also report payments made for the benefit of a physician, dentist, or other practitioner in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action against the practitioner. A payment resulting from a claim that is solely against an entity (e.g. Hospital, clinic, group practice) and that does not name an individual practitioner is not reportable. The information required to be reported shall be reported regularly (but not less often than monthly) to the NPDB and to the Texas Medical Board and/or other appropriate Board and must include:

1. The name of the practitioner for whose benefit the payment is made;
2. The amount of the payment;
3. The name (if known) of any hospital with which the practitioner is affiliated or associated;
4. A description of the acts or omissions and injuries or illnesses upon which the action or claim was based; and
5. Such other information as the Secretary determines is required for appropriate interpretation of information reported under this 42 U.S.C. Section 11131.

To the extent the aforementioned state and federal laws change, this section shall conform to such changes without regard to whether an amendment has yet been adopted in accordance with these bylaws.

ARTICLE XI MEDICAL STAFF OFFICER

11.0 Officer

The officer of the Medical Staff is: Chief of Staff

11.1 Qualifications of Officer

Officer must be a Member of the Active Staff at the time of nomination and election, and must remain a Member in good standing during their terms of office. Failure to maintain such status shall immediately create a vacancy in the office.

11.2 Duties of Officer

The Chief of Staff shall:

- a. Act on behalf of the Medical Staff and the Board of Directors as the chief medical officer of the Hospital, in coordination and cooperation with the Hospital CEO in matters of mutual concern involving the Hospital;
- b. Act on behalf of the Medical Staff and represent the views, policies, needs, and grievances of the Medical Staff and communicate on the medical activities of the Medical Staff to the Board of Directors and to the Hospital President;
- c. Call, preside, and be responsible for the agenda of all regular and special meetings of the Medical Staff;

- d. Recommend to the Medical Board appointment of committee chairs and members, in accordance with the provision of these Bylaws, to all standing and special Medical Staff committees except the Medical Board;
- e. Serve as chair of the Medical Board and as an ex-officio member, without vote, of all Medical Staff committees;
- f. Provided day-to-day liaison on medical matters with the Hospital President and the Board of Directors;
- g. Receive and interpret the policies of the Board of Directors to the Medical Staff and communicate to the Board of Directors on Medical Peer Review activities the performance and maintenance of quality with respect to the delegated responsibilities of the Medical Staff;
- h. Serve on such other committees as may be required;

11.3 Election of Office

The Chief of Staff attains office by vote of the Medical Executive Committee. Candidates are presented or nominated from the active medical staff.

A candidate must not have an objection from the other active staff members that cannot be resolved.

11.4 Terms of Office

The Chief of Staff shall serve a two (2) year term from the date they assume office and until a successor is installed in office. Officer shall assume office on the first day of the Medical Staff Year or January 1 following the election and after approval by Board of Directors, except that an officer elected or appointed to fill a vacancy assumes office immediately on election or appointment.

Members at large: The members at Large shall serve for a two year (2) period. Officers shall serve their term from their election date or until a successor is elected.

11.5 Resignation/Removal of Officer

11.5.1 Resignation.

Any officer may resign at any time by giving written notice to the Medical Board. The resignation, which may or may not be made contingent on acceptance by the Medical Board, shall be effective on the date received by the Medical Board or at any later date specified in the resignation.

11.5.2 Removal.

An officer may be removed from office for cause including and without limitation:

- a. Failure to perform the duties of the position held in a timely and appropriate manner from whatever cause, including physical or mental infirmity;
- b. Failure to continuously satisfy the qualifications for the office;
- c. Having an automatic or summary suspension imposed by operation of Article X or a corrective action matter pursuant to Article X, resulting in a final decision other than to take no action; and
- d. Conduct or statements inimical or damaging to the best interest of patient care, or to the Medical Staff for the Hospital or to their goals, programs or public image.

- e. The Medical Executive Committee, by a two-thirds (2/3) majority vote of those present at a duly called meeting at which a quorum is present, may remove a Medical Staff officer. Notice of the meeting at which such action takes place shall have been given in writing to such officer at least ten (10) days prior to the date of such meeting. The officer shall be afforded the opportunity to speak to the Medical Board prior to the taking of any vote on the officer's removal.
- f. The Medical Staff may remove a Medical Staff officer on the affirmative vote of two-thirds (2/3) of the Active Staff members present at a duly called meeting at which a quorum is present subject to ratification by the Board of Directors.
- g. The Board of Directors may remove a Medical Staff officer, but must first refer the matter to a special committee composed of an equal number of Board of Directors members and of Active Staff members appointed, respectively, by the Chairman of the Board of Directors and the highest ranking Staff officer not the subject of the removal action. The Hospital President also sits with the special committee s ex-officio, non-voting member. As soon as reasonably practicable after the referral to it, the special committee will submit its written report to the Board of Directors, Action by the Board of Directors after receiving the special committee's report is the final decision in the matter.

11.6 Vacancies in Office

If there is a vacancy in the office of Chief of Staff prior to the expiration of their term, the Hospital President shall appoint interim Chief of Staff who will assume the duties and authority of the Chief of Staff for the remainder of the unexpired term and his or her own full term as Chief of Staff.

ARTICLE XII COMMITTEES

12.1 Medical Executive Committee

The Organized Medical Staff has delegated to the Medical Executive Committee the authority to carry out responsibilities of the Medical Staff, including the Medical Staff's responsibility to be accountable to the Board of Directors for the quality of medical care provided to patients. Therefore, the Medical Executive Committee shall act on the authority of the Board of Directors on matters of a medical nature, and shall perform any other duties that the Board of Directors may require in order to promote quality of care.

12.1.1 Composition:

The Medical Executive Committee shall be a standing committee and may include physicians and other licensed independent practitioners of any discipline or specialty. The majority voting Medical Staff Executive Committee members is fully licensed doctors of medicine or osteopathy actively practicing in the Hospital. The Medical Executive Committee shall consist of the officer of the Medical Staff, and two (2) other members elected for two (2) year terms. The Hospital President shall attend each Medical Executive Committee meeting on an ex-officio basis without vote. The primary function of the organized Medical Staff or Medical Executive Committee is to approve and amend Medical Staff Bylaws and to provide oversight for the quality of care, treatment, and services provided by practitioners with privileges.

12.1.2 Self-governance of the organized Medical Staff includes the following:

- a. Initiating and developing the Medical Staff Bylaws, Rules and Regulations;
- b. Recommending approval and disapproval of amendments to the Medical Staff Bylaws to the Medical Staff and Board of Directors;
- c. Selecting and removing the Medical Staff officer;

- d. Determining the mechanism for establishing and enforcing criteria and standards for Medical Staff membership;
- e. Determining the mechanism for establishing and enforcing criteria for delegating oversight responsibilities to practitioners with independent privileges;
- f. Determining the mechanism for establishing and maintaining patient care standards and credentialing and delineation of clinical privileges including requesting evaluations where there is doubt about an applicant's ability to perform the privileges requested; and,
- g. Engaging in performance improvement activities.

12.1.3 Duties: The duties of the Medical Executive Committee shall be:

- a. To represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;
- b. To work with the Board of Directors to define their shared and unique responsibilities;
- c. To work with the Board of Directors and senior leaders to identify skills required of individual leaders within management;
- d. To work with the Board of Directors and senior leaders to create the Hospital's mission, vision and goals;
- e. To work with the Hospital's Board of Directors and senior leaders to define what constitutes a conflict of interest that could affect safety and quality;
- f. To work with the Hospital's Board of Directors and senior leaders in developing a policy that defines how conflicts of interest will be addressed;
- g. To work with senior leaders in developing processes that support efficient patient flow;
- h. To act on behalf of the Medical Staff between meetings;
- i. To receive and act upon reports and recommendations from Medical Staff committees; and any ad hoc committees;
- j. To provide liaison between the Medical Staff and the administrator and the Board of Directors;
- k. To make recommendation son Hospital management matters (for example, long range planning) to the Board of directors through the administrator;
- l. To fulfill the Medical Staff's accountability to the Board of Directors for promoting patient safety and the quality of medical care;
- m. To ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital;
- n. To provide for the preparation of all meeting programs, either directly or through delegation to a Program Committee or other suitable agent;
- o. To review the credentials of all applicants and to make recommendations for staff membership, assignment to department and delineation of clinical privileges to the Board of Directors;
- p. To review periodically all information available regarding the performance and clinical competence of staff members and other practitioners with clinical privileges and as a result of such reviews to make recommendations for reappointments and renewal or changes in clinical privileges;
- q. To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;
- r. To recommend appointment of committee members in accordance with these Bylaws, Rules and Regulations;
- s. To be responsible for the organization of the performance improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate and revise such activities;
- t. To provide oversight in the process of analyzing and improving patient satisfaction;

- u. To keep regular minutes of their proceedings and report any relevant information at each general staff meeting or to the Board of Directors, as appropriate.

12.1.4 Meetings: The Medical Executive Committee shall meet at least six times per year.

ARTICLE XIII PRACTITIONER RIGHTS

Each physician on the Medical Staff has the right to an audience with the Medical Executive Committee. In the event a practitioner is unable to resolve a difficulty working with his/her respective department chair, that physician may, upon presentation of a written notice, meet with the Medical Executive Committee to discuss the issue.

Any practitioner has the right to initiate a recall election of a medical staff officer and/or appointment of a department chair. A petition for such recall must be presented, signed by at least 25% of the members of the Active Staff. Upon presentation of such valid petitioner, the Medical Executive Committee will schedule a special general staff meeting for the purposes of discussing the issue and (if appropriate) entertain a no-confidence vote.

Any practitioner may call a general staff meeting. Upon presentation of a petition signed by 30% of the members of the active staff, the Medical Executive Committee will schedule a general staff meeting for the specific purpose addressed by the petitioners. No business other than that in the petition may be transacted.

Any practitioner may raise a challenge to any rule or policy established by the Medical Executive Committee. In the event a rule, regulation or policy is felt to be inappropriate, any physician may submit a petition signed by 30% members of the Active Medical Staff. When such petition has been received by the Medical Executive Committee, it will either: (1) provide the petitioners with information clarifying the intent of such rule, regulation or policy and/or (2) schedule a meeting with the petitioners to discuss the issue.

This section is common to Section 1 through 4 above. This section does not pertain to issues involving disciplinary action, denial of request for appointment or clinical privileges, or any other matter relating to individual "credentialing" actions. Section 7 and the Fair Hearing Plan provide recourse in these matters.

Any physician has a right to a hearing/appeal to the institution's Fair Hearing Plan in the event any of the following actions are taken or recommended:

1. Denial of initial staff appointment;
2. Denial of reappointment;
3. Revocation of staff appointment;
4. Denial or restriction of requested clinical privileges;
5. Reduction in clinical privileges;
6. Revocation of clinical privileges;
7. Individual application of, or individual changes I, mandatory consultation requirements; and
8. Suspension (for reason of competence or conduct) of staff appointment or clinical privileges if such suspension is for more than 14 days.

ARTICLE XIV MEDICAL STAFF MEETINGS

Regular Meetings

Medical Staff. The Medical Staff will hold an Annual Staff meeting. Written notice of the meeting is sent by electronic mail to all Medical Staff Members in advance of the meeting at the office or email address on file with the Medical Staff Office. The primary objective of the meetings is to report on the activities of the Medical Staff and conduct other business. A printed agenda is provided prior to the meetings and will be communicate by voice, electronically, print, or other modes of communication as selected by the Hospital. Written minutes of the meeting are prepared and maintained.

Special Meetings

Committee. A special meeting of any Medical Staff committee may be called by or at the request of the chair and shall be called within fifteen (15) days at the written request of the Board of Directors, the Hospital President, the Chief of Staff, or one-third (1/3) of the committee's voting members in good standing, but not less than two (2) members.

Medical Staff. Special meetings of the Medical Staff may be called at any time by the Chief of Staff and must be called within thirty (30) days of written request by the Board of Directors, the President of the Hospital, a majority of the Medical Board, or a petition signed by not less than twenty-five percent (25%) of the voting staff.

Any notice of meetings may be sent by print or electronically unless otherwise provided by the Bylaws.

Quorum

A quorum is required for the transaction of business at a meeting.
A quorum consists of those members present.

ARTICLE XV CONFLICT RESOLUTION MECHANISM

Process for Managing Conflict between the Medical Executive Committee (MEC) and the Organized Medical Staff.

For the purposes of these bylaws, the process for conflict management outlines below applies only to conflict between the MEC and the organized Medical Staff regarding adoption or amendment of the rules and regulations, and/or policy.

Should there be disagreement between the MEC and the organized Medical Staff over the adoption or amendment of medical staff rules and regulations, and/or policy, the following shall occur:

- a. The MEC will inform the Board of Directors that either they or the organized Medical Staff has adopted or amended medical staff rules and regulations, and/or policies, and that there is a disagreement between the two bodies.
- b. The Board of Directors shall appoint a special committee consisting of four (4) individuals- one each from the MEC and the organized Medical Staff, and two (2) members of the Board of Directors – who are neither members of the MEC or the organized Medical Staff, one of whom shall serve as chair.
- c. The Special Committee shall review the adoption or amendment as well as the MEC's reason for disagreement. By majority decision, the special committee will make a recommendation to the

Board of Directors to whether allow the adoption or amendment to be proposed, or to decline receiving said proposal.

- d. Based on the recommendation from the special committee the Board of Directors shall decide whether or not to receive the proposed adoption or amendment. The decision by the Board of Directors is final. Both the MEC and the organized Medical Staff shall be notified in writing of the Board of Directors' decision.

Nothing in this process is to be construed as preventing the organized Medical Staff from communicating directly with the Board of Directors. The Board of Directors will determine the method of communication in such matters.

ARTICLE XVI. IMMUNITY FROM LIABILITY

The following shall be express conditions to any practitioner's application for, or exercise of, clinical privileges at this Hospital:

First, any act, communication, report, recommendation, or disclosure, with respect to any such practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged and confidential.

Second, such privilege shall extend to all person, organizations and committees under applicable law including, without limitation, Board of Directors, officers and administrative staff, and to third parties who provide information to any of the foregoing authorized to receive, release or act upon the same. Third parties' means both individuals and organizations from whom information has been requested by an authorized representative of the Board of Directors or Medical Staff.

Third, there shall be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

Fourth, such immunity shall apply to all acts, communications, reports, recommendation, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to: (1) applications for appointment or clinical privileges, (2) periodic reappraisals for reappointment or clinical privileges (3) corrective action, including summary suspension, (4) hearings and appellate reviews, (5) medical care evaluations, (6) utilization reviews, and (7) other Hospital, departmental, service or committee activities related to quality patient care and unprofessional conduct.

Fifth, the acts, communications, reports, recommendations and disclosures referred to in this Article XIII may relate to a practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

Sixth, each practitioner shall upon request of the Hospital execute releases in accordance with the tenor and import of this Article XIII in favor of the individuals and organizations specified in paragraph second, subject to such requirements as may be applicable under the laws of Texas.

Seventh, the consents, authorizations, releases, rights, privileges and immunities provided by section 1 and 2 of Article V of these Bylaws in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article XVI.

ARTICLE XVII. RULES AND REGULATIONS

The medical staff shall adopt such rules and regulations as may be necessary to implement safe and effective care, subject to the approval of the governing body. These shall relate to the proper conduct of medical staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the hospital. Such rules and regulations shall be a part of these bylaws, except that they may be amended or repealed by a simple majority of the Executive Committee at any regular meeting at which a quorum is present and without previous notice. Such changes shall become effective when approved by the Board of Directors. The Medical Executive Committee shall have the authority to make amendments that are of a technical or typographical nature, without further approval or vote.

ARTICLE XVIII. AMENDMENTS

18.1 General

The authority to formulate, adopt or amend the Medical Staff Bylaws resides with the organized Medical Staff and the Board of Directors and cannot be delegated. Such authority and responsibility is exercised in good faith and in a reasonable, responsible, and timely manner.

The Chief of Staff shall instruct the executive committee to review the bylaws for necessary or desired amendments on an as needed basis, but not less often than biannually.

18.2 Adoption and Amendment of Bylaws

All proposed amendments to the Medical Staff Bylaws or adoption of new bylaws, whether originated by the Medical Board, another standing committee, or by a Member of the Active Staff, must be reviewed and approved as follows prior to a recommendation to the Board of Directors:

By the Medical Executive Committee after a majority vote, provided that the proposed adoption or amendment(s) was first distributed (or made available electronically) to the Members of the Active Staff at least twenty-one (21) days before a Medical Board vote. The Medical Board's recommendation for the proposed adoption or amendment may be acted upon by the Board of Directors unless more than ten percent (10%) of the Members of the Active Staff object in writing to the Medical Board prior to fourteen (14) days the vote by the Medical Executive Committee. If more than two percent (10%) of the Members of the Active Staff object to a proposed adoption or amendment, the Chief of Staff shall schedule and hold a special Medical Staff meeting at which the proposed adoption or amendment is presented, discussed, and acted upon. The affirmative vote of a majority of those members of the Active Staff present and voting is required for passage. Mailed ballots shall be permitted and counted as Members present and voting if requested two (2) weeks prior to the Medical Staff meeting and received by the Medical Staff Office prior to the start of the meeting at which the voting will be conducted. Proxy voting is not permitted.

By the Medical Staff on an affirmative vote of the majority of the Members of the Active Staff at any regular or special meeting of the Medical Staff at which a quorum is present provided that the proposed adoption or amendment(s) is first presented to the Medical Board at one of its regular meetings for

comment and that the Medical Board's comments are presented at the Staff meeting at which the voting is conducted.

Subject to approval of the Board of Directors, the Medical Board has the power to adopt, without prior notice to or approval by the Medical Staff such amendments to the Bylaws as are, in the Medical Board's judgment, technical or legal modifications or clarifications; reorganization or renumbering; or amendments needed because of punctuation, spelling, or other errors of grammar or expressions.

If the Board of Directors makes any changes to the proposed adoption or amendment(s) from what was submitted by the Medical Board or the Medical Staff, the Board of Directors shall notify the Members of the Active Staff by regular mail of the changes and allow at least thirty (30) days for the submission of comments by those Members to the Board of Directors, before final action.

ARTICLE XIX. ADOPTION

ADOPTED BY THE BOARD OF DIRECTORS AFTER RECEIPT OF A RECOMMENDATION FROM THE MEDICAL EXECUTIVE COMMITTEE ON, REVISED..... TO REFLECT HOSPITAL NAME CHANGE AND TITLE CHANGE FROM TRUSTEES TO DIRECTORS.