TEXAS SPINE AND JOINT HOSPITAL LTD.

MEDICAL STAFF BYLAWS

Effective: August 1, 2007
Revised: April 22, 2011, Aug. 22, 2014

TEXAS SPINE AND JOINT HOSPITAL LTD

MEDICAL STAFF BYLAWS

TABLE OF CONTENTS

PREAMBLE **8**
A. DEFINITIONS 8
B. OBJECTIVES 9
ARTICLE I. MEDICAL STAFF MEMBERSHIP **10**
1.1 GENERAL 10
1.2 BASIC QUALIFICATIONS FOR MEMBERSHIP 11
1.2.1 Basic Qualifications 11
1.2.3 Nondiscrimination 13
1.3 BASIC RESPONSIBILITIES OF INDIVIDUAL STAFF MEMBERSHIP 13
1.4 CONDITIONS AND DURATION OF APPOINTMENT 14
1.5 HEALTH STATUS 15
1.6 TERMINATION OF CONTRACT 15
1.7 CONTINUING NOTIFICATION 16
ARTICLE II. CATEGORIES OF THE MEDICAL STAFF **16**
2.1 CATEGORIES 16
2.2 ACTIVE STAFF 16
2.2.1 Qualification 16
2.2.2 Prerogatives 17
2.2.3 Responsibilities 17
2.3 COURTESY STAFF 18
2.3.1 Qualifications 18
2.3.2 Prerogatives 18
2.3.3 Responsibilities 19
2.4 CONSULTING STAFF 19
2.5 CONTRACT STAFF 19
2.6 TELEMEDICINE STAFF 19
2.7 HONORARY STAFF 20
2.7.1 Qualifications 20
2.7.2 Prerogatives 20
2.7.3 Responsibilities 20
2.8 OPTIONAL ADDITION OF CATEGORIES OF STAFF 20
Intentionally Left Blank. 20
2.9 LIMITATION OF PREROGATIVES 20
2.10 WAIVER OF QUALIFICATIONS 20
ARTICLE III. ALLIED HEALTH PROFESSIONALS **21**
3.1 QUALIFICATIONS 21
3.2 PROCEDURE FOR SPECIFIED SERVICES 21
3.3 PREROGATIVES 22
3.4 RESPONSIBILITIES 22
3.5 DENTAL SERVICES 23

3.6 PODIATRIC SERVICES 23
ARTICLE IV. PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT 24
4.1 AVOIDING UNNECESSARY PROCESSING OF APPLICATIONS 24
4.2 APPLICATION FORM 26
4.3 ACKNOWLEDGEMENTS 27
4.4 INITIAL APPOINTMENT PROCESS 31
4.4.1 Administrative Review 31
4.4.2 MEC Review 32
4.4.3 Board Action Review 33
4.4.4 Notice of Final Decision 33
4.4.5 Time Requirements 34
4.5 APPLICATION FOR REAPPOINTMENT 34
4.6 REAPPOINTMENT PROCESS 34
4.6.1 Delivery of Form 34
4.6.2 Administrative Review 35
4.6.3 Review by Credentials Committee 35
4.6.4 Board Action Review 35
4.6.5 Compliance with Procedures for Appointment 35
4.7 MISCELLANEOUS 36
4.7.1 Withdrawal 36
4.7.2 Eligibility for Reapplication after Adverse Action 36
4.7.3 Denial for Hospital's Inability to Accommodate Applicant 36
4.7.4 Custody of Application 36
4.8 IMMUNITY FROM LIABILITY 36
4.8.1 Persons Protected 36
4.8.2 Acts Covered 37
4.9 LEAVE OF ABSENCE 37
ARTICLE V. DETERMINATION OF CLINICAL PRIVILEGES 38
5.1 CLINICAL PRIVILEGES RESTRICTED 38
5.2 BASIS FOR CLINICAL PRIVILEGES 38
5.3 CLINICAL PRIVILEGES RESTRICTED OR EXPANDED 38
5.4 PERFORMANCE IMPROVEMENT PROGRAM 38
5.5 TERMINATION OF EXISTING PRIVILEGES 39
5.6 TEMPORARY PRIVILEGES 39
5.6.1 Requirements 39
5.6.2 Grant of Temporary Privileges 40
5.6.3 Termination 40
5.7 EMERGENCY DISASTER PRIVILEGES 41
5.8 TELEMEDICINE PRIVILEGES 42
5.8.1 Qualifications of Applicants for Telemedicine Privileges 42
5.8.2 Processing Requests for Telemedicine Privileges 43
5.9 44
RIGHTS ASSOCIATED WITH TEMPORARY, LOCUM TENENS, EMERGENCY AND DISASTER PRIVILEGES 44
5.10 44

PROCEDURES NOT PERMITTED TO BE PERFORMED 44
ARTICLE VI. CORRECTIVE ACTION 44
6.1 ROUTINE CORRECTIVE ACTION 44
6.1.1 Criteria for Initiation 44
6.1.2 Requests and Notice 44
6.1.3 MEC Action 45
6.1.4 Procedural Rights 45
6.1.5 Other Action 46
6.2 SUMMARY ACTION 46
6.2.1 Summary Action 46
6.2.2 MEC Action 47
6.2.3 Procedural Rights 47
6.3 AUTOMATIC SUSPENSION 47
6.3.1 License 47
6.3.2 DPS Number and DEA Number 48
6.3.3 Medical Records 48
6.3.3.1 Post-Anesthesia Assessment 48
6.3.4 Malpractice Insurance 49
6.3.5 Procedural Rights 49
6.3.6 Voluntary Separation from Staff 49
6.3.7 Conviction of a Felony 49
6.3.8 Loss of Medicare/Medicaid Participation 49
6.3.9 Hearing Entitlement 50
6.3.10 50
Attorney Representation 50
6.3.11 51
Payment of Attorney Fees 51
6.4 APPLICATION FOR REINSTATEMENT TO STAFF MEMBERSHIP. 51
6.4.1 Immediate Application for Reinstatement 51
6.4.2 Delayed Application for Reinstatement to Medical Staff Membership 51
ARTICLE VII. INTERVIEWS, HEARINGS AND APPELLATE REVIEW 52
7.1 INTERVIEWS 52
7.2 HEARINGS AND APPELLATE REVIEW 52
7.2.1 Unfavorable MEC Recommendation or Board Action 52
7.2.2 Procedure and Process 52
7.2.3 Exceptions 53
ARTICLE VIII. OFFICER (CHAIRPERSON) 53
8.1 OFFICER/CHAIRPERSON OF THE STAFF 53
8.1.1 Identification 53
8.1.2 Qualifications 53
8.1.3 Election 53
8.1.4 Term of Office 53
8.1.5 Removal of General Staff Officer(s) 53
8.1.6 Vacancies in Elected Office 54
8.2 DUTIES OF GENERAL OFFICERS 54

8.2.1 Chairperson of the Medical Staff (Chief of Staff) 54
8.2.2 Vice Chairperson of the Medical Staff 55
8.2.3 Secretary-Treasurer 55
ARTICLE IX. COMMITTEES AND FUNCTIONS 56
9.1 DESIGNATION AND SUBSTITUTION 56
9.2 ORGANIZATION OF COMMITTEES 56
9.3 COMMITTEE CHAIRPERSON 56
9.3.1 Selection 56
9.3.2 Term 56
9.4 MEMBERSHIP AND APPOINTMENT 56
9.4.1 Eligibility 56
9.4.2 Selection 57
9.4.3 Administrator 57
9.4.4 Term 57
9.5 REQUIREMENTS FOR MEDICAL STAFF COMMITTEE SERVICE 57
9.6 MEDICAL EXECUTIVE COMMITTEE 57
9.6.1 Composition 57
9.6.2 Duties 58
9.6.3 Meetings and Procedures 59
9.7 STAFF FUNCTIONS 60
9.8 BYLAWS 61
9.8.1 Composition 61
9.8.2 Responsibilities 61
9.8.3 Procedures 61
9.9 CONTINUING EDUCATION COMMITTEE 62
9.9.1 Composition 62
9.9.2 Responsibilities 62
9.9.3 Procedures 62
9.10 ENVIRONMENT OF CARE COMMITTEE 63
9.10.1 Composition 63
9.10.2 Responsibilities 63
9.10.3 Procedures 64
9.11 INFECTION CONTROL COMMITTEE 64
9.11.1 Composition 64
9.11.2 Responsibilities 64
9.11.3 Procedures 65
9.12 MEDICAL RECORDS COMMITTEE 65
9.12.1 Composition 65
9.12.2 Responsibilities 66
9.12.3 Procedures 66
9.13 ANCILLARY SERVICE COMMITTEE 67
9.13.1 Composition 67
9.13.2 Pharmacy Responsibilities 67
9.13.3 Laboratory and Transfusion Responsibilities 68
9.13.4 Other Ancillary Services 69

9.13.5 Procedures 69
9.14 TISSUE REVIEW COMMITTEE 69
9.14.1 Composition 69
9.14.2 Responsibilities 69
9.14.3 Procedures 70
9.15 PERFORMANCE (QUALITY) IMPROVEMENT COMMITTEE 70
9.15.1 Composition 70
9.15.2 Responsibilities 70
9.15.3 Procedures 71
9.16 UTILIZATION REVIEW COMMITTEE 71
9.16.1 Composition 71
9.16.2 Responsibilities 71
9.16.3 Procedures 72
9.17 MORTALITY/MORBIDITY COMMITTEE 72
9.17.1 Composition 72
9.17.2 Responsibilities 72
9.17.3 Procedures 72
9.18 STANDING COMMITTEES 72
9.19 SPECIAL COMMITTEES 73
ARTICLE X. MEETINGS 73
10.1 GENERAL STAFF MEETINGS 73
10.1.1 Annual Meeting 73
10.1.2 Regular Meetings 74
10.1.3 Notice 74
10.1.4 Closed Meetings 74
10.2 COMMITTEE MEETINGS 75
10.2.1 Regular Meetings 75
10.2.2 Special Meetings 75
10.2.2 Notice 75
10.3 QUORUM 75
10.3.1 Annual Meeting 75
10.3.2 General and Special Staff Meetings 75
10.3.3 Committee Meetings 75
10.4 MANNER OF ACTION 76
10.5 AGENDA 76
10.5.1 Regular Staff Meetings 76
10.5.2 Special Meetings 76
10.6 MINUTES 76
10.7 ATTENDANCE REQUIREMENTS 76
10.7.1 Regular Attendance 76
10.7.2 Courtesy Staff 77
10.7.3 Absence from Meeting 77
ARTICLE XI. CONFIDENTIALITY, IMMUNITY AND RELEASES 77
11.1 SPECIAL DEFINITIONS 77
11.2 CONFIDENTIALITY OF INFORMATION 78

11.3 IMMUNITY FROM LIABILITY 78
11.3.1 For Action Taken 78
11.3.2 For Providing Information 78
11.4 ACTIVITIES AND INFORMATION COVERED 78
11.4.1 Activities 78
11.4.2 Information 79
11.5 RELEASES 79
11.6 CUMULATIVE EFFECT 79
ARTICLE XII. GENERAL PROVISIONS 80
12.1 STAFF RULES AND REGULATIONS 80
12.2 PROFESSIONAL LIABILITY INSURANCE 80
12.3 WAIVER 80
12.4 FORMS 81
12.5 CONSTRUCTION OF TERMS AND HEADINGS 81
12.6 TRANSMITTAL OF REPORTS 81
12.7 CREDENTIAL FILES 81
12.8 MEDICAL STAFF GOVERNANCE DOCUMENTS AND CONFLICT MANAGEMENT 82
12.9 AUTHORITY; MEDICAL STAFF BYLAWS CONTROL 82
ARTICLE XIII. ADOPTION AND AMENDMENT OF MEDICAL STAFF BYLAWS .. 84
13.1 ADOPTION 84
13.2 AMENDMENTS 85

TEXAS SPINE AND JOINT HOSPITAL, LTD

BYLAWS OF THE MEDICAL STAFF

PREAMBLE

Texas Spine and Joint Hospital, Ltd. (referred to as the "Hospital") is a limited partnership organized under the laws of the State of Texas, with its purpose being to serve as a specialty surgical hospital, providing patient care, education, and research. It is recognized that the Medical Staff is responsible for the quality of care in Texas Spine and Joint Hospital, Ltd., and it must accept and discharge this responsibility, subject to the ultimate authority of the Hospital's Board of Directors.

The physicians practicing in this Hospital shall organize their activities in order to carry out the functions delegated to the Medical Staff by the Board in conformity with these Bylaws. These Bylaws, the Fair Hearing Plan and the Rules are created to set forth principles, requirements, and procedures within which the physicians shall carry out the responsibilities delegated to the Medical Staff, subject to the ultimate authority of the Board.

A. DEFINITIONS

1. "Administrator" means the Administrator or equivalent officer of the Hospital as designated by the Board.

2. The term "Adverse Action" means a final action by the Board with respect to an individual Physician, which begins with an Adverse Recommendation and results in denying a material portion of an application (including initial, renewal, or modification) for appointment to the Medical Staff, or terminating, suspending, or materially diminishing membership on the Medical Staff or clinical privileges, as more specifically defined in the Fair Hearing Plan.

3. The term "Adverse Recommendation" means a recommendation for Adverse Action with respect to a Physician.

4. "Board of Directors" or "Board" means the governing body of Texas Spine and Joint Hospital, Ltd.

5. "Bylaws" means these Medical Staff Bylaws of the Hospital.

6. "Complete application" means an application in which all questions have been answered and for which all information requested has been provided and all documentation and verification solicited by the Hospital have been received.

7. "DEA" means the United States Drug Enforcement Agency.

8. “DPS” means the Texas Department of Public Safety.

9. “Fair Hearing Plan” means the Fair Hearing Plan of the Medical Staff, which is specifically made a part of these Bylaws.

10. “Hospital” means Texas Spine and Joint Hospital, Ltd. of Tyler, Texas.

11. “Medical Executive Committee” or “MEC” means the Executive Committee of the Medical Staff.

12. “Medical Staff” or “Staff” means the formal organization of all licensed physicians who have been granted privileges in accordance with these Bylaws.

13. “Medical Staff Development Plan” means that certain staffing plan developed by the Board periodically to address the medical staffing needs of the Hospital.

14. “Medical Staff Year” means a year which commences on the first day of January and ends on the thirty-first day of December each year.

15. "Physician” means, unless otherwise expressly limited, any physician applying for or having privileges in this Hospital.

16. “Rules” means the Rules and Regulations of the Medical Staff, which are specifically made a part of these Bylaws.

17. "Special Notice” means written notification sent by personal delivery or certified or registered mail, return receipt requested.

18. “Staff Member” or “Member” means a physician who has been granted membership on the Medical Staff.

B. OBJECTIVES

The objectives of this organization are:

1. To strive that all patients admitted and/or treated in any of the Hospital departments or services, shall receive care of the quality and level appropriate to their needs by:

    a. Granting clinical privileges appropriate to the Physician’s documented training and experience, and peer recommendations regarding demonstrated competence.

    b. Using criteria approved by the Medical Staff and meeting national standards of practice, establish and adhere to a planned and systematic process for on-going review, monitoring and evaluation of each Physician’s performance.

c. Utilizing the findings in (b) above for corrective actions as/if needed and to be considered at the time of reappointment.

2. Establish, and adhere to, Bylaws, Rules and Regulations that establish a framework for self-governance, reflect national standards of practice and accountability to the Board.
3. Provide a means for effective communication among the Medical Staff, Board and the Administrator.

4. To strive for Medical Staff representation and participation in any official deliberation of issues affecting or concerning the Medical Staff and their responsibilities.

5. To strive that all Physicians with clinical privileges participate in medical education programs offered at the Hospital and/or those appropriate to their clinical privileges or area of clinical practice offered by the various local, state or national organizations.

ARTICLE I. MEDICAL STAFF MEMBERSHIP

1.1 GENERAL

No applicant or member of the Medical Staff has a right to apply for or be granted staff privileges. Membership on the Medical Staff or the exercise of temporary privileges is a privilege and not a right. These Bylaws should not be construed in a manner as to create a contract, employment, property or liberty right, or interest in privileges or the continuation of privileges at the Hospital. Privileges may be extended only to professionally competent Physicians who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment to and membership on the Staff shall confer on the appointee or member only such clinical privileges as have been granted by the Board in accordance with these Bylaws. No Physician shall admit or provide services to patients in the Hospital unless he or she has been granted privileges in accordance with the procedures set forth in these Bylaws.

No individual shall be entitled to appointment to the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that such individual (a) is licensed to practice a profession in this or any other state, (b) is a member of any particular professional organization, (c) has had in the past, or currently has, medical staff appointment or privileges at any hospital, or (d) resides in the geographic service area of the Hospital as defined by the Board.

The Board of the Hospital specifically reserves the authority to take any direct action that is appropriate with respect to any individual appointed to the Medical Staff or given clinical privileges or the right to practice in the Hospital entity. Actions taken by the Board may, but need not, follow the procedures outlined in the Medical Staff Bylaws or Fair Hearing Plan.

An applicant or member is neither an employee nor an independent contractor of the Hospital, unless such a relationship is separately established between the Hospital and such Medical Staff Applicant or Member. In the event of any conflict between the language of these Medical Staff By1aws or Fair Hearing Plan, and a specific contract between the Hospital and a Medical Staff Member, the language of the contract shall control.

1.2 BASIC QUALIFICATIONS FOR MEMBERSHIP

1.2.1 Basic Qualifications

To be eligible for membership on the Medical Staff, Physicians must continuously meet the following prerequisites, unless otherwise provided in these Bylaws:

a. Licensure - be licensed to practice in the State of Texas (except as to exceptions set forth for telemedicine privileges), and to be currently registered at both the State of Texas and Federal levels to prescribe all medications typically used by physicians in the same field.

b. Proximity - agree to establish his/her primary medical within fifteen (15) miles of the Hospital or within a distance greater than fifteen (15) miles and less than thirty (30) miles provided that a written plan for coverage of the Physician's patients when the Physician is not available is submitted to and approved by the MEC and the Board.

c. Health Status - attest as to his/her ability to perform the essential functions of the privileges requested (with or without accommodation), including freedom from dependence on alcohol or other substances, as more specifically set forth in Section 1.5.

d. Experience - have sufficient documented experience, background, training, ability and physical and mental health status to demonstrate to the Medical Staff and the Board:

   i. that any patient treated by them will receive care of the generally recognized professional level of quality and efficacy;

   ii. their ability to practice in an economically efficient manner taking into account the patient's medical needs, the Hospital's services and resources; and

   iii. that they are qualified to provide a needed service within the Hospital;

e. Cooperation – is determined to adhere to the ethics of their respective professions, to work cooperatively with others, and to be willing to participate in the discharge of Staff responsibilities;

f. Competence - possesses sufficient character, competence, training, experience, and judgment to provide medical services at the Hospital;

g. Professional Liability Insurance – maintain not less than the minimum amount of professional liability insurance coverage as determined by resolution of the Board after consultation with the MEC. A current certificate of professional liability insurance from an insurance company recognized as acceptable by the Texas Department of Insurance must be presented. In addition, each Physician must report final judgments or settlements involving any individual professional liability action or claim.

h. Policies – compliance with Hospital policies, Bylaws, Rules and Regulations, and federal and state regulations;

i. Cooperative Interaction - maintains quality of care and harmonious Hospital operations, including cooperative interactions with Hospital personnel and staff;

j. Records – adequately maintains Hospital records; and

k. Physician Examination – have provided adequate documentation to demonstrate these qualifications (the MEC and the Board reserve the right to request that a Physician undergo a physical examination if the MEC or Board doubts a Physician's documented condition of health)

l. Ethics – agree that he/she will strictly abide by the ethics of his/her profession, as they may be amended from time to time.

1.2.2 Effect of Other Affiliations

No Physician shall be automatically entitled to membership on the Medical Staff or to the exercise of particular Clinical Privileges merely because he/she is licensed to practice in this or in any other state, or because he/she is a member of any professional organization, or because he/she is certified by any clinical board, or because he/she had, or presently has, staff membership or privileges at the Hospital or at another healthcare facility or in another practice setting.

1.2.3 Nondiscrimination

No aspect of Medical Staff membership or particular Clinical Privileges shall be denied on the basis of sex, sexual preference, race, age, creed, color, national origin, or any other basis prohibited by law.

1.3 BASIC RESPONSIBILITIES OF INDIVIDUAL STAFF MEMBERSHIP

Basic Responsibilities of Staff Members shall include:

a. Providing patient care at the level of quality and efficiency achievable by the state of the healing arts and the resources locally available and meeting the professional standards of the Medical Staff and the applicable profession.

b. Abiding by the terms, conditions and procedures of these Bylaws, the Rules, and governing policies of the Hospital.

c. Accepting and discharging in a responsible and cooperative manner committee assignments and such other reasonable duties as may be assigned by the Medical Staff, MEC and/or the Board, including, but not limited to, participation in the Emergency Department "on call" system to the extent required by the Hospital and federal and state law.

d. Accepting consultation assignments.

e. Staffing the emergency service area and other special care units in accordance with the Staff Member's clinical privileges, as may be required by the Board and/or the MEC. Nothing herein shall preclude the Board from contracting with a third person(s) for such emergency room coverage.

f. Furnishing continuous care and/or making arrangements for the continuous care of the Staff Member's patients.

g. Participating in peer review or the review of the quality of professional services provided as may be requested or required by the MEC or Board. This includes cooperating in any review of a Physician's (including one's own) credentials, qualifications or compliance with these Bylaws, and refraining from directly or indirectly interfering, obstructing or hindering any such review, whether by threat of harm or liability, by withholding information by refusing to serve or participate in assigned responsibilities or otherwise.

h. Furnishing any release and immunity from civil liability required by these Bylaws.

i. Working cooperatively and professionally with members of the Medical Staff, nurses, Hospital administration, Board, and refraining from disruptive behavior which has or could interfere with patient care or the smooth operation of the Hospital and its Medical Staff.

j. Participating in continuing education programs as required by the MEC, Board, or Medical Staff.

k. Perform a sufficient number of procedures, a sufficient number of cases, and have sufficient patient care contacts within the Hospital to permit the Medical Staff to assess the Physician's current competency for all privileges, whether being requested or already granted.

l. Work cooperatively with the MEC and administration to meet and practice within the guidelines established by the Hospital and/or the Medical Staff.

m. Provide services to medical assistance patients and other patients without personal physicians in accordance with the protocol adopted by the Staff delineating responsibilities for services to such patients.

n. As a condition to the exercise of clinical privileges at the Hospital, each Staff Member agrees, upon request of the Hospital or its Medical Staff, to provide appropriate and necessary emergency or non-emergency medical treatment within the scope of such Physician's privileges to any patient seeking such treatment, regardless of such patient's ability to pay.

o. Discharging such other Staff obligations as may be lawfully established from time to time by the MEC, Board or Medical Staff.

The foregoing qualifications shall not be deemed exclusive of other qualifications and conditions deemed by the Hospital or Medical Staff to be relevant in considering a Physician's qualifications for exercising privileges in the Hospital.

1.4 CONDITIONS AND DURATION OF APPOINTMENT

Appointments and reappointments to the Medical Staff will be made by the Board. The Board shall act on appointments, reappointments or revocation of appointments after there has been a recommendation from the MEC as provided in these Bylaws. In the event of unwarranted delay on the part of the MEC, however, the Board may act without such recommendation on the basis of documented evidence of the applicant's or Staff Member's professional and ethical qualifications obtained from reliable sources other than the MEC. Unwarranted delay as used herein is a delay inconsistent with the appointment guidelines provided in Article IV.

Reevaluation of Medical Staff qualifications can be made at any time. No Physician has a right to continued staff privileges. Appointment to the Medical Staff will confer only those privileges as set forth on the approved privilege delineation form.

Initial appointments to the Medical Staff shall be for a period of two (2) Medical Staff Years.

1.5 HEALTH STATUS

In order to promote the quality and safety of patient care in the Hospital, whenever the physical and/or mental health status of a Staff Member is called into question, the MEC may at any time require such Staff Member to submit to a mental or physical examination by a physician approved by the MEC. The results of such examination shall be reported to the chairman of the MEC and shall at a minimum address:

- whether the Staff Member has the ability to continue to provide patient care in the Hospital at a general professionally recognized level of quality and efficiency;

- whether such ability is compromised by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of any mental or Physical condition; and

- whether there should be any restriction, limitation or consultation requirement placed upon the Staff Member's Medical Staff membership or clinical privileges as a result of any such illness, use or condition.

Every person who shall apply for or accept the privilege of Medical Staff membership at the Hospital shall be deemed to have given his or her consent to submit to such mental or physical examination, and if such person fails at any time to submit to such an examination when properly directed to do so, his/her Medical Staff membership and privileges may be suspended by the MEC. Such Staff Member shall thereupon have access to the hearing and appellate review procedures set forth in the Fair Hearing Plan.

1.6 TERMINATION OF CONTRACT

The Staff appointment and clinical privileges of any Medical Staff member who has a contractual relationship with the Hospital, or is either an agent, employee, or principal of, or partner in, an entity that has a contractual relationship with the Hospital, relating to providing services to patients at the Hospital, shall terminate automatically and immediately upon (i) the expiration or other termination of the contractual relationship with the Hospital, or (ii) the expiration or other termination of the relationship of the Staff member with the entity that has a contractual relationship with the Hospital. In the event of such a termination of Medical Staff appointment and/or clinical privileges, no rights to a hearing or appellate review provided in the Fair Hearing Plan shall apply.

1.7 CONTINUING NOTIFICATION

Each Staff Member must promptly notify the Chairperson of the Medical Staff of

i. the revocation or suspension of his/her professional license, or the imposition of terms of probation or limitation of practice by any state licensing agency;

ii. his/her loss of staff membership or loss, curtailment or restriction of privileges at any hospital or healthcare institution;

iii. the cancellation or restriction of his/her professional liability coverage or DEA number;

iv. an adverse determination by a peer review organization or a third party payor reimbursement program concerning his/her quality of care;

v. the commencement of formal investigation or the filing of charges by the Department of Health and Human Services or any law enforcement agency or health regulatory agency of the United States or the State of Texas, or any other state;

vi. or the filing of a claim or action against the Staff Member alleging professional liability.

ARTICLE II. CATEGORIES OF THE MEDICAL STAFF

2.1 CATEGORIES

The Staff shall include an Active, Courtesy, Consulting Contract, Honorary, and Telemedicine category.

2.2 ACTIVE STAFF

2.2.1 Qualification

The Active Staff shall consist of Physicians, each of whom:

a. meets the basic qualifications set forth in Section 1.2.1 of these Bylaws.

b. No Volume/Low Volume Practitioners: If a Physician has not had any cases at the Hospital, the Physician will be required to submit an OPPE report or proof of clinical competency from the Physician's primary facility within the time frame determined, in order to maintain the Physician's existing privileges. Failure to submit the requested documentation will result in automatic status

change of the Physician's current active staff to another category. Two peer references from the same field and/or specialty that are not partners in the Physician's group and have firsthand current knowledge of the Physician's ability to perform the requested privileges will also be required.

2.2.2 Prerogatives

The prerogatives of an Active Staff Member shall be to:

a. admit patients to the Hospital without limitation; unless otherwise provided in the Medical Staff Rules and Regulations.

b. exercise such Clinical Privileges as are granted to him/her pursuant to Article V.

c. vote on all matters presented at a general and special meeting of the Medical Staff, and of the committees of which he/she is a member, unless otherwise provided by resolution of the Staff.

d. hold office in the Staff organization and committees of which he/she is a member, unless otherwise provided by resolution of the Staff.

2.2.3 Responsibilities

Each member of the Active Staff shall:

a. meet the basic responsibilities set forth in Section 1.3 of the Bylaws.

b. retain responsibility within his/her area of professional competence for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services or arrange a suitable alternative for such care and supervision by other members of the Staff.

c. actively participate in the patient care performance (quality) improvement program and other quality and utilization review, evaluation and monitoring activities required by the Hospital, in supervising initial appointees of his/her same profession, in the emergency services program, in at least one regular Staff committee, and in discharging such other Staff functions as may be required from time to time.

d. satisfy the requirements set forth in Article X for meeting attendance.

e. participate in continuing education programs as required and recommended by the Joint Commission on Accreditation of Healthcare Organizations and other applicable professional laws or guidelines.

f. have obligations for emergency room coverage as determined by the Medical Staff according to the limitations of Member's clinical competence and privileges; specialists in limited practice shall be available on an established schedule for consultation and special service in response to the needs of the emergency room patients.

2.3 COURTESY STAFF

2.3.1 Qualifications

The Courtesy Staff shall consist of physicians, each of whom:

a. meets the basic qualifications set forth in Section 1.2.1, with the exception of mileage restriction.

b. is a member of the active or associate staff of another hospital where he/she actively participates in a patient care performance (quality) improvement and other quality and utilization review, evaluation and monitoring activities similar to those required of the Active Staff of this Hospital.

2.3.2 Prerogatives

The prerogatives of a Courtesy Staff member shall be to:

a. admit patients to the Hospital within the limitations provided as follows:

i. May not admit a patient without co-admitting by member of the Active or Provisional Staff.

ii. Must have as co-surgeon or assistant surgeon a member of the Active Staff for major surgeries.

iii. May be subject to 100% chart review and/or assigned a member of the Active Staff as proctor or monitor.

b. exercise such Clinical Privileges as are granted to him/her pursuant to Article V.

c. attend meetings of the Staff, serve on committees of the Staff, and participate in any Staff or Hospital education programs.

d. consult with other members of the Staff who request consultation on matters related to the provisions of quality patient care. Members of the Courtesy Staff shall not be eligible to vote or to hold Medical Staff Office.

e. admit only twelve (12) patients per year. When more than this number are admitted, the Courtesy Medical Staff member will be required to seek Active Staff Membership.

2.3.3 Responsibilities

Each member of the Courtesy Staff shall be required to discharge his/her basic responsibilities specified in Section 1.3 and, further, shall retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision by other Medical Staff Members.

2.4 CONSULTING STAFF

The Consulting Medical Staff shall consist of those Physicians named and approved by the MEC and certified by the Board for approval who serve primarily in the role of specialist or consultant. Members of the Consulting Medical Staff must be a member of the Active Medical Staff at another hospital acceptable to the Board, where they participate regularly in quality assessment activities and their performance is evaluated. Consulting Medical Staff members shall not be eligible to admit patients, to vote, hold office or to serve on standing Medical Staff committees. They may attend Medical Staff and Department meetings.

2.5 CONTRACT STAFF

To the extent the Hospital may have specific Contract Service Physicians, they must meet the general qualifications required for Medical Staff membership. Temporary appointment to the Contract Staff may be made by the concurrent approval of both the Administrator and the Chairperson of the Medical Staff, this temporary appointment to be valid only until action by the Medical Staff is completed and in no instance to exceed six months. Contract Staff privileges may be terminated, effective instantly, at any time by the concurrent written notice of the Administrator and the Chairperson of the Medical Staff, subject to review and reinstatement by the Medical Staff. Where a Contract Physician's activities in the Hospital are the result of a contract with the Hospital or with a group with whom the Hospital contracts, the Physician shall ipso facto lose all Medical Staff membership and privileges whatsoever upon the termination of the contractual relationship either between the Physician's employer and Physician or the Hospital and Physician's employer.

2.6 TELEMEDICINE STAFF

Physicians who diagnose or treat patients via telemedicine link are subject to the credentialing and privileging processes of the Hospital related to Consulting Staff privileges and as more specifically set forth in Section 5.8. Any Physician who prescribes, renders a diagnosis or otherwise provides clinical treatment to a Hospital patient through any electronic or telemedicine technology shall be required to obtain privileges in this category. The Medical Staff shall

recommend the types of clinical services to be provided by Telemedicine Physicians. Telemedicine Physicians shall not have any admission privileges, nor shall they be entitled to vote or hold office on the Medical Staff. To the extent a Physician is licensed outside the State of Texas, such Physician will satisfy the Texas Board of Medical Examiners requirements for a Special Purpose License for practice of medicine across state lines.

2.7 HONORARY STAFF

2.7.1 Qualifications

The Honorary Staff shall consist of Physicians who are not currently active in the Hospital and who are recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences, or their previous long-standing service to the Hospital

2.7.2 Prerogatives

Honorary Staff members are not eligible to admit patients to the Hospital or to exercise Clinical Privileges in the Hospital. They may, however, attend Staff meetings and any Staff or Hospital education meetings. Honorary Staff members shall not be eligible to vote or to hold office in this Medical Staff organization.

2.7.3 Responsibilities

Honorary Staff Members are not required to assume responsibilities of the Hospital.

2.8 OPTIONAL ADDITION OF CATEGORIES OF STAFF

Intentionally Left Blank.

2.9 LIMITATION OF PREROGATIVES

The Prerogatives set forth under each Staff category are general in nature and may be subject to limitation by special conditions attached to a Physician's Staff membership by other Sections of these Bylaws, the Rules and Regulations of the Medical Staff, and other Rules and policies of the Staff, the Department or the Hospital.

2.10 WAIVER OF QUALIFICATIONS

Any qualification may be waived at the discretion of the Board upon determination that such waiver will serve the best interests of the patients and the Hospital.

ARTICLE III. ALLIED HEALTH PROFESSIONALS

3.1 QUALIFICATIONS

Allied Health Professionals (which shall mean without limitation podiatrists, dentists, certified registered nurse anesthetists, psychologists, nurse practitioners, and physician assistants) (collectively "AHP(s)") holding a license, certificate or other legal credentials required by Texas Law, are not eligible for membership on the Staff because they are not licensed Physicians, but those who meet the following qualifications, shall be eligible to provide specified services in the Hospital:

a. have documented their experience, background, training, demonstrated ability, physical health status and upon request of the MEC or of the Board, 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 and that they are qualified to provide a needed service within the Hospital; and

b. are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions as applicable and to work cooperatively with others

c. When appropriate, the MEC may establish particular qualifications required of members of a specific category of AHP's provided that such qualifications are not founded on an arbitrary or discriminatory basis and are in conformance with applicable laws.

The Chairperson of the Medical Staff or his/her designee shall oversee an AHP's activities and ensure compliance with pertinent aspects of these Bylaws, the Rules, and policies and procedures.

AHP's who are employees of Physicians shall be the direct responsibility of each employing Physician in accordance with the applicable provisions of these Bylaws and Rules.

AHP's who are employees of the Hospital shall be subject to Hospital personnel policies and procedures. Termination of employment shall automatically terminate Allied Health Professional status at the Hospital. Specified personnel may be assigned to individual Staff Members, and shall carry out their activities subject to the applicable policies and procedures and in conformity with the applicable provisions of these Bylaws and Rules.

3.2 PROCEDURE FOR SPECIFIED SERVICES

An application for specified services for an AHP shall be submitted and processed in the same manner as provided in Article V for Clinical Privileges, provided that the Board may delegate to the Administrator the authority to take action for it on any such applications from specific

categories of AHP's. An AHP who applies for specific privileges must document his/her experience, background, training, demonstrated ability, current competence and health status and provide references as requested. AHP's must be reappraised and reappointed biannually. By filing an application to provide specified services in the Hospital as an AHP, an applicant specifically consents to be bound by these Bylaws, the Medical Staff Rules and Regulations, and all other rules and policies of the Staff, or the Hospital. Such limitations are subject to waiver by the Board in individual cases. An AHP shall be individually assigned to the clinical area appropriate to his/her professional training and shall be subject in general to the same terms and conditions as specified in Section 1.4 for Medical Staff Appointments' provided, however, that AHP's are not and shall not be considered members of the Medical Staff and that corrective action with regard to AHP's, including termination or suspension of services authorized, shall he accomplished in accordance with usual Hospital personnel practices or the individual's employment, if any. The hearing and appellate procedures specified in Article VII for members of the Medical Staff and as more fully set forth in the Fair Hearing Plan shall not apply to AHP's for any actions taken by the MEC or the Board.

3.3 PREROGATIVES

The prerogatives of an AHP shall be to:

a. provide specified patient care services under the supervision or direction of a Physician member of the Medical Staff (except as otherwise expressly provided by resolution of the MEC approved by the Board).

b. write orders only to the extent established by the Medical Staff, but not beyond the scope of the AHP's license, certificate or other legal credentials.

c. serve on Staff and Hospital committees, but not serve as Chairperson of a standing committee of the Medical Staff.

d. attend meetings of the Medical Staff, and Hospital education programs.

e. exercise such other Prerogatives as shall, by resolution or written policy duly adopted by the Staff or by any of its committees and approved by the MEC and by the Board, be accorded to AHP's as a group or to any specific category of AHP's, such as the right to vote on specified matters, to hold defined offices, or any other Prerogatives for which medical education, training and experience, beyond that which an AHP can demonstrate, is not a prerequisite.

3.4 RESPONSIBILITIES

Each AHP shall:

a. meet the same basic responsibilities as required by Section 1.3 of these Bylaws for Medical Staff members.

b. retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision.

c. participate as appropriate in the patient care evaluation and other quality review, evaluation and monitoring activities required of the Staff, in supervising initial appointees of his/her same profession during the observation period, and in discharging such other Staff functions as may be required from time to time.

d. satisfy the requirements set forth in Article X for attendance at meetings of the department and committees of which he/she is a member.

e. satisfy requirement of a minimum of $200,000/$600,000 for professional liability insurance.

3.5 DENTAL SERVICES

The scope and extent of surgical procedures that each dentist may perform in the Hospital shall be specifically delineated and granted in the same manner as all other surgical privileges.
Surgical privileges performed by dentists shall be under the overall supervision of the Chairperson of the Medical Staff or his/her designee. Dentist members of the Medical Staff shall be responsible for the part of their patients' history and physical examinations that relate to dentistry, and a physician shall perform a baseline history and physical exam to the extent that he/she deems appropriate; provided that qualified oral and maxillofacial surgeons may perform the medical history and physical if they have such privileges. Admission of a dental patient is the dual responsibility of the dentist and a physician member of the Medical Staff. A physician member of the Medical Staff shall be responsible for the general medical care of the patient, including any medical problem that may be present at the time of admission or that may arise during hospitalization.

3.6 PODIATRIC SERVICES

The scope and extent of surgical procedures that each podiatrist may perform in the Hospital shall be specifically delineated and granted in the same manner as all other surgical privileges.
Surgical procedures performed by podiatrists shall be under the overall supervision of the Chairperson of the Medical Staff or his/her designee. Podiatrist members of the Medical Staff shall be responsible for the part of their patients' history and physical examinations that relate to podiatry and a physician shall perform a baseline history and physical to the extent that he/she deems appropriate. Admission of a podiatric patient is the dual responsibility of the podiatrist and a physician member of the Medical Staff. A physician member of the Medical
Staff shall be responsible for the general medical care of the patient, including any medical problem that may be present at the time of admission or that may arise during hospitalization. A

podiatrist may write orders and prescribe medications only within the limits of his/her license to practice podiatry.

ARTICLE IV. PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

4.1 AVOIDING UNNECESSARY PROCESSING OF APPLICATIONS

4.1.1. Grounds for Not Providing Application Form. No application for appointment shall be provided to a Physician, nor shall an application be accepted from a proposed applicant, if the Hospital President/CEO or Board of Directors determines based on information from a pre-application questionnaire or any other source that:

a. the Hospital does not have the ability to provide adequate facilities or services for the applicant or the patients to be treated by the prospective applicant;

b. The prospective applicant has interests or activities that are inconsistent with the needs, mission, operations and plans of the Hospital and the communities it serves, including any medical staff development plan;

c. the Hospital has contracted with an individual or group to provide the clinical services sought by the prospective applicant on an exclusive basis, and the prospective applicant will not be associated with the individual or group contracted with;

d. The prospective applicant has been excluded from participation in Medicare or Medicaid;

e. The prospective applicant does not meet the requirements relating to licensure and registration, professional liability insurance, board certification, or reapplication after adverse decision or resignation while under investigation or to avoid an investigation;

f. The prospective applicant is not a type of Allied Health Care Professional approved by the Board of Directors to provide patient care services in the Hospital;

g. The prospective applicant does not have a valid unrestricted Texas license, or is subject to any form of counseling, monitoring, supervision, educational requirement or any other ongoing review, condition, requirement or restriction of any kind;

h. The prospective applicant has been convicted of a felony or convicted of a misdemeanor related to the prospective applicant's fitness to practice medicine, dentistry or podiatry;

i. The prospective applicant has provided materially false or misleading information on any pre-application questionnaire or in connection with any pre-application review process.

No application for reappointment shall be provided to a practitioner who is currently a member of the medical staff or holds clinical privileges if the practitioner has not provided requested information or documents or not responded to requests for comments concerning peer review or quality improvement matters or the practitioner's qualification for medical staff membership and privileges, provided the staff member has been notified in writing of the requested information and has had a reasonable opportunity to respond [has not responded within thirty (30) calendar days].

The applicant or prospective applicant shall be advised of the information relied on as grounds for not providing an application and the applicant or prospective applicant shall have a reasonable opportunity to submit information or evidence that the information relied on is not accurate.

No individual shall be entitled to a hearing or any other procedural rights as a result of a refusal by the Hospital to provide the individual an application form for initial appointment or reappointment.

4.1.2. Restriction on Reapplication. An applicant who has received a final adverse decision concerning appointment, re-appointment, or clinical privileges, or who has resigned or failed to apply for reappointment while under investigation, in order to avoid investigation, or following an adverse recommendation by the Credentials Committee or Medical Executive Committee, shall not be eligible to reapply for appointment to the medical staff for a period of five (5) years unless the Board of Directors expressly provides otherwise. Upon any reapplication, the applicant shall submit, in addition to all of the other information required, specific information showing that the condition or basis for the earlier adverse decision, recommendation or resignation no longer exists.

4.1.3. Incomplete Applications. No application for appointment or reappointment shall be accepted for processing until all information and documents required have been provided. The applicant shall be notified of any missing information or verifications and it shall be the responsibility of the applicant to have any missing information sent to the Medical Staff Office. If the applicant fails to provide or cause to be provided any information or verification within thirty (30) calendar days after being requested to do so, the application shall be automatically deemed to be withdrawn and the application, along with all fees, returned to the applicant, unless the time to obtain the information is extended by the Chief of Staff and the Hospital CEO or designee.

No application shall be considered to be complete until it has been reviewed by the appropriate department chair, Credentials Committee and Medical Executive Committee, and all have determined that no further documentation or information is required to permit consideration of the application. Additional information or documentation may be requested by any department chair, by the Credentials Committee or by the Medical Executive Committee. If the applicant fails to submit the requested information or documentation within thirty (30) calendar days after being requested to do so, the application shall be deemed to be incomplete and automatically

withdrawn, unless the time to obtain the information is extended by the person or committee requesting the information.

4.2 APPLICATION FORM

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 that the Board has approved after consultation with the MEC. The applicant must indicate on the form his/her desired Medical Staff category and clinical privileges. The application shall require detailed information concerning the applicant's professional qualifications and shall include the names of at least three (3) persons who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's professional competence and ethical character. An applicant shall complete this form, without limitation, with information on the following:

i. All previous medical education and training;

ii. Previous and current medical staff memberships at other hospitals or health care entities and any denials, suspensions, non-renewals, or voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital or entity;

iii. Proof of current licensure to practice medicine, dentistry or podiatry, as appropriate, in Texas;

iv. Proof of controlled substance certification to prescribe such substances in the United States and Texas;

v. Any previously successful or currently pending challenges to any of the applicant's licensure, certification, or registration (e.g., state or district, DEA, or DPS) or voluntarily relinquishment of such licensure, certification, or registration;

vi. Past and current malpractice history, including final judgments and settlements, evidence of adequate malpractice insurance, and a consent to the release of information from his past and current malpractice insurance carrier(s);

vii. Present membership in any professional societies and any previous clinical or disciplinary actions by such a society;

viii. Investigations commenced, charges filed, or final actions taken against the applicant by the Department of Health and Human Services, a peer review organization, or any law enforcement agency or health regulatory agency of the United States or any state; and

ix. Certification by the applicant, or by a physician, if so requested by the MEC, that his/her physical and mental health status (including, but not limited to, drug or alcohol abuse) does not impair his/her ability to exercise the clinical privileges requested and to fulfill the essential functions of Medical Staff membership with or without accommodation.

x. Such other information as the Board may require.

4.3 ACKNOWLEDGEMENTS

The application form shall include a statement that the applicant has received and read the most current Bylaws and Rules and that he/she agrees to be bound by the terms thereof (including but not limited to provisions regarding release and immunity from civil liability). Every application shall also contain the applicant's specific acknowledgment of his/her obligations:

i. to provide Continuous care and supervision of his/her patients,

ii. to provide as it occurs, with or without request, new or updated information that is pertinent to any question on the application form,

iii. to consent to the inspection of records and documents pertinent to his/her licensure, specific training, experience, current competence, and ability to perform the privileges requested, and, if requested, to appear for an interview,

iv. to accept Medical Staff committee assignments,

v. to participate in staffing the emergency service area, and

vi. to accept consultation assignments.

By applying for appointment or reappointment to the Medical Staff and/or clinical privileges and as long as the Practitioner is a member of the Medical Staff or has clinical privileges, each applicant Practitioner automatically:

a. Authorizes Hospital representatives to solicit and act upon information, including otherwise privileged or confidential information, provided by third parties bearing on his or her credentials and agrees that any information so provided shall not be required to be disclosed to him or her if the third party providing such information does so on the condition that it be kept confidential.

b. Authorizes third parties to release information, including otherwise privileged or confidential information, as well as reports, records, statements, recommendations and other documents in their possession, bearing on his or

her credentials to any Hospital representative, and consents to the inspection and procurement by any Hospital representative of such information, records and other documents.

c. Authorizes the Hospital and Hospital representatives to release such information, when requested by the applicant, to other hospitals, health care facilities and their agents, who solicit such information for the purpose of evaluating the individual's professional qualifications pursuant to the individual's request for appointment, reappointment or clinical privileges;

d. Agrees to appear for a personal interview at any reasonable time requested by any Hospital representative.

e. Authorizes and consents to the Hospital, its officers, agents employees Medical Staff members and its representatives providing other hospitals, medical associations, licensing boards, the National Practitioner Data Bank and other health care organizations concerned with provider performance, conduct, and the quality, appropriateness, and efficiency of patient care, with any information or opinions related to such matters which the Hospital or any of its officers, agents, employees Medical Staff members or representatives may have concerning the practitioner, and absolutely and unconditionally releases the Hospital and its officers, agents employees, Medical Staff members and representatives from any and all liability for providing such information.

f. Absolutely and unconditionally consents to the reporting by any Hospital representative of information to the National Data Bank established pursuant to the Health Care Quality Improvement Act of 1986, which such Hospital representative believes in good faith is required by law to be reported;

Releases from any and all liability (1) the Hospital and all Hospital Representatives, employees, or agents for their acts performed in connection with providing, obtaining, reviewing or evaluating his or her credentials or releasing information to their institutions for the purpose of evaluating his or her credentials or making recommendations or decision concerning the applicant and the applicant's credentials, in compliance with the Bylaws; and (2) all third parties who provide information, including otherwise privileged or confidential information, to the Hospital and Hospital representatives concerning his or her credentials, unless such information is false and the third party providing it knew it was false. The term "Hospital Representatives" includes the members of the Board of Directors, all officers, employees, and agents of the Hospital, and all members and officers of the Medical Staff, its departments and committees, and any outside reviewers, who have responsibility for collecting, providing or evaluating information concerning

the applicant's credentials or making recommendations or acting on any application for Medical Staff membership or clinical privileges.

g. Agrees that, if any Adverse Action or Adverse Recommendation is made with respect to him or her, (1) he or she will follow and exhaust the administrative remedies afforded by the Medical Staff Bylaws and the Fair Hearing Plan as a prerequisite to any other action, and (2) he or she will have the burden of demonstrating that he or she meets the standards for appointment or continued appointment to the Medical Staff or for the clinical privileges requested.

h. Agrees that the foregoing provisions are in addition to any agreements, understandings, covenants, waivers, authorizations or releases provided by law or contained in any application or request forms.

i. Agrees to have his or her performance evaluated at initial appointment, reappointment or when requesting additional privileges. At initial appointment and when requesting additional privileges the practitioner will have a focused Professional Practice Evaluation (FPPE) the duration to be determined by the medical staff. Following the initial appointment, the medical staff office will collect data to be analyzed by the medical staff at six months intervals. This process shall be referred to as Ongoing Professional Practice Evaluation (OPPE).

j. Agrees to notify the Chief of Staff and the Hospital CEO immediately in writing upon learning that the applicant or practitioner:

i. is the subject of a complaint or investigation by, or has been charged with misconduct by, any licensing or disciplinary authority of any state or federal agency or professional organization;

ii. has been charged with a misdemeanor, excluding traffic offenses, or a felony;

iii. has been notified that their professional liability insurance carrier intends to cancel, not renew, restrict or impose any conditions or deductibles on their professional liability insurance for any reason related to the practitioner's clinical practices or claims history;

iv. has been notified of the loss of their DEA number or exclusion from the Medicaid or Medicare program, is under investigation by Medicaid or Medicare, or has been subjected to any fine, penalty or sanction by Medicare or Medicaid;

v. is or has been the subject of any actual or proposed disciplinary action, including any modification of clinical privileges, restriction of clinical

privileges, or placing of conditions on clinical privileges (including any form of monitoring or review), by any other hospital or health care facility or organization;

vi. is or has been the subject of any actual or proposed disciplinary action by any regulator, licensing or disciplinary authority or professional organization, including any form of reprimand or sanction;
vii. has voluntarily relinquished, agreed not to exercise, or involuntarily lost any licensure, certification, registration, medical staff membership or clinical privileges at any healthcare facility;

viii. has entered into a contract or agreement with any impaired physicians committee or similar entity as a result of any substance abuse or other disease or disorder; or

ix. has developed any mental or physical illness or sustained any injury which could have an effect on the exercise of the individual's clinical privileges.

k. Agrees to provide any information or documentation, including appropriate medical records, which may be requested to answer any questions or resolve any issues concerning the practitioner's clinical competence or conduct, or to provide information concerning any matters or actions set forth in section j above.

l. Agrees that the failure of an applicant or practitioner to provide the notification as required by section j above shall be grounds for summary suspension or other action related to the practitioner's medical staff membership and/or privileges.

m. Agrees to maintain professional liability insurance providing coverage for the entire time the member has privileges at the Hospital with an insurer approved by the Hospital Board of Directors in no less than the minimum amount and in such form as may be required from time to time by the Board of Directors, or provide such other evidence of financial responsibility as the Board of Directors may approve.

n. Acknowledges that any material misstatement or omission on any application, or made at any time during the appointment or reappointment process, or after medical staff membership and/or clinical privileges have been granted, shall be grounds for immediate denial of the application for appointment or reappointment, or summary suspension and termination of Medical Staff membership and clinical privileges if the misstatement or omission is discovered after the practitioner is appointed or reappointed.

o. Acknowledges that the failure to provide complete and accurate information in connection with any investigation concerning the practitioner's Medical Staff membership, or clinical privileges, shall be grounds for immediate suspension and termination of Medical Staff membership and clinical privileges.

p. Agrees to immediately notify the Medical Staff Office in writing of any change in the practitioner's home or office addresses or telephone numbers so that the Medical Staff Office has current addresses and telephone numbers at all times. The practitioner further agrees that any notice delivered to the home or office address of the practitioner which is on file in the Medical Staff Office shall be conclusively deemed to have been received by the practitioner. Any notice sent by regular mail shall be conclusively deemed to have been received on the second business day after the date the notice was mailed.

q. Agrees to submit any reasonable evidence of current health status which may be reasonably requested by the chair of any department, the Chair of the Medical Staff, the Credentials Committee or its Chair, or the Medical Staff Executive Committee, and to submit to such mental or physical examination, including providing blood, urine, or other samples, as the Section Chair, Department Chair, Chair of the Medical Staff, Chair of the Credentials Committee, Senior Vice President for Medical Affairs or Medical Staff Executive Committee might require at any time and for any reason, including random, unannounced drug screens without cause.

r. Acknowledges that a practitioner who fails or refuses to provide any requested evidence of current health status, including providing blood, urine or other samples for testing for drug or alcohol use, shall be deemed to be no longer qualified for medical staff membership and clinical privilege, in which event the medical staff membership and clinical privileges shall be automatically terminated for administrative reasons and the practitioner shall not be entitled to a hearing.

s. Agrees that if at any time, an adverse ruling is made or action taken with respect to the practitioner's membership, staff status, and/or clinical privileges, the applicant shall be required to exhaust all remedies afforded by these Bylaws and the Fair Hearing and Appellate Review Plan, before resorting to formal legal action

4.4 INITIAL APPOINTMENT PROCESS

4.4.1 Administrative Review

The applicant shall submit the application to the Administrator or his/her designee. If the Hospital has contracted with a delegated or centralized credentialing verification service or otherwise delegated the credentials-gathering function, then the Hospital may direct the

submission of the application to that service or entity. The Administrator (or his/her designee) or the delegated credentialing service or entity shall review the application to determine that all questions have been answered, file a query with the National Practitioner Data Bank, collect necessary references, and verify all pertinent information or materials (such as licensure, specific training, experience, and current competence) from primary sources whenever required. The Hospital may also seek information about the applicant from other sources, such as the American

Medical Association Physician Masterfile and the Federation of State Medical Boards Physician Disciplinary Data Bank.

There shall be no obligation to process an application that is incomplete. An application that is in any manner deficient may be returned to the applicant. The applicant shall have the burden of producing all necessary information, including references, for a proper evaluation of his/her credentials within sixty (60) days of the date the application was submitted. If the Administrator determines that the application is not complete, he/she shall so notify the applicant and the application shall not be processed further until all apparent deficiencies have been corrected and the application has been resubmitted. The applicant's failure to furnish the information initially or subsequently requested in connection with an application shall constitute a waiver of the applicant's right, if any, to further processing and shall not give rise to any right of review.

4.4.2 MEC Review

The Administrator shall transmit a complete application and all supporting materials to the Credentials Committee for evaluation. The Credentials Committee will review the clinical privileges requested and determine whether the requested privileges fall within the scope of training of the applicant. Furthermore, the Credentials Committee will determine if the privileges requested are within the restraints of the hospital's capacity. After approval of the Credentials Committee, the approved applications will be forwarded to the MEC for approval. MEC shall examine evidence of the character, professional competence, qualifications, and ethical standing of the Physician and shall determine through information provided by the Physician's references and from other sources available to the MEC whether the Physician meets all of the necessary qualifications for staff membership and the clinical privileges requested. Within ninety (90) days after an application is complete, the MEC shall forward its written report and recommendation to the Administrator for transmittal to the Board. All recommendations for appointment must specifically recommend the clinical privileges to be granted, with or without qualification.

i. Limited Membership Departments. If a Physician has applied for participation in a department, subspecialty, or staff category for which limited or no openings are currently available, as openings subsequently arise in such department, subspecialty or staff category, the MEC shall make recommendations to the Board for filling such positions by selecting from the available list of deferred Physicians whose applications are current those Physicians found to be best qualified for staff appointment, regardless of the date of application. If a Physician is not selected for staff appointment within

the six-month period following the date of his or her application, the application will be considered to have been withdrawn unless it is adequately and properly renewed in writing.

ii. Denial for Hospital's Inability to Accommodate. Upon a recommendation by the MEC or a decision by the Board to deny Staff membership, or Staff category assignment, or particular Clinical Privileges based upon either:

- the Hospital's present inability to provide adequate facilities or supportive services for the applicant and his/her patients, or
- inconsistency with the Hospital's Medical Staff Development Plan, including the mix of patient care services to be provided, as currently being implemented, or
- an insufficient patient population (current or expected) to support an additional Physician with skills and education of applicant:

Upon written request by the applicant to the Administrator, the application shall be kept in a pending status for the next succeeding six (6) months. If during this period, the Hospital finds it possible to accept Staff applications for which the applicant is eligible the Administrator shall promptly so notify him/her. Within thirty (30) days of receipt of such notice, the applicant shall provide, in writing on the prescribed form, such supplemental information as is required to update all elements of his/her original application. Thereafter, the procedure provided in Article IV for initial appointments shall apply,

iii. Adverse Recommendation. In the event of an Adverse Recommendation by the MEC, the provisions of the Fair Hearing Plan shall apply.

4.4.3 Board Action Review

Within ninety (90) days after a favorable recommendation of the MEC, the Board shall act on the matter. If the Board's decision is also favorable, the applicant will be appointed to the Medical Staff with clinical privileges specifically delineated. If the Board's decision is adverse to the Physician, the provisions of the Fair Hearing Plan shall apply.

4.4.4 Notice of Final Decision

When the Board's decision is final, the Administrator shall, within twenty (20) days, send written notice thereof to the Physician.

4.4.5 Time Requirements

The time requirements referenced in this section shall be measured from the time a complete application was submitted. Such time requirements, however, shall be suspended pending waiver or completion of the hearing and/or appellate review procedures.

4.5 APPLICATION FOR REAPPOINTMENT

The reappointment application form shall request data necessary to update the Hospital and Medical Staff files on the staff member's qualifications. A staff member shall complete this form, without limitation, with information about the following:

i. Request for specific clinical privileges;
ii. Justification for new or expanded privileges;
iii. Continuing medical education, training, and experience since the previous appointment that demonstrates current competence and qualifies the staff member for the privileges sought on reappointment;
iv. The name and address of any other health care organization or practice setting where the staff member has provided clinical services during the preceding period;
v. Membership, awards, or other recognition conferred or granted by professional health care societies, institutions, or organizations during the preceding period;
vi. Update of information set forth in Section 4.2 as required in the reappointment application form; and
vii. Such other specifics about the staff member's professional ethics, qualifications, and ability that may bear on his/her ability to provide quality patient care in the Hospital.

Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon such member's professional ability and clinical judgment in the treatment of patients, his/her professional ethics, discharge of Medical Staff obligations, compliance with these Bylaws and the Rules, cooperation with other Physicians, Hospital employees, and patients, documented continuing medical education, and other matters bearing on his/her ability and willingness to contribute to quality patient care in the Hospital, including findings from the Hospital's Performance Improvement Program.

4.6 REAPPOINTMENT PROCESS

4.6.1 Delivery of Form

The Administrator or his/her designee shall, at least ninety (90) days prior to expiration of the present staff appointment of each Medical Staff member, provide such staff member with an application for reappointment. At least sixty (60) days prior to the final scheduled meeting of the

Board in the current Medical Staff Year, each Medical Staff member who desires reappointment shall send his/her reappointment application form to the Administrator or his/her designee.

Failure, without good cause as determined by the MEC, to so return the form shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership and clinical privileges at the expiration of the member's current term, without a right to a hearing under the Fair Hearing Plan. A Physician whose membership is so terminated may reapply to the Medical Staff and his/her application shall be processed as an application for initial appointment.

4.6.2 Administrative Review

The Administrator or his/her designee, or a delegated credentialing verification service or other delegated credentials-gathering entity, shall seek to collect additional information or verify the information on each reappointment application form and collect any other materials or information deemed pertinent, including findings from the Hospital's Performance Improvement Program and information regarding the Medical Staff member's professional activities, performance, and conduct in the Hospital. The Administrator or his/her designee shall also obtain any necessary information from the National Practitioner Data Bank.

There shall be no obligation to process an application that is incomplete. An application that is in any manner deficient may be returned to the applicant. The applicant shall have the burden of producing all necessary information for a proper evaluation of his/her credentials within thirty (30) days of the date the application was submitted.

4.6.3 Review by Credentials Committee

The Administrator shall transmit the completed application for reappointment and supporting materials to the Credentials Committee. The Credentials Committee shall review each reappointment form and all other relevant available information and shall forward its report and recommendation to the Administrator for transmittal to the Board.

4.6.4 Board Action Review

As soon as practicable after a favorable recommendation of the MEC, the Board shall act on the matter. If the Board's decision is also favorable, the applicant will be reappointed to the Medical Staff with clinical privileges specifically delineated.

4.6.5 Compliance with Procedures for Appointment

Where applicable and not in conflict, the procedures provided in Section 4.4 relating to the initial appointment process shall be followed in this section. For purposes of reappointment, the terms "applicant" and "appointment" as used in that section shall be read, respectively, as "Medical Staff member" and "reappointment."

4.7 MISCELLANEOUS

4.7.1 Withdrawal

An applicant may, with the written approval of the Administrator, withdraw his/her application for appointment or reappointment at any time prior to the effective date of a final decision without prejudice to subsequent reapplication; provided, however, the Hospital shall make any reports regarding the withdrawal of an application that are required by law.

4.7.2 Eligibility for Reapplication after Adverse Action

A Physician may not apply to the Medical Staff of the Hospital for five (5) years if he/she has been denied membership at the Hospital due to his/her professional competence or conduct. Further, such a Physician shall accompany any application submitted after five (5) years with clear and convincing written evidence that the basis for the previous Adverse Action no longer exists.

4.7.3 Denial for Hospital's Inability to Accommodate Applicant

A decision by the Board to deny Medical Staff membership or clinical privileges because of an exclusive contractual arrangement or the Hospital's present inability to provide adequate facilities or support services shall not constitute an Adverse Action and shall not entitle the applicant to a hearing and appellate review in accordance with the Fair Hearing Plan.

4.7.4 Custody of Application

A written record of all matters considered in each Physician's initial appointment and reappointment appraisal(s) shall be maintained separately as part of the confidential peer review files of the Medical Staff. All Medical Staff applications and credentials shall remain in the custody of the Administrator or his/her designee.

4.8 IMMUNITY FROM LIABILITY

4.8.1 Persons Protected

By applying for and/or accepting appointment to the Medical Staff and by applying for, accepting and/or exercising clinical privileges within the Hospital, each applicant and Medical Staff Member extends absolute immunity to, and releases from all claims, damages and liability whatsoever:

a. The Hospital and any Hospital representative, employee or agent, for any Adverse Action taken or statement or Adverse Recommendation made by any Hospital representative within the scope of his or her duties as a Hospital representative in compliance with the Bylaws, including disclosures made to other health care facilities pursuant to the Bylaws.

b. Any third party for releasing or disclosing information, including otherwise privileged or confidential information, to any Hospital representative concerning any former or current applicant or Medical Staff appointee unless such information is false and the third party providing it knew it was false.

4.8.2 Acts Covered

The immunity provided by the Medical Staff Bylaws shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with the Hospital's activities, including, but not limited to:

a. Applications for appointment and/or clinical privileges;

b. Periodic reappraisals undertaken for reappointment or for changes in clinical privileges;

c. Corrective action;

d. Hearings and appellate reviews;

e. Patient care audits;

f. Medical care evaluations;

g. Utilization reviews;

h. Other Hospital, staff, department, service, committee and subcommittee activities related to monitoring and maintaining quality patient care and appropriate professional conduct;

i. Matters or inquiries concerning the credentials of any applicant or Medical Staff appointee;

j. Matters directly or indirectly affecting patient care or the efficient operation of the Hospital; and

k. Reports to the National Data Bank established pursuant to the Act.

4.9 LEAVE OF ABSENCE

Members of the Medical Staff may apply for a leave of absence not to exceed 24 months, but renewable under appropriate conditions. During the leave of absence, Medical Staff privileges and membership will be administratively inactive. Reinstatement of Medical Staff privileges may be requested through the Department chairperson and Credentials Committee without formal

reapplication, and with the concurrence of the MEC. When requesting reinstatement, the Physician should submit a summary of clinical activities during the leave of absence. Failure to request reinstatement will be deemed a voluntary resignation.

ARTICLE V. DETERMINATION OF CLINICAL PRIVILEGES

5.1 CLINICAL PRIVILEGES RESTRICTED

Medical Staff appointment or reappointment shall not confer any clinical privileges or right to practice at the Hospital. Every Physician at this Hospital by virtue of Medical Staff membership or otherwise, is entitled to exercise only those clinical privileges specifically granted to him/her by the Board, and such privileges shall be subject to removal or curtailment in accordance with the provisions of these Bylaws. The scope of each level of privileges shall be well-defined, and the standards to be met by the Physician shall be stated clearly.

5.2 BASIS FOR CLINICAL PRIVILEGES

The MEC is responsible for developing the criteria for and recommending clinical privileges. The evaluation of all requests for clinical privileges shall be based upon the applicant's demonstrated current competence, including documented experience in treatment areas or procedures, results of treatment, and (when available) conclusions from the Hospital's Performance Improvement Program (as set forth in Section 5.4). Education, training, experience, references, the Hospital's available resources and personnel, and other relevant information shall also be used in making this determination. While not a requirement for membership on the Medical Staff, board eligibility or board certification may be considered in delineating clinical privileges. When privilege delineation is based primarily on experience, the Physician's credentials record must reflect his/her specific experience and successful results that formed the basis for the granting of privileges. The applicant shall have the burden of establishing his/her qualifications and competency for the clinical privileges he/she requests.

5.3 CLINICAL PRIVILEGES RESTRICTED OR EXPANDED

Periodic redetermination of clinical privileges and the expansion or curtailment of clinical privileges shall be made at least every two (2) years in conjunction with the application for reappointment. In addition, any Medical Staff member may request, in writing and on a prescribed form, additional specific clinical privileges at any time with information on relevant recent training and/or experience. This application shall be processed in the same manner as an application for initial appointment.

5.4 PERFORMANCE IMPROVEMENT PROGRAM

As a result of performance improvement program findings, the MEC may recommend practice changes, continuing education or proctorship to a Physician, and the Physician shall be afforded the opportunity to implement those recommendations by written agreement with the MEC.

Although the recommendations shall be made in the course of professional review activity, the implementation of the recommendations shall not constitute a complete or final professional review action and shall not entitle the Physician to the rights under the Fair Hearing Plan.

5.5 TERMINATION OF EXISTING PRIVILEGES

If the Hospital contracts with a Physician or Physicians for professional services on an exclusive basis, non-contracting Medical Staff Physicians with clinical privileges that are encompassed within the contract's exclusivity clause shall not be authorized to exercise those privileges during the pendency of the contract. There shall be no procedural rights of review under the Fair Hearing Plan afforded as a result of the inability to exercise the privileges.

5.6 TEMPORARY PRIVILEGES

The Administrator may, with the written concurrence of the Chairperson of the Medical Staff, grant temporary admitting and/or clinical privileges only under those conditions described in this section. It may be acceptable to grant temporary privileges to (i) fulfill an important patient care need, or (ii) when a new applicant with a complete medical staff application raises no concerns and is awaiting review and approval of the MEC and the Board. Special requirements of supervision and reporting may be imposed by the Chairperson of the Medical Staff for any Physician who is awarded temporary privileges.

5.6.1 Requirements

In all cases, licensure must be verified through primary sources (a documented telephone call to the relevant state board is sufficient) and copies of a malpractice insurance policy summary must be submitted before the granting of temporary privileges may be considered. Before any such privileges are granted, the individual requesting temporary privileges must agree to be bound by the terms of these Bylaws and the Rules. Additionally, temporary privileges for new applicants may be granted while awaiting review and approval of the MEC, upon verification of:

1. current licensure;
2. relevant training or experience;
3. current competence;
4. ability to perform privileges requested;
5. a query and evaluation of the National Practitioner Data Bank;
6. a complete application;
7. no current or previously successful challenge to licensure or registration;

8. not been subject to involuntary termination of medical staff membership at another institution; and

9. any other criteria required by these Bylaws.

5.6.2 Grant of Temporary Privileges

a. Prior to Membership. Temporary privileges may be granted to an initial applicant to the Medical Staff for the duration of the application process, if good cause is shown. The applicant shall then act only under the supervision of the Chairperson of the Medical Staff or his/her designee. Temporary privileges granted under this subsection will be limited to a period of up to one hundred twenty (120) days, after which they must be reviewed and may be extended for additional periods of up to thirty (30) days by the Administrator and the Chairperson of the Medical Staff. Temporary privileges for new applicants may not exceed one hundred twenty (120) days.

b. For Specific Patients. Temporary clinical privileges may be granted for the care of a specific patient, if good cause is shown. Temporary clinical privileges granted under this subsection will expire when the patient is discharged. Any Physician who has treated three (3) patients in any one Medical Staff Year shall be required to apply for membership on the Medical Staff before attending additional patients during that year.

c. Locum Tenens. Temporary privileges may be granted to a Physician serving as a locum tenens for a member of the Medical Staff. After ninety (90) days, the Physician serving as locum tenens must apply for membership on the Medical Staff to continue to provide care for patients at the Hospital. The Physician serving as a locum tenens shall be under the authority of the Chairperson of the Medical Staff or his/her designee.

d. Peer Review. Temporary non-clinical privileges may be granted to a Physician to serve as a member of or consultant to a medical peer review committee during the pendency of an investigation and corrective action.

5.6.3 Termination

The Administrator or the Chairperson of the Medical Staff may, at any time, terminate a Physician's temporary privileges. The Chairperson of the Medical Staff shall assign a member of the Medical Staff to assume responsibility for the care of the terminated Physician's patient(s) until they are discharged from the Hospital, considering the wishes of the patient where feasible. The denial or termination of temporary privileges shall not entitle the Physician to any of the rights provided in the Fair Hearing Plan.

5.7 EMERGENCY DISASTER PRIVILEGES

a. Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the Hospital must obtain his or her valid government-issued photo identification and at least one of the following:

- A current picture identification card from a health care organization that clearly identifies 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), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group;
- Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances;
- Confirmation by a licensed independent practitioner currently privileged by the Hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

b. During a disaster, the Medical Staff oversees the performance of each volunteer licensed independent practitioner.

c. Based on its oversight of each volunteer licensed independent practitioner, the Hospital determines within 72 hours of the practitioner's arrival if granted disaster privileges should continue.

d. Primary source verification of license occurs as soon as the disaster is under control or within 72 hours from the time the volunteer licensed independent practitioner presents him or her self to the hospital, whichever comes first. If primary source verification of licensure, certification, or registration (if required by law and regulation in order to practice) for a volunteer practitioner who is not a licensed independent practitioner cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the Hospital documents all of the following:

- Reason(s) it could not be performed within 72 hours of the practitioner's arrival
- Evidence of the volunteer 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.

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

f. The Hospital assigns disaster responsibilities to volunteer practitioners who are not licensed independent practitioners only when the Emergency Operations Plan has been activated in response to disaster and the Hospital is unable to meet immediate patient needs.

g. The Hospital identifies, in writing, those individuals responsible for assigning disaster responsibilities to volunteer practitioners who are not licensed independent practitioners.

h. The Hospital determines how it will distinguish volunteer practitioners who are not licensed independent practitioners from its staff.

i. The Hospital describes, in writing, how it will oversee the performance of volunteer practitioners who are not licensed independent practitioners who have been assigned disaster responsibilities. Examples of methods for overseeing their performance include direct observation, mentoring, and medical record review.

In case of a patient care emergency, any Physician who is a member on the Medical Staff, to the degree permitted by his/her license and regardless of Medical Staff category, shall be permitted to do everything possible to save the life of or prevent serious permanent harm to a patient, including the calling for any necessary or desirable consultation. When an emergency situation no longer exists, such Physician must request the privileges necessary to continue to treat the patient if he/she does not have the proper clinical privileges. In the event such privileges are denied or the Physician does not have the desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff.

5.8 TELEMEDICINE PRIVILEGES

Telemedicine Privileges means the authorization granted by the Hospital to render a diagnosis or otherwise provide clinical treatment to a patient at the Hospital through the use of electronic communication or other communications technologies. After considering the recommendations of the administrator, the MEC shall make a recommendation to the Board regarding the clinical services that should be offered through telemedicine. Specific services provided at the Hospital via telemedicine will be recommended by the Medical Staff.

5.8.1 Qualifications of Applicants for Telemedicine Privileges

Any Physician who wishes to be granted Telemedicine Privileges must provide documentation of the following:

a. current license(s) to practice medicine;

b. current DEA certificate, if applicable;

c. professional liability insurance coverage in such minimum amounts as may be required by the Hospital from time to time;

d. current Texas controlled substance certificate, if applicable; (e) no exclusion from any federal health care program;

e. active medical staff appointment and clinical privileges in good standing at another accredited hospital; and

f. such additional information as may be requested by the Hospital.

The loss or suspension of any license, certificate or authorization described above must be reported immediately to the Hospital and shall result in the immediate relinquishment of any and all Telemedicine Privileges with no right to a hearing or appeal as outlined in the Medical Staff Bylaws or credentialing policies.

5.8.2 Processing Requests for Telemedicine Privileges

a. Required documentation shall be submitted to the Hospital Medical Staff office or its designee.

b. The Administrator or his or her designee shall submit a query to the National Practitioner Data Bank.

c. The OIG's List of Excluded Providers shall be checked to determine that the applicant has not been excluded from any federal health care program.

d. The Administrator or his or her designee shall verify the applicant's status at his or her primary hospital.

e. The documentation, results of the query and information from the Applicant's primary hospital shall be reviewed by the relevant department chief, who shall forward a report to the Administrator.

f. The Administrator shall make a recommendation to the MEC regarding whether the physician's request for Telemedicine Privileges should be granted.

g. The MEC shall make a recommendation to the Board regarding whether the request for Telemedicine Privileges should be granted. The decision of the Board shall be final.

5.9 RIGHTS ASSOCIATED WITH TEMPORARY, LOCUM TENENS, EMERGENCY AND DISASTER PRIVILEGES

The granting of temporary, locum tenens, emergency or disaster privileges shall not confer Medical Staff membership on any practitioner, nor shall practitioners holding such privileges be considered to be members of the Medical Staff or have any of the rights provided to Medical Staff members by these Bylaws or otherwise except as expressly stated herein. The refusal to grant, or termination or withdrawal of, temporary, locum tenens, emergency or disaster privileges shall not entitle the practitioner involved to a hearing or any other procedural rights or review unless the action is reportable to the National Practitioner Data Bank.

5.10 PROCEDURES NOT PERMITTED TO BE PERFORMED

The Board of Directors may at any time after considering the recommendation of the Medical Executive Committee direct that specific procedures or clinical practices not be performed at the Hospital if the Board of Directors determines that such practices or procedures are not medically acceptable, cannot be properly performed at the Hospital, are inconsistent with the mission, operations or principles of the Hospital, or for any other reason determines that the procedures or services should not be performed in the Hospital. There shall be no appeal or hearing with regard to any decision by the Board of Directors that any practices or procedures are not permitted to be performed in the Hospital.

ARTICLE VI. CORRECTIVE ACTION

6.1 ROUTINE CORRECTIVE ACTION

6.1.1 Criteria for Initiation

Whenever a member of the Medical Staff engages in conduct which fails to meet the letter or the spirit of the Medical Staff Bylaws, or makes or exhibits, acts, statements, demeanor or professional conduct detrimental to the delivery of quality patient care, disruptive or detrimental to Hospital operations (including repetitive use of the Hospital's resources for himself or his/her patients in a manner which is adverse to the financial interests of the Hospital), or detrimental to the Hospital or to patient safety, corrective action against such Physician may be initiated by any officer of the Medical Staff, Administrator, or by the Board.

6.1.2 Requests and Notice

All requests for corrective action shall be in writing, submitted to the MEC and may be supported by reference to the specific activities or conduct, which constitute the grounds for request. The MEC shall promptly notify the Administrator in writing of all requests for corrective action received by the MEC and shall continue to keep him/her fully informed of all action taken in conjunction therewith.

6.1.3 MEC Action

The MEC shall immediately investigate the matter or appoint an ad hoc committee composed of Active Staff members to investigate. A Medical Staff Member initiating the request for corrective action may not serve on the investigating committee. The affected Staff Member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating committee deems appropriate, including an opportunity for an interview. At such interview, the Staff Member shall be informed of the general nature of the charges and shall be invited to discuss, explain or refute them. This interview shall not constitute a "hearing," as that term is used in the Fair Hearing Plan and shall be preliminary in nature, and none of the procedural rules provided in the Fair Hearing Plan shall apply thereto. A record of such interview may be made by the investigating committee.

As soon as is practicable after the receipt of request of corrective action, the MEC shall prepare a written report and recommendation regarding the request. Before issuing such report, the MEC may investigate the allegations, as it deems appropriate. The MEC may interview witnesses, and the affected individual may have an opportunity to meet with the MEC after being informed of the general nature of the evidence supporting the investigation. The recommendations of the MEC may include, without limitation:

a. Rejecting the request for corrective action.

b. Issuing a warning, a letter of admonition, or a letter of reprimand.

c. Recommending terms of non-voluntary probation or individual requirements of non-voluntary consultation.

d. Recommending denial, reduction, suspension or revocation of Clinical Privileges.

e. Recommending unrequested reduction of Staff category or limitation of any Staff Prerogatives directly related to patient care.

f. Recommending suspension or revocation of Staff membership or other Adverse Recommendation.

6.1.4 Procedural Rights

Any action by the MEC pursuant to Section 6.1.3 which shall entitle the Physician to the procedural rights as provided in Article VII, and as otherwise set forth in Section 1.1 of the Fair Hearing Plan, and the matter shall be processed in accordance with the provisions of the Fair Hearing Plan.

6.1.5 Other Action

If the MEC's recommended action is as provided in Section 6.1.3 (a), or (b), such recommendation shall be transmitted to the Board. Thereafter, the procedure to be followed shall be as provided in Section 4.7.2, as applicable.

6.2 SUMMARY ACTION

6.2.1 Summary Action

The Medical Executive Committee, the Chief of Staff, the chair of the staff member's department, or the Hospital CEO may summarily suspend, restrict or place conditions or requirements on all or any portion of the clinical privileges of any practitioner in accordance with this section. Any such suspension, restrictions, conditions or requirements shall be effective immediately and shall remain in effect until terminated by the Hospital CEO or the Board of Directors after considering the recommendations of the Medical Executive Committee. Grounds for imposition of summary suspension, restriction or conditions shall include, but not be limited to, the following:

(i) the conduct of a practitioner creates a reasonable possibility of injury or damage to any patient, employee or person present in the Hospital or to the Hospital;

(ii) a practitioner is charged with the commission of a felony;

(iii) a practitioner is charged with the commission of a misdemeanor which may relate to the practitioner's suitability for Medical Staff membership;

(iv) a practitioner engages in or is charged with unlawful or unethical activity related to the practice of medicine, **[**

(v) a practitioner engages in any dishonest, unprofessional, abusive or inappropriate conduct which is or may be disruptive of Hospital operations and procedures;

(vi) the practitioner has had any medical staff membership, clinical privileges, certification, licensure or registration terminated, suspended, restricted, limited, reduced or modified in any way, has resigned from any other medical staff in order to avoid an investigation or proposed action concerning medical staff membership or clinical privileges, or has voluntarily surrendered or agreed not to exercise any clinical privileges while under investigation or to avoid an investigation;

(vii) it is determined that the practitioner made a material misstatement or omission on any pre-application or application for appointment or reappointment, or at any time provided incorrect information or otherwise deceived or attempted to deceive or mislead the Medical Staff and/or the Hospital;

(viii) a practitioner has falsified or inappropriately destroyed or altered any medical record;

(ix) a practitioner refuses to submit to evaluation or testing relating to the practitioner's mental or physical status, including refusal to submit to any testing related to drug or alcohol use;

(x) a practitioner abandons a patient or wrongfully fails or refuses to provide care to a patient;

(xi) a practitioner fails to maintain appropriate malpractice insurance or a current, unrestricted active state license to practice medicine; or

(xii) a practitioner engages in clinical activities outside the scope of the practitioner's approved clinical privileges.

6.2.2 MEC Action

As soon as possible after such summary action, a meeting of the MEC shall be convened to review and consider the action taken. The MEC may recommend to the Board whether the summary action should be modified, continued or terminated including whether further corrective action should be taken. Unless the summary action was imposed by action of the Board, such recommended action by the MEC shall take immediate effect and remain in effect pending a final decision by the Board.

6.2.3 Procedural Rights

Unless the MEC recommends immediate reinstatement and the suspension and cessation of all further corrective action, the Physician shall be entitled to the procedural rights as provided in Article VII, and the matter shall be processed in accordance with the provisions of the Fair Hearing Plan. The terms of the summary action as originally imposed shall remain in effect pending a final decision by the Board.

6.3 AUTOMATIC SUSPENSION

6.3.1 License

A Staff Member or Allied Health Professional whose license, certificate or other legal credential authorizing him/her to practice in the State of Texas has been revoked or suspended shall immediately and automatically be suspended from practicing in the Hospital. Such automatic suspension shall not entitle the affected Physician to the procedural rights provided under Article VII nor the provisions contained in the Fair Hearing Plan.

6.3.2 DPS Number and DEA Number

A staff member whose DPS or DEA number is revoked or suspended shall immediately and automatically be divested at least of his/her right to prescribe medications covered by such number. As soon as practicable after such automatic suspension, the MEC shall convene to review and consider the facts under which the DPS or DEA number was revoked or suspended.
The MEC may then take such further corrective action as is appropriate to the facts disclosed in its investigation. The affected Staff member shall not be entitled to the procedural rights provided under Article VII and the matter shall be processed in accordance not with the provisions of the Fair Hearing Plan.

6.3.3 Medical Records

Incomplete charts greater than thirty (30) days old shall be counted delinquent. Incomplete and delinquent charts shall be readily accessible for physician completion at all times. Records pending completion are filed by physician name in the Hospital's medical record department. Physicians with incomplete/delinquent charts will receive a weekly list of charts showing the age of the chart(s). The list will serve as first notice to the Physician to complete charts.

In the event that charts are not completed within 15 days of discharge the medical records department will call the Physician as a reminder.
Physicians with delinquent charts greater than 50% of their average monthly discharges or 9 records (whichever is greatest) shall receive written notification of pending corrective action/suspension. Upon receipt of notification the Physician will have 15 days to complete all delinquent records.

Should notification fail to be effective, letters will be mailed to the CEO and Chairperson of the Medical Staff for further recommendations and action, which may include temporary or permanent suspension of medical staff privileges.

Recommendations for suspension shall be recorded in the Physician profile (credentialing/recredentialing).

A physician examination and medical history will be done on patients who are admitted to the Hospital no more than thirty (30) days before or within 24 hours after an admission. Any changes in the patient's condition should be noted in the medical record if the history and physical was completed within 30 days before admission. The medical history and physical examination must be placed in the medical record within 24 hours after admission. In elective surgery, the history and physical must be documented prior to surgery.

6.3.3.1 Post-Anesthesia Assessment

The anesthesiologist or nurse anesthetist shall record an assessment of the patients' blood pressure, respirations, oxygen saturation and level of consciousness, along with an evaluation of their recovery from anesthesia, prior to the patient's transfer from the recovery room. All

postoperative patients shall be evaluated again for recovery from anesthesia within 48 hours of surgery using the criteria below. Out-patients may be discharged from the hospital after evaluation by a registered nurse against these criteria:

a. Vital signs stable and within 20% of pre-anesthesia levels.

b. Swallow and cough reflex present

c. Absence of respiratory distress.

d. Tolerates PO fluids with minimal nausea or vomiting

e. Alert and oriented or at pre-surgery level

f. Pain controlled with analgesics.

6.3.4 Malpractice Insurance

A Physician who fails to maintain the amount of professional liability insurance required of his/her under Section 12.2 shall immediately be voluntarily relinquished or restricted until the matter is resolved and insurance coverage is restored consistent with the Bylaws.

6.3.5 Procedural Rights

A physician under automatic suspension by operation of Section 6.3.3 or Section 6.3.4 shall not be entitled to the procedural rights provided in Article VII, or in the Fair Hearing Plan.

6.3.6 Voluntary Separation from Staff

Any Medical Staff member may voluntarily terminate his/her membership on the Medical Staff, and/or his/her Privileges, in whole or in part, by submission of a written notice of his/her intentions to the MEC which shall forward notice of such termination to the Board. The MEC shall arrange for notice of termination of membership, clinical area affiliation, and/or Privileges to be disseminated as appropriate.

6.3.7 Conviction of a Felony

In the event a physician is convicted of a felony, his/her Privileges at the Hospital will be automatically suspended.

6.3.8 Loss of Medicare/Medicaid Participation

A Physician whose participation in the Medicare or Medicaid programs is suspended, terminated or voluntarily relinquished shall immediately cease treating Medicare or Medicaid beneficiaries, as appropriate, at the Hospital. Such automatic suspension shall not entitle the Physician

to the procedural rights provided under Article VII nor the provisions contained in the Fair Hearing Plan. The MEC may make an additional Adverse Recommendation after review of the facts that led to suspension, termination, or relinquishment of participation, which would entitle the Physician to a hearing.

6.3.9 Hearing Entitlement

No practitioner shall be entitled to a hearing as a result of any action which is recommended or taken which is not reportable to the state or the National Practitioner Data Bank, including, but not limited to, the following:

a. Letters of warning, reprimand, or admonition;

b. Imposition of monitoring, proctoring, review or consultation requirements;

c. Requiring provision of information or documents, such as office records, or notice of events or actions;

d. Imposition of educational or training requirements;

e. Placement on probationary or other conditional status;

f. Appointment or reappointment for less than two (2) years;

g. Failure to place a practitioner on any on-call or interpretation roster, or removal of any practitioner from any such roster; or,

h. Continuation of provisional appointment.

j. Termination of medical staff membership and/or clinical privileges as a result of matters which are not related to the practitioner's professional qualifications, competence or conduct such as (i) failure to pay dues or assessments, (ii) failure to meet any objective requirement imposed on all staff members that specific numbers of procedures be performed to maintain or demonstrate clinical competence, or (iii) the Hospital elects to enter into an exclusive contract for the provision of certain services. If any action is taken which does not entitle the practitioner to a hearing, the practitioner shall be offered the opportunity to submit a written statement or any information which the practitioner wishes to be included in the practitioner's peer review records along with the documentation regarding the action taken.

6.3.10 Attorney Representation

No practitioner shall be entitled to be accompanied by an attorney in connection with any investigation or interview prior to the time that the practitioner is entitled to a hearing in accordance with these Bylaws. However, the practitioner may be accompanied by an attorney at any hearing or in connection with any appearance before the Medical Executive Committee or

the Board of Directors, provided that the practitioner shall be required to respond personally to any questions directed to the practitioner. If the practitioner will be represented by counsel or another representative at any hearing or appearance, the practitioner shall notify the Medical Staff of the name of the attorney or other representative at least ten calendar (10) days prior to the hearing or appearance. Failure to do so shall result in the practitioner's not being permitted to be accompanied by counsel.

6.3.11 Payment of Attorney Fees

If any practitioner who is the subject of an adverse recommendation or action in connection with the practitioner's medical staff membership or clinical privileges initiates a suit against any entity or person who is in any way involved in any peer review, credentialing, recredentialing, corrective action, or other action, recommendation or decision, the practitioner filing the suit shall be required to pay all costs and expenses incurred by each individual defendant in defending the suit, including reasonable attorney fees, unless the practitioner substantially prevails against the individual defendant.

6.4 APPLICATION FOR REINSTATEMENT TO STAFF MEMBERSHIP.

6.4.1 Immediate Application for Reinstatement

A former Medical Staff member may apply for reinstatement to the Medical Staff at any time following denial of reappointment, revocation, or suspension of membership status if such change in status was predicted on the occurrence of any of the following:

a. Failure to fulfill requirements for attendance at meetings, as required in these Bylaws.

b. Failure to attend Medical Staff committee meetings, as required in these Bylaws.

c. Failure to pay membership dues on a timely basis, without good cause for such delinquency, as approved under Article XII of these Bylaws.

d. Failure to submit timely application for reappointment to membership on the Medical Staff, as required under Section 4.6.1 of these Bylaws.

e. Failure to submit timely application for reinstatement from leave of absence, as required under Section 4.9 of these Bylaws.

f. Failure to adhere to these Bylaws, to the Rules and Regulations of the Medical Staff, or to the Medical Staff or Hospital policies.

6.4.2 Delayed Application for Reinstatement to Medical Staff Membership

a. Notwithstanding any other provision to the contrary, a former member of the Medical Staff may not apply for reinstatement to the Medical Staff until at least five (5) years following denial of reappointment, suspension, or revocation of Medical Staff membership, if such denial, suspension, or revocation was predicted on the occurrence of any of the following events:

1. Revocation or suspension of the affected Staff member's license, certificate, or other authority to practice medicine within the State by the licensing board, authority, or other entity with jurisdiction over issuance of such licensure.

2. Conviction of a felony.

3. Failure to conform to relevant standards of professional competence or ethical conduct.

b. Where a former member of the Medical Staff has had an application for reinstatement to the Medical Staff denied, or had membership status on the Medical Staff revoked or suspended, for reasons other than those set forth in Section 6.4.1 (a-e) and 6.4.2(a), the former Staff member may not apply again for reinstatement to the Medical Staff until at least two (2) years following the denial of reinstatement, or the suspension or revocation of his/her Medical Staff membership status.

ARTICLE VII. INTERVIEWS, HEARINGS AND APPELLATE REVIEW

7.1 INTERVIEWS

When the MEC, other relevant Staff committee, or the Board or any appropriate committee thereof receives or is considering initiating an unfavorable recommendation concerning a Physician, the Physician may be afforded an interview. The interview shall not constitute a hearing, shall be preliminary in nature, and shall not be conducted according to the procedural rules provided with respect to hearings. The Physician shall be informed of the general nature of the circumstances and may present information relevant thereto.

7.2 HEARINGS AND APPELLATE REVIEW

7.2.1 Unfavorable MEC Recommendation or Board Action

Except as otherwise set forth in these Medical Staff Bylaws, when any Physician receives notice of an unfavorable recommendation of the MEC or unfavorable action of the Board, he/she may be entitled, upon request, to a hearing and procedures set forth in the Fair Hearing Plan.

7.2.2 Procedure and Process

All hearings and appellate reviews shall be in accordance with the procedure and safeguards set forth in the Fair Hearing Plan attached to these Bylaws.

7.2.3 Exceptions

Neither the issuance of a warning, a letter of admonition, or a letter of reprimand, nor the denial, termination or reduction of temporary privileges, nor any other actions except those specified in the Fair Hearing Plan shall give rise to any right to a hearing or appellate review.

ARTICLE VIII. OFFICER (CHAIRPERSON)

8.1 OFFICER/CHAIRPERSON OF THE STAFF

8.1.1 Identification

The general officer of the Staff shall be accountable to the Medical Staff for implementing the policies and directives of its various committees. Currently the only officer is:

Chairperson of the Medical Staff (also called, "Chief of Staff"); and may (but it is not mandatory) also include:

Vice Chairperson of the Medical Staff.; or

Secretary-Treasurer.

8.1.2 Qualifications

The officer(s) must be members of the Active Staff and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

8.1.3 Election

The Board appoints the officer(s).

8.1.4 Term of Office

Each officer shall serve a two (2) year term, commencing on the first day of the Medical Staff year following his/her appointment. Each officer shall serve until the end of his/her term and until a successor is appointed, unless he/she shall sooner resign or be removed from office.

8.1.5 Removal of General Staff Officer(s)

Except as otherwise provided, removal of an officer may be initiated by the Board acting upon its own recommendation or by a two-thirds (2/3) vote of the members of the Active Staff. Removal may be based only upon failure to perform the duties of the position held as described in these Bylaws. If an officer is deemed a medico-administrative officer, his/her removal shall be accomplished pursuant to Section 7.3 of these Bylaws.

8.1.6 Vacancies in Elected Office

Vacancies of offices shall be fulfilled by the Board.

8.2 DUTIES OF GENERAL OFFICERS

8.2.1 Chairperson of the Medical Staff (Chief of Staff)

The Chairperson of the Medical Staff shall serve as the chief medical officer of the Hospital and shall be appointed by the Board. As such, he/she shall be responsible for implementing the general responsibilities of the Medical Staff, including, without limitation to:

a. aid in coordinating the activities and concerns of the Hospital administration and of the nursing and other patient care services with those of the Medical Staff.

b. be accountable to the Board, in conjunction with the MEC, for the quality and efficiency of clinical care and performance within the Hospital and for the effectiveness of the patient care audit and other quality and utilization review, evaluation and monitoring functions delegated to the Staff by means of regular reports and recommendations based on the results of these activities.

c. develop and implement, in cooperation with the MEC, methods for retrospective patient care audits, ongoing monitoring of practice, credentials review, delineation of privileges and specified services, continuing education, and utilization review.

d. communicate and represent the opinions, policies, concerns, needs and grievances of the Medical Staff to the board, the Administrator, and other officials of the Staff.

e. be responsible for the enforcement of the Medical Staff Bylaws, Rules and Regulations, and Fair Hearing Plan, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Physician.

f. call, preside at, and be responsible for the agenda of all general and special meetings of the Medical Staff and of the MEC.

g. serve as chairperson of the MEC and as ex-officio member of all other Medical Staff committees.

h. report Medical Staff disciplinary decisions to the appropriate licensing agency.

8.2.2 Vice Chairperson of the Medical Staff

The medical staff may, but is not required, to have a Vice Chairperson. If a Vice Chairperson is appointed by the Board, the Vice Chairperson of the Medical Staff shall be a member of the MEC and shall be required to assist the Chairperson of the Medical Staff and to perform such duties as may be assigned to him/her by the Chairperson of the Medical Staff. In the absence of the Chairperson of the Medical Staff or upon the occurrence of a vacancy in the office of the Chairperson of the Medical Staff or upon the occurrence of a vacancy in the office of the Chairperson of the Medical Staff, the Vice Chairperson of the Medical Staff shall assume the responsibilities, exercise the authority, and perform the duties assigned to the Chairperson of the Medical Staff until the Chairperson of the Medical Staff returns or that office is filled.

8.2.3 Secretary-Treasurer

The medical staff may, but is not required to have a secretary-treasurer. If a secretary-treasurer is appointed by the Board, the secretary-treasurer shall be a member of the MEC and an ex-officio member without vote of all other Staff committees. His/her duties shall be to:

a. give proper notice of all Staff and MEC meetings on order of the Chairperson of the Medical Staff.

b. prepare accurate and complete minutes for all Staff and MEC meetings and furnish such minutes to the Board.

c. supervise the collection and accounting for any funds that may be collected in the form of Staff dues, assessments, or application fees.

d. supervise the conduct of elections.

e. record and codify these Bylaws Medical Staff Rules and Regulations, and Fair Hearing Plan, the changes therein or amendments thereto

f. attend to all correspondence.

g. submit a complete financial report at the annual general meeting of the Staff and a quarterly financial report and a report on spending policies to the MEC.

h. perform such other duties as ordinarily pertain to his office.

ARTICLE IX. COMMITTEES AND FUNCTIONS

9.1 DESIGNATION AND SUBSTITUTION

There shall be a Medical Executive Committee (MEC) that will function as a committee-of-the-whole to perform the Staff functions listed in Section 9.7, as well as such other functions as the Board shall direct and elsewhere in these Bylaws.

The MEC may, by resolution and upon approval by the Board, establish standing or special Staff committees to perform one or more of the required Staff functions. Those functions requiring participation of, rather than direct oversight by, the Staff may be discharged by Medical Staff representation on such Hospital committees as are established to perform such functions.

9.2 ORGANIZATION OF COMMITTEES

Each standing and special committee shall be organized as a separate part of the Medical Staff and shall undertake the responsibilities and have the authority set forth in these Bylaws and any resolution of the MEC defining such responsibilities and authority. No Committee shall have authority, responsibility, or jurisdiction in excess of that conferred upon the MEC, which shall be ultimately responsible to the Medical Staff and shall exert jurisdiction on behalf of the Medical Staff in all matters relating to the Medical Staff and the general welfare of the Hospital.

9.3 COMMITTEE CHAIRPERSON

9.3.1 Selection

With the exception of the MEC, the Chairperson of each standing or special committee shall be appointed by the Chairperson of the Medical Staff.

9.3.2 Term

Each committee Chairperson shall serve a term of one (1) year, coinciding with the Medical Staff year beginning on January 1 next following the date of his/her respective appointment.

9.4 MEMBERSHIP AND APPOINTMENT

9.4.1 Eligibility

Members of the Active Staff shall be eligible for appointment to any standing or special committee of the Medical Staff established to perform one or more of the functions required by these Bylaws. Members of the Courtesy and Provisional Staffs shall be eligible for appointment

to any standing or special committee of the Medical Staff established to perform one or more of the functions required by these Bylaws, with the exception of the MEC.

Where specified in these Bylaws, or where the MEC deems it appropriate to the functions of a committee of the Medical Staff, members of other categories of the Medical Staff, Health Professional Affiliates, and representatives from various departments of the Hospital, including, without limitation, the Administration and the Dietary, Laboratory, Radiology, Nursing, Housekeeping, Medical Records, and Pharmacy departments, shall be eligible for appointment to specific committees of the Medical Staff.

9.4.2 Selection

Unless otherwise provided in these Bylaws, Medical Staff members of any Medical Staff committees, other than the MEC, shall be appointed by the Chairperson of that committee. Health Professional Affiliates shall be appointed to such committees by the Chairperson of the respective committee.

Members of Medical Staff committees representing non-Medical Staff Hospital departments shall be appointed by the Administrator.

9.4.3 Administrator

The Administrator or his/her designee shall serve as an ex-officio member of all Medical Staff committees.

9.4.4 Term

Each Medical Staff committee member shall serve a term of two (2) years, coinciding with the Medical Staff Year beginning on January 1 next following his/her appointment.

9.5 REQUIREMENTS FOR MEDICAL STAFF COMMITTEE SERVICE

All members of the Active, Courtesy and Provisional Staffs are expected to participate in designated and committee activities. Failure to so participate, when requested, shall be grounds for appropriate disciplinary action, including, without limitation, denial of reappointment to the Medical Staff.

9.6 MEDICAL EXECUTIVE COMMITTEE

9.6.1 Composition

The Medical Executive Committee (MEC) shall consist of at least six (6) members (who are appointed by the Board of Directors on an annual basis), including the following:

a. Chairperson of the Medical Staff.

b. Vice Chairperson of the Medical Staff (if one is selected). (c) Secretary-Treasurer of the Staff (if one is selected).

c. Other Medical Staff members as deemed appropriate by the Chairperson of the Medical Staff.

d. The Administrator and Chief Nursing Officer shall serve as an ex-officio member without vote

A quorum shall consist of fifty percent of the current voting membership of the committee.

9.6.2 Duties

The duties of the MEC shall be to:

a. Receive and act upon reports and recommendations from the clinical areas, committees and officers of the Staff and recommend to the Board specific programs and systems to implement these functions.

b. Coordinate and implement the activities of and policies adopted by the Staff, clinical areas and committees.

c. Review application for appointment and reappointment and recommend to the Board all matters relating to appointments, reappointments, Staff category, clinical area assignments, Clinical Privileges and corrective action.

d. Account to the Board and to the Staff for the overall quality and efficiency of patient care in the Hospital.

e. Take reasonable steps to insure professionally ethical conduct and competent clinical performance on the part of Staff members, including initiating investigations and initiating and pursuing corrective action, when warranted, and in accordance with the provisions of these Bylaws.

f. Make recommendations on medico-administrative and Hospital management matters.

g. Inform the Medical Staff of the accreditation program and the accreditation status of the Hospital.

h. Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs.

i. Serve as a liaison between the Medical Staff and the Board and the Administration of the Hospital, including considering and recommending action of the Joint Commission Committee, the Board, and Administration of the Hospital on all medico-administrative matters

j. Undertake all steps necessary to provide that the Hospital meet or exceed the requirements for accreditation imposed by relevant entities and authorities, including, without limitation, the Joint Commission on Accreditation of Healthcare Organizations, the Texas Medical Association, and the Texas Department of Human Services.

k. Evaluate and recommend proposed steps and policies to provide that variations from relevant accreditation standards are noted and corrected by the Medical Staff, the Board, and Administration.

l. Provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other designee.

m. Evaluate the quality of services to include equipment, space, and operating policies and practices of all ancillary services and make appropriate recommendations to the Administrator and the Board.

n. Represent and act on behalf of the Staff, subject to such limitations as may be imposed by these Bylaws.

9.6.3 Meetings and Procedures

a. The MEC shall meet by-monthly, at least six (6) times and nine (9) months per year, and maintain a permanent record of its proceedings and actions. The MEC may meet the requirement for by-monthly meetings by holding such meetings with a committee of the entire Medical Staff.

b. The MEC shall present at each regular meeting of the Medical Staff a report of any action undertaken by the MEC since the last prior meeting of the Medical Staff.

c. The MEC shall meet in executive session when necessary, thereby excluding all non-Medical Staff members except the Administrator and Chief Nursing Officer. The Administrator and Chief Nursing Officer can be requested by the Committee as a whole to leave any such executive session, and shall then do so unless he/she believes in good faith that his/her failure to be present would be detrimental to the best interests of the Hospital.

d. Any member of the MEC may request that any vote of the MEC be taken by secret ballot.

9.7 STAFF FUNCTIONS

Provision shall be made in these Bylaws or by resolution of the MEC approved by the Board, either through assignment to the clinical departments, to Staff committees, to the Staff as a whole or to interdisciplinary Hospital committees, or an individual, for the effective performance of the Staff functions specified in this Section 9.7 and described in Section 9.8 of all other Staff functions required by these Bylaws, and of such other Staff functions as the MEC or the Board shall reasonably require.

a. Conduct, coordinate and review patient care audit and monitoring activities, including tissue, blood usage and antibiotic reviews and analysis of autopsy reports.

b. Conduct, coordinate and review, or oversee the conduct of utilization review activities.

c. Conduct, coordinate and review credentials investigations and recommendations regarding Staff membership and grants of Clinical Privileges and specified services.

d. Monitor and evaluate care provided in and develop clinical policy for: special care units, patient care support services, such as respiratory therapy, and emergency, outpatient, home care, and other ambulatory care services.

e. Provide continuing education opportunities responsive to quality activity findings, new state-of-the-art developments and other perceived needs and supervise the Hospital's professional library services.

f. Review the completeness, timeliness and clinical pertinence of patient medical and related records.

g. Develop and maintain surveillance over drug utilization policies and practices.

h. Prevent, investigate and control Hospital-acquired infections and monitor the Hospital's infection control program.

i. Plan for response to fire and other disasters, for Hospital growth and development, and for the provision of services required to meet the needs of the community.

j. Supervise and train medical and dental students and graduate trainees.

k. Direct Staff organizational activities, including Staff Bylaws review and revision, Staff officer and committee nominations, liaison with the Board and Hospital administration, and review and maintenance of Hospital accreditation.

9.8 BYLAWS

9.8.1 Composition

Unless a separate Bylaws Committee is established, the Bylaws Committee responsibilities shall be fulfilled by the MEC acting as committee-of-the-whole. At the discretion of the MEC, members may be appointed and a separate committee established. The members shall be appointed by the Chairperson of the Medical Staff, subject to the approval of the MEC. Membership shall be for a two year term.

9.8.2 Responsibilities

The duties involved in maintaining the appropriate Bylaws, Rules, Regulations, Fair Hearing Plan, and other organizational documents pertaining to the Staff are to:

a. Conduct regular review of these Bylaws, of the Rules, Regulations, Fair Hearing Plan, and other organizational documents pertaining to the Medical Staff, and of procedures and forms promulgated in connection with the Bylaws, Rules and Regulations, and Fair Hearing Plan to reflect current practices within the Medical Staff and the Hospital.

b. Conduct an annual comprehensive review of the Bylaws, of the Rules and Regulations of the Medical Staff and of the procedures and forms promulgated in connection with the Bylaws, and submit recommendations based on such review and evaluation, including proposed changes, to the Board.

9.8.3 Procedures

a. The Bylaws Committee shall meet as frequently as necessary to perform its functions, and at least annually, shall maintain a permanent record of its findings, proceedings and actions.

b. The Bylaws Committee shall report to the Board as frequently as necessary to carry out its required functions. The Committee shall submit a report of its findings and recommendations in connection with its annual review of these Bylaws and related documents to the Board as frequently as may be necessary to carry out its required functions, and at least annually.

9.9 CONTINUING EDUCATION COMMITTEE

9.9.1 Composition

Unless, a separate Continuing Education Committee is established, the Continuing Education Committee responsibilities shall be fulfilled by the MEC acting as a committee-of-the-whole. At the discretion of the MEC, members may be appointed and a separate committee established. The members shall be appointed by the Chairperson of the Medical Staff, subject to the approval of the MEC. Membership shall be for a two (2) year term.

9.9.2 Responsibilities

The duties involved in organizing continuing education programs and supervising the Hospital's professional library services are to:

a. develop and plan, or participate in, programs of continuing education that are designed to keep the Medical Staff informed of significant new developments and new skills in medicine and that are responsive to audit findings.

b. evaluate, through the patient care audit function, the effectiveness of the educational programs developed and implemented.

c. analyze, on a continuing basis, the Hospital's and Staff's needs for professional library services.

d. act upon continuing education recommendations from the MEC, clinical areas, the Staff, or committees responsible for patient care audit and other quality review, evaluation and monitoring functions.

e. maintain a record of education activities and submit periodic reports to the MEC concerning these activities, specifically including their relationship to the findings of the patient care audit and other quality review, evaluation and monitoring functions.

9.9.3 Procedures

a. The Continuing Education Committee shall meet as frequently as necessary to carry out its required functions, and at least annually and shall maintain a permanent record of its findings, proceedings and actions.

b. The Continuing Education Committee shall make reports on a regular basis to the MEC as frequently as may be necessary to carry out its required functions, and at least annually.

c. The Continuing Education Committee may hold its meetings jointly with appropriate representatives of other local hospitals.

9.10 ENVIRONMENT OF CARE COMMITTEE

9.10.1 Composition

a. Unless a separate Environment of Care Committee is established, the Environment of Care Committee responsibilities shall be fulfilled by the MEC acting as a committee-of-the-whole. At the discretion of the MEC, members may be appointed and a separate committee established. The Administrator or his/her designee, and at least one (1) representative from Nursing, shall serve as ex-officio members of the Committee. The members shall be appointed by the Chairperson of the Medical Staff, subject to the approval of the MEC. Membership shall be for a two year term.

9.10.2 Responsibilities

The duties involved in planning to provide appropriate response to, and the protection and care of Hospital patients and others at the time of, internal and external disasters are to:

a. Develop and periodically review, in cooperation with the Hospital administration, a written plan designed to safeguard patients at the time of an internal disaster and require that all personnel rehearse fire and other types of disaster drills at least four times a year for each shift.

b. Develop and periodically review, in cooperation with the Hospital Administration, a written plan for the care, reception and evacuation of mass casualties, and assure that such plan is coordinated with the inpatient and outpatient services of the Hospital that is adequately related to other available resources in the community and coordinates the Hospital's role with other agencies in the event of disasters in the Hospital and nearby communities, and that the plan is rehearsed by all personnel involved at least twice yearly.

c. Oversee the practice of emergency medicine within the Hospital and administration of the Emergency Room.

d. Formulate and implement plans for emergency care of patients within the Hospital.

e. Review and evaluate the quality and appropriateness of patient care provided within the Emergency Room, through monitoring the quality and appropriateness of patient care and establishing appropriate quality control mechanisms.

f. Formulate and implement written policies and procedures regarding the provision of emergency patient care, including the scope and conduct of patient care to be rendered in the Emergency Room.

g. Monitor the facility's compliance with all Federal and State Guidelines with regard to patient transfer.

9.10.3 Procedures

a. The Committee shall meet monthly, and shall maintain a permanent record of its findings, proceedings and actions.

b. The Committee shall report on a quarterly basis to the MEC on such activities and recommendations.

c. The Committee shall perform reviews of relevant policies, procedures, and plans as often as necessary and at least annually, including written policies and procedures for emergency patient care and disaster and mass casualty plans. The Committee shall be responsible for submitting recommendations to the MEC regarding its evaluation and review of such policies, plans, and procedures as frequently as necessary to perform its required functions, and at least annually.

9.11 INFECTION CONTROL COMMITTEE

9.11.1 Composition

a. Unless a separate Infection Control Committee is established, the Infection Control Committee responsibilities shall be fulfilled by the MEC acting as a committee-of-the-whole. At the discretion of the MEC, members may be appointed and a separate committee established. These responsibilities are Hospital-wide, and their fulfillment will require the involvement of administrative (to include Laboratory, Housekeeping, and Dietary) and nursing personnel. The members shall be appointed by the Chairperson of the Medical Staff, subject to the approval of the MEC. Membership shall be for a two (2) year term.

9.11.2 Responsibilities

The duties involved in preventing, investigating, and controlling Hospital-acquired infections are to:

a. maintain surveillance over the Hospital infection control program.

b. develop a system for reporting, identifying and analyzing the incidence and cause of all infections.

c. develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques.

d. develop, evaluate and revise preventive, surveillance and control policies and procedures relating to all phases of the Hospital's activities, including: operating rooms, delivery room (Emergency Room), special care units; central service, housekeeping and laundry; sterilization and disinfecting procedures by heat, chemicals, or otherwise; isolation procedures prevention of cross-infection by anesthesia apparatus of inhalation therapy equipment; testing of Hospital personnel for carrier status; disposal of infectious materials; food sanitation and waste management; and other situations as requested.

e. coordinate action on findings from the Medical Staff's review of the clinical use of antibiotics.

f. act upon recommendations related to infection control received from the Chairperson of the Medical Staff, the MEC, the departments and other Staff and Hospital committees.

g. maintain a record of all activities relating to infection control and submit periodic reports thereon to the MEC and the Administrator, and to the Director of Nursing Service.

9.11.3 Procedures

a. The Infection Control Committee shall meet monthly, at least ten (10) times per year and shall maintain a permanent record of its findings, proceedings and actions.

b. The Committee shall report such findings, proceedings and actions to the MEC, to the Board, and to the Director of Nursing services as frequently as necessary, and at least quarterly.

9.12 MEDICAL RECORDS COMMITTEE

9.12.1 Composition

Unless a separate Medical Records Committee is established, the Medical Records Committee responsibilities shall be fulfilled by the MEC acting as a committee-of-the-whole. At the discretion of the MEC, members may be appointed and a separate committee established. The fulfillment of these responsibilities will require the active involvement of the administrative and

nursing members of the Hospital-wide quality committee, including the Administrator, the Director of Nursing and the Director of Medical Records. Membership shall be for a period of two years and the terms shall be staggered so that the Committee always includes experienced voting members.

9.12.2 Responsibilities

The duties involved in reviewing the completeness, timeliness and clinical pertinence of patient medical records are to:

a. review and evaluate medical records to determine that they: (1) properly describe the condition and progress of the patient, the therapy provided, the results thereof, and the identification of responsibility for all actions taken; and (2) are sufficiently complete at all times so as to facilitate continuity of care and communications between all those providing patient care services in the Hospital.

b. review Staff and Hospital policies, Rules and Regulations relating to medical records, including medical records completion, forms, formats, filing, indexing, storage, destruction and availability, and recommend methods of enforcement thereof and changes therein.

c. act upon recommendations from the MEC, the departments and other committees responsible for patient care audit and other quality review, evaluation and monitoring functions.

d. provide liaison with Hospital administration and the medical records professionals in the employ of the Hospital on matters relating to medical records practices.

e. maintain a record of all actions taken and submit periodic reports and recommendations to the MEC concerning medical records practices in the Hospital.

9.12.3 Procedures

a. The Medical Records Committee shall meet as often as necessary to perform it functions and at least quarterly.

b. The Committee shall maintain a permanent record of all evaluations performed on individual medical records, of all medical records policies and procedures, and of all recommendations and conclusions resulting there from. The Committee shall submit regular reports to the MEC and the Board regarding its activities and recommendations, as often as it may deem necessary, and at least quarterly.

9.13 ANCILLARY SERVICE COMMITTEE.

9.13.1 Composition

Unless a separate Ancillary Service Committee is established, the Committee's responsibilities shall be fulfilled by the MEC acting as a committee-of-the-whole. At the discretion of the MEC, members may be appointed and a separate committee established. There may be appointed other ex-officio members as the Chairperson may select. If possible, the Chairperson shall appoint at least one (1) member from each Service to serve as a member of the Committee and one (1) member who is directly involved in the provision of laboratory services and transfusion practices at the Hospital. The members shall be appointed by the Chairperson of the Medical Staff, subject to the approval of the MEC. Membership shall be for a two year term.

9.13.2 Pharmacy Responsibilities

The duties of the Pharmacy/Therapeutics portion of this committee are to:

a. Develop and evaluate on an ongoing basis pharmacy policies and practices within the Hospital, including, without limitation, drug utilization policies and practices relating to the selection, intra-Hospital distribution and handling, and safe administration of drugs and chemicals.

b. Evaluate and make recommendations to the Pharmacist, Nursing services, and the Medical Staff regarding the choice of drugs to be made available within the Hospital, the stocking of drugs within nursing units and Services, and other matters concerning availability of drugs within the Hospital.

c. Develop and review for adequacy, on an annual or more frequent basis, a formulary or drug list for utilization within the Hospital.

d. Monitor and evaluate possible unnecessary duplication in the stocking of drugs, including availability of drugs and combinations having substantially identical proportions or similar therapeutic ingredients.

e. Review and evaluate clinical data, and formulate recommendations concerning new drugs or preparations requested for availability and use within the Hospital. •

f. Monitor and review all unexplained or untoward drug reactions.

g. Review, evaluate and approve protocols and standards for the use of investigational or experimental drugs and for research in the use of recognized drugs within the Hospital.

h. Review and analyze the clinical use of antibiotics, including, without limitation, establishing criteria for the prophylactic and therapeutic use of antibiotics, reviewing departures from such criteria, and making clinical reviews and statistical prevalence studies of utilization of antibiotics.

i. Document ongoing antibiotic usage review within the Hospital, including findings, conclusions, actions recommended and undertaken, and corrective measures specified.

j. Perform such other duties as may be assigned to it by the Chairperson of the Medical Staff or the MEC.

k. Maintain a record of all activities relating to the pharmacy and therapeutics function and submit periodic reports and recommendations to the MEC concerning drug utilization policies and practices in the Hospital.

l. The term "therapeutics" used in this Section 9.13.2, is considered to include all dietary and total parenteral responsibilities. The Pharmacy and Therapeutics Committee shall be responsible for reviewing special menus and approving the Hospital Dietary Manual and for retrospective reviews of all patients on hyper alimentation.

9.13.3 Laboratory and Transfusion Responsibilities

The duties of the Laboratory and Transfusion portion of this Committee are to:

a. Develop, review and continuously evaluate written policies and procedures to provide that Hospital laboratory services are furnished in a timely and accurate fashion, that accurate records and reports of all laboratory procedures are kept, and that the laboratory operates in accordance with sound medical practice.

b. Continuously review and evaluate the performance of procedures by the Hospital laboratory, and assist in providing consistency with relevant policies, procedures, and standards for the performance of laboratory functions.

c. Undertake such activities and formulate such recommendations for the Chairperson of the Medical Staff, and Board as the committee may deem appropriate and necessary to ensure that the Hospital laboratory operates in accordance with sound medical practice.

d. Continuously review and evaluate blood transfusion practices in the Hospital, evaluation of actual or suspected patient reactions to transfusions, and to the amounts of blood requested, the amounts used, and the amount of waste, if any.

e. Develop and continuously review and evaluate policies relating to transfusions, including, without limitation, formulating policies providing that actual or suspected patient reactions to blood transfusions shall be evaluated and reported on a timely and complete basis.

f. Review and evaluate on a regular basis the performance of specific transfusions within the Hospital to the extent necessary to achieve the provision of quality patient care.

9.13.4 Other Ancillary Services

In addition, to Pharmacy/Therapeutics, Laboratory and Transfusion, the Ancillary Services Committee (if one is established), or the MEC acting as a committee-of-the-whole may also review and evaluate physical therapy, respiratory therapy, or other such services as the Committee (if applicable) or the MEC shall dictate.

9.13.5 Procedures

a. The Committee shall meet as often as necessary to perform its required functions, and at least quarterly.

b. The Committee shall carry out patient specific reviews of transfusions by whatever method it deems appropriate, and as frequently as necessary, but not less than quarterly. Such reviews shall be documented.

c. The Committee shall maintain permanent records of its activities and recommendations, including written reports of all evaluations performed and actions taken, and shall submit such reports to the MEC and Board as frequently as necessary, and at least quarterly.

9.14 TISSUE REVIEW COMMITTEE

9.14.1 Composition

Unless a separate Tissue Review Committee is established, the Tissue Review Committee responsibilities shall be fulfilled by the MEC acting as a committee-of-the-whole. At the discretion of the MEC, members may be appointed and a separate committee established. The members shall be appointed by the Chairperson of the Medical Staff, subject to the approval of the MEC. Membership shall be for a two (2) year term.

9.14.2 Responsibilities

The duties of the Tissue Review Committee shall be to:

a. review all surgical cases where specimens both were or were not removed.

b. analyze indications for surgery and conduct continuing education and utilization review.

c. analyze and evaluate all cases in which major disagreements existed between preoperative and postoperative diagnoses as well as any pathological diagnoses.

d. formulate screening mechanisms, based on pre-determined criteria, for cases in which no specimens were removed.

9.14.3 Procedures

a. The Tissue Review Committee shall meet quarterly, at least four times per year.

b. The Committee shall maintain written records that reflect the results of all evaluations performed and actions taken. The Committee shall report to the MEC and the Board regarding all of its activities and recommendations as often as necessary to perform its functions, and at least quarterly.

9.15 PERFORMANCE (QUALITY) IMPROVEMENT COMMITTEE

9.15.1 Composition

The Performance Improvement Committee functions shall be fulfilled by the Hospital-wide Quality Committee, which includes the MEC, acting as a committee-of-the-whole. At the discretion of the Hospital-wide Quality Committee, members may be appointed and a separate committee established. The members shall be appointed by the Chairperson of the Medical Staff, subject to the approval of the MEC. Membership shall be for a two year term.

9.15.2 Responsibilities

The duties of the Performance Improvement Committee shall be to:

a. Develop a written (Quality) Improvement Plan designed to promote the quality of patient care at the Hospital.

b. Coordinate all Performance Improvement activities throughout the Hospital into a well integrated system.

c. Identify problems and assess their cause and significance.

d. Set priorities for both investigation and resolution.

e. Implement decisions or actions designed to eliminate any significant problems.

f. Monitor to assure that the desired result has been attained.

g. Document the effectiveness of the overall program.

9.15.3 Procedures

a. The Performance (Quality) Improvement Committee shall meet on a monthly basis, at least ten (10) times per year.

b. The Committee shall make a monthly report of its activities and recommendations to the MEC and the Board.

9.16 UTILIZATION REVIEW COMMITTEE

9.16.1 Composition

Unless a separate Utilization Review Committee is established, the Utilization Review Committee responsibilities shall be fulfilled by the Hospital-wide Quality Committee, which includes the MEC, acting as a committee-of-the-whole. At the discretion of the Hospital-wide committee, members may be appointed and a separate committee established.

9.16.2 Responsibilities

The duties of the Utilization Review Committee shall be to:

a. Develop a written utilization review plan that is appropriate to the Hospital and meets the requirements of law, of the Joint Commission on Accreditation of Healthcare Organizations, including without limitation, delineation of the responsibility provisions for review of admissions and of continued Hospital stays, patterns of patient care, discharge planning, data collection and recording and cost-effectiveness and appropriate utilization of healthcare resources.

b. Submit such an approved plan to the MEC, Administration, and Board for review, evaluation and approval.

c. Provide that the utilization review plan is in effect, known to Medical Staff members, and functioning.

d. Conduct such studies, take such actions, submit such reports, and make such recommendations as are required by the utilization review plan, as reviewed and approved by the MEC and the Board of Trustees.

9.16.3 Procedures

a. The Utilization Review Committee shall meet monthly, at least ten times per year and shall maintain a permanent record of its findings, proceedings, and actions.

b. The Committee shall make a monthly report of its activities and recommendations to the MEC and to the Board.

9.17 MORTALITY/MORBIDITY COMMITTEE

9.17.1 Composition

Unless a separate Mortality/Morbidity Committee is established, the Mortality/Morbidity Committee responsibilities shall be fulfilled by the MEC acting as a committee-of-the-whole. At the discretion of the MEC, members may be appointed and a separate committee established. The members shall be appointed by the Chairperson of the Medical Staff, subject to the approval of the MEC. Membership shall be for a two year term.

9.17.2 Responsibilities

The Committee shall conduct a regular review of all deaths occurring in the Hospital.

9.17.3 Procedures

a. The Committee shall meet on an as needed basis, at least ten (10) times per year.

b. The Committee shall maintain a permanent record of all reviews performed and of all recommendations and conclusions resulting there from. An annual report of its findings shall also be submitted to the MEC.

9.18 STANDING COMMITTEES

Standing Committees of the Medical Staff shall consist of those committees named in these Bylaws. Additionally, any Standing Committee subsequently created by action of the Medical Staff, subject to approval of the Board, shall be considered to be a Standing Committee of the Medical Staff for purposes of these Bylaws or for any other purposes.

9.19 SPECIAL COMMITTEES

a. The Chairperson of the Medical Staff, with the approval of the MEC, may appoint such Special Committees as may be necessary to perform the required functions of the Medical Staff.

b. A Special Committee shall be responsible for those specific functions designated by the Chairperson of the Medical Staff, with the approval of the MEC, and shall have such authority as may be necessary to carry out such responsibilities. The authority of a Special Committee shall be limited to that necessary to carry out the special functions for which it was created.

c. A Special Committee shall conduct such meetings, carry out such evaluations, make such findings and recommendations, and undertake such reports to the Chairperson of the Medical Staff, the Executive Committee, and the Board as may be deemed necessary to the performance of its required functions. Upon completion of its required functions, as determined by the MEC and the Board, a Special Committee shall cease to exist.

ARTICLE X. MEETINGS

10.1 GENERAL STAFF MEETINGS

10.1.1 Annual Meeting

a. Business to be transacted: The Medical Staff shall hold an election meeting on an annual basis, which meeting shall be the last regularly scheduled meeting before the conclusion of the Medical Staff Year. The business to be conducted at such meeting shall include, without limitation:

1. Presentation and consideration of reports and recommendations from the current officers of the Staff and from any or all of such committees of the Staff as may desire to make such reports.

2. Such other business as may be deemed appropriate or relevant by the MEC.

3. Notice: written mailed notice of each annual meeting shall be sent to each Active Staff member to the address of each such member appearing on the records of the Staff, and shall be posted not less than twenty (20) days before such meeting. Such notice shall state the place, day, and hour of the meeting.

10.1.2 Regular Meetings

See Section 10.2.1

10.1.3 Notice

The MEC shall provide for written notice of each regular meeting to each member of the Staff. The Staff or the MEC may establish the time for holding regular meetings by resolution, without notice other than such resolution.

a. Order of Business and Agenda

The order of business at a regular meeting shall be determined by the Chairperson of the Medical Staff. The agenda shall include at least:

1. Reading and acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting.

2. Administrative reports from the Chairperson of the Medical Staff, the Administrator, clinical areas and committees.

3. Review and evaluation of continuing education materials prepared by the MEC, clinical area, or any other individual or entity, which materials relate to enhancement of the care of patients within the Hospital.

4. Reports and recommendations from the current officers, committees and clinical areas on the overall results of patient care audit and other quality review, evaluation and monitoring activities of the Staff and on the fulfillment of the other required Staff functions.

5. Recommendations for improving patient care within the Hospital

6. Such other business as may be deemed appropriate or relevant by the MEC and any new business.

7. Adjournment.

10.1.4 Closed Meetings

Executive sessions of the Staff may be conducted by the Active Staff for a part of any Medical Staff meeting or for the entirety thereof. Upon vote of a majority of the Active Staff members present and voting, all persons other than Active Staff members, the members of the Board and the Administrator, may be so excluded from Medical Staff meetings.

10.2 COMMITTEE MEETINGS

10.2.1 Regular Meetings

Committees and departments may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall then be required. The frequency of such meetings shall be as required by these Bylaws.

10.2.2 Special Meetings

A special meeting of any committee may be called by, or at the request of, the Chairman thereof, the Board, the Chairperson of the Medical Staff, or by two-thirds (2/3) of the group's current members. No business shall be transacted at any special meeting except that stated in the meeting notice.

10.2.2 Notice

Written or oral notice stating the place, day, and hour of any regular or special meeting, except a meeting held pursuant to resolution, shall be given by the person or persons calling the meeting, to each member of the committee or department that is to meet, not less than ten (10) days before the date of such meeting. If mailed, the notice of the meeting shall be posted to the member, at his/her address as it appears on the records of the Hospital, at least ten (10) days before the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

10.3 QUORUM

10.3.1 Annual Meeting

The presence of fifty percent (50%), plus one or more of the total membership of the Active Staff shall constitute a quorum at any annual meeting.

10.3.2 General and Special Staff Meetings

The presence of fifty percent (50%) plus one of the voting members of the Active Medical Staff at any regular or special meeting shall constitute a quorum for the transaction of all business.

10.3.3 Committee Meetings

Fifty percent (50%), plus one of the voting members of a committee, but not less than two members, shall constitute a quorum at any meeting of such department or committee.

10.4 MANNER OF ACTION

Except as otherwise specified, the action of a majority of which the members present and voting at a meeting at which a quorum is present shall be the action of the Staff. Action may be taken without a meeting by a department or committee by a unanimous written consent setting forth the action so taken and signed by each member who would be entitled to vote at that meeting.

10.5 AGENDA

10.5.1 Regular Staff Meetings

The agenda at any regular meeting shall be as set forth in Section 10.1.3(a).

10.5.2 Special Meetings

The agenda at special meetings shall be as follows:

a. Reading of the notice calling the meeting.

b. Transaction of the business for which the meeting was called.

c. Adjournment

10.6 MINUTES

Minutes of all meetings shall be prepared by the secretary of the meeting and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer, approved by the attendees and forwarded to the MEC. A permanent file of the minutes of each meeting shall be maintained in the Medical Staff office.

10.7 ATTENDANCE REQUIREMENTS

10.7.1 Regular Attendance

Each member of the Active Staff is required to attend:

a. the annual Medical Staff meeting.

b. at least four meetings per calendar year and may be met by one representative of a group practice of all other general Medical Staff meetings duly convened pursuant to these Bylaws.

c. at least fifty percent (50%) of all meetings of each department and committee of which he/she is a member.

10.7.2 Courtesy Staff

Members of the Courtesy Staff shall not be required to attend Medical Staff meetings, but it is expected that they will attend and participate in these meetings unless they are unavoidably prevented from doing so.

10.7.3 Absence from Meeting

Any member who is compelled to be absent from any Medical Staff, department or committee meeting shall promptly provide to the regular presiding officer thereof, the reason for such absence. Unless excused for good cause, failure to meet the attendance requirement of Section 10.7.1 may be grounds for any other corrective actions specified in Section 6.3.3 and including, in addition removal from such department or committee. Reinstatement of a Staff member's whole membership after having been revoked because of absence from meetings, shall be made only on application, and any such application shall be processed in the same manner as an application for initial appointment.

ARTICLE XI. CONFIDENTIALITY, IMMUNITY AND RELEASES

11.1 SPECIAL DEFINITIONS

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

a. INFORMATION means records of proceedings, minutes, records, reports, memoranda, statements, recommendations, data and other disclosures whether in written or oral form relating to any of the subject matter specified in Section 11.4.2

b. MALICE means the dissemination of a known falsehood or of information with a reckless disregard for whether or not it is true or false.

c. PHYSICIAN means a Staff member or applicant or an Allied Health Professional.

d. REPRESENTATIVE means a board and any director or committee thereof; a Administrator or his/her designee; a Medical Staff organization and any member, officer, service or committee thereof, and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

e. THIRD PARTIES means both individuals and organizations providing information to any Representative.

11.2 CONFIDENTIALITY OF INFORMATION

Information with respect to any Physician submitted, collected or prepared by any Representative of this or any other healthcare facility or organization or medical staff for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality, or contributing to clinical research shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a Representative nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to Information of like kind that may be provided by Third Parties. This Information shall not become part of any particular patient's file or of the general Hospital records.

Additionally, each member of the Medical Staff agrees to maintain as confidential all information and documents related to patients' condition or treatment, peer review, performance improvement and evaluation, risk management, utilization review, and other information related to the evaluation of the provision of health care, or actions or conduct of health care providers. Failure to maintain the confidentiality of confidential information shall be grounds for immediate suspension and/or termination of Medical Staff membership and clinical privileges.

11.3 IMMUNITY FROM LIABILITY

11.3.1 For Action Taken

No Representative of the Hospital, the Hospital itself, or Medical Staff shall be liable to a Physician for damages or other relief for any action taken or statement or recommendation made within the scope of his/her duties as a Representative, if such Representative acts after a reasonable effort under the circumstances to ascertain the truthfulness of the facts and in a reasonable belief that the action, statement, or recommendation is warranted by such facts. Regardless of the provisions of State law, truth shall be an absolute defense in all circumstances.

11.3.2 For Providing Information

No representative of the Hospital or Medical Staff and no Third Party shall be liable to a Physician for damages or other relief by reason of providing Information, including, otherwise privileged or confidential information to a Representative of this Hospital or Medical Staff, or to any other healthcare facility or organization of health professionals concerning a Physician or Allied Health Professional who is, or has been, an applicant to, or member of, the Staff or who did or does exercise Clinical Privileges or provide specified services at this Hospital.

11.4 ACTIVITIES AND INFORMATION COVERED

11.4.1 Activities

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other healthcare facilities or organization's activities concerning, but not limited to:

a. applications for appointment, Clinical Privileges or specified services.

b. periodic reappraisals for reappointment, Clinical Privileges or specified services.

c. corrective action.

d. hearings and appellate reviews.

e. patient care audits.

f. utilization review.

g. other Hospital, department, committee or Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

11.4.2 Information

The acts, communications, reports, recommendations, disclosures and other information referred to in this Article may relate to a Physician's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

11.5 RELEASES

Each Physician shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith, absence of malice and exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of Texas. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

11.6 CUMULATIVE EFFECT

Provision in these Bylaws and in application forms relating to authorization, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof, and in the event of conflict, the applicable law shall be controlling.

ARTICLE XII. GENERAL PROVISIONS

12.1 STAFF RULES AND REGULATIONS

Subject to approval by the Board, the Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found in these Bylaws. 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 Physician or Allied Health Professional in the Hospital. Such Rules and Regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Board.

12.2 PROFESSIONAL LIABILITY INSURANCE

Each Physician in the Hospital shall maintain in force professional liability insurance in not less than the minimum amounts, if any, as from time to time may be determined by the Board. A current Certificate of Insurance for the professional liability insurance must be provided to the Administrator which shall indicate that the insurance carrier will provide to the Hospital not less than thirty (30) days' advance written notice of any changes to or cancellation of such insurance. Failure to provide a current Certificate of Insurance shall result in the automatic suspension of the Physician pursuant to Section 6.3.4. Subject to the approval of the Board, the MEC may, for good cause shown by a Physician, waive this requirement with regard to such Physician provided that any such waiver is not granted or withheld on an arbitrary, discriminatory or capricious basis.

In determining whether an individual exception is appropriate, the following factors may be considered:

a. whether the applicant has applied for the requisite insurance.

b. whether he/she has been refused insurance, and if so, the reasons for such refusal.

c. whether insurance is available to the applicant, and if not, the reasons for its unavailability.

d. whether there is an available alternative means of assuring that the applicant possesses satisfactory financial solvency in the event he/she is sued as a defendant in a civil action or actions involving his/her professional capability.

12.3 WAIVER

Waiver The Hospital Board of Directors may, after considering the recommendations of the Medical Executive Committee and any appropriate department chairs, waive any of the

requirements for Medical Staff membership and clinical privileges established pursuant to these Bylaws or the rules and regulations of the Medical Staff or any department or division for good cause shown if the Board determines that such waiver is necessary to meet the needs of the Hospital and the community it serves. The refusal of the Board of Directors to waive any requirement shall not entitle any practitioner to a hearing or any other rights of review.

12.4 FORMS

Application forms and any other prescribed forms required by these Bylaws for use in connection with Staff appointments, reappointments, delineation of Clinical Privileges, corrective action, notices, recommendations, reports, and other matters shall be subject to adoption by the Board after considering the advice of the MEC.

12.5 CONSTRUCTION OF TERMS AND HEADINGS

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

12.6 TRANSMITTAL OF REPORTS

Reports and other information which these Bylaws require the Medical Staff to transmit to the

Board shall be deemed so transmitted when delivered, unless otherwise specified, to the Administrator.

12.7 CREDENTIAL FILES

a. A separate credential file shall be maintained for each Physician and Health Professional Affiliate on the Staff.

b. All credential files are the property of the Hospital and shall not be removed from the Hospital’s office without authorization.

c. Credential files may be reviewed by clinical departments, Medical Staff committees and/or the Board and the MEC as may be required to conduct quality and utilization review, credentialing and privileging, and/or quality of care monitoring studies.

d. No individual Physician shall have the right to inspect the credentials of another except as outlined in item (c) above.

12.8 MEDICAL STAFF GOVERNANCE DOCUMENTS AND CONFLICT MANAGEMENT

12.9 AUTHORITY; MEDICAL STAFF BYLAWS CONTROL

12.9.1 The Medical Staff shall adopt, using the procedures below, Rules and Regulations, a Fair Hearing and Appellate Review Plan and other Policies as may be necessary to implement the processes and requirements set out in these Bylaws. The Rules and Regulations, and Policies shall be reviewed periodically to ensure compliance with legal and accreditation requirements and current Medical Staff practice.

12.9.2 Any documents adopted pursuant to this Article shall be subject to and governed by these Bylaws. The definition in these Bylaws shall be applicable to the Rules and Regulations, and Policies, although they may include additional definitions. In the event of a conflict between the Rules and Regulations, or a Policy and the Medical Staff Bylaws, these Bylaws shall control.

12.10 ADOPTION AND AMENDMENT OF RULES AND REGULATIONS

12.10.1 By MEC

12.10.1.1 Regular Amendment. The Rules and Regulations may be adopted or amended at a regular meeting (or a special meeting called for such purpose) of the MEC; provided that, at least 20 days prior to the meeting, the MEC must notify the Medical Staff of the proposal. The notice shall advise the Members of the opportunity and procedures to submit written comments on the proposal to the MEC for their consideration prior to voting on the proposal. Adoption of amendment shall require the affirmative vote of majority of the voting members present at a meeting of the MEC. The approved amendments shall be made available to the Members of the Medical Staff. (The procedures for management of continued conflict between the Medical Staff and the MEC on the approved amendment are set out below in Section 12.11).

12.10.1.2 Urgent Amendment. In cases of a documented need for an urgent amendment of the Rules and Regulations to comply with a law or regulations, the MEC may provisionally adopt or amend the Rules and Regulations and forward it to the Board of Directors for approval without prior notification of the Medical Staff as required above. In such case, the Members of the Medical Staff shall be notified of the amendment after approval. The notice shall advise the Members of the opportunity and procedures to submit written comments on the proposal to the MEC within 10 days of the notice. The procedures for invoking the conflict management process are set out in Section 12.11 below. If the conflict management process is not invoked, no further action is required.

12.10.2 By Medical Staff. The Rules and Regulations may be adopted or amended at a regular meeting (or special meeting called for such purpose) of the Medical Staff or by mail ballot. To be submitted for a vote, a written petition setting out the proposed amendment or changes and signed by at least 33% of the Members of the Organized Medical Staff must first be

filed in the Medical Staff Services Office. Adoption or amendment at a meeting shall require a two-thirds affirmative vote of the Members of the Organized Medical Staff present at a meeting where a quorum of at least 20% of the members of the Organized Medical Staff are present; provided that, the Medical Staff has been notified of the proposal at least 20 days prior to the meeting. The procedures for mail ballot are set out in Section _13.7and adoption or amendment shall require voting by at least 30% of the members of the Organized Medical Staff and a two-thirds affirmative vote of those voting. A copy of the proposal must also be submitted to the MEC through the Medical Staff Services Office within the same time frame and the comments of the MEC presented at the Staff meeting prior to the vote or with the mail ballot.

12.11 CONFLICT MANAGEMENT PROCESS

12.11.1 In the event of disagreement between the Medical Staff and the MEC on adoption or amendment of the Rules and Regulations under Section 12.10 above, implementation of the following conflict management procedures may be requested by submission of a written petition signed by at least 33% of the Members of the Organized Medical Staff within 10 days of the MEC's affirmative vote on the proposal under Section 12.10.1.1 or notice to the Medical Staff of the urgent amendment under Section 12.10.1.2. The petition must identify the specific disagreement with the amendment and identify at least two Members of the Organized Medical Staff who have signed the petition and will serve as representatives of the Medical Staff on this disagreement.

12.11.2 On request under Section 12.11.1, the MEC shall call a special meeting of the MEC, inviting at least the two representative Members identified, to discuss the disagreement or conflict. The MEC, with the approval of the Hospital CEO, may use the services of a facilitator or mediator at the meeting. The MEC and the Members attending the special meeting will exchange information relevant to the issue and work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership of the MEC, and the safety and quality of patient care delivered at the Hospital. Within five days of the conclusion of the meeting, the MEC will reconsider the proposed change, take a new vote on the issue at a regular or special called meeting, and provide the Medical Staff with notice of the new vote. There shall be no further right to the conflict management process once the new vote is taken.

12.12 ADOPTION AND AMENDMENT OF MEDICAL STAFF POLICIES

12.12.1 Adoption or amendment of a Medical Staff Policy may be accomplished:

12.12.1.1 On the affirmative vote of a majority of the members of the MEC at a regular or special meeting of the MEC at which a quorum is present; or

12.12.1.2 By the Medical Staff using the procedures in Section 12.10.2 above.

12.12.2 On approval or adoption of a Policy by the MEC, notice of the Policy shall be provided to the Medical Staff. The conflict management process shall be implemented on

submission of a written petition signed by at least 33% of the Members of the Organized Medical Staff within 10 days of the provision of notice of the Policy to the Medical Staff.

12.13 APPROVAL BY BOARD OF DIRECTORS

The Rules and Regulations, and any amendments thereto, shall be effective only on approval by the Board of Directors. Policies shall be effective on approval by the Medical Staff or MEC in accordance with the procedures in Section 12.12; provided that Policies dealing with Medical Peer Review activities shall require approval by the Board of Directors and not be effective until so approved. The Medical Staff complies with and enforces the Rules and Regulations, and Policies approved as provided by this Article, and the Board of Directors upholds those documents it approves.

12.14 NOTICE TO MEDICAL STAFF

Any notices to the Medical Staff required by this Article 12 shall be deemed effective when sent by mail or electronic transmission using the contact information currently on file in the Medical Staff Services Office at the time of the notice.

12.15 TECHNICAL CORRECTIONS

Corrections that are strictly limited to correcting typographical or inadvertent errors or updating references in the Rules and Regulations, or Policies, such as titles of positions or names of policies, that do not involve a substantive change may be made by the Medical Staff Services Office, with the approval of the Co-Chairs of the MEC, without the necessity of compliance with the procedures in this Article.

12.16 PROHIBITION ON UNILATERAL AMENDMENT

Except as noted under Section 12.12 for certain Medical Staff policies, neither the Medical Staff, nor the Board of Directors may unilaterally adopt or amend the Rules and Regulations, or a Policy.

ARTICLE XIII. ADOPTION AND AMENDMENT OF MEDICAL STAFF BYLAWS

13.1 ADOPTION

1. Amendments shall be effective when approved by the Medical Executive Committee (MEC) and then the Governing Board or the Chief Executive Officer acting for the Governing Board.
2. To be adopted, an amendment must receive a majority of the votes cast by the voting Staff who are present at the time of such vote and who do vote.
3. Amendments so adopted shall be effective when approved by the board

13.2 AMENDMENTS

1. The Medical Staff Bylaws shall be reviewed at least every two years by a committee appointed by the Chair of the Medical Executive Committee (MEC).
   a. Amendment an Initiation of the Medical Staff. Subject to approval by the Board of Directors, these Medical Staff Bylaws may be amended by the Medical Staff at any regular annual meeting or any special meeting provided that a copy of the proposed amendment(s) as approved by the Medical Executive Committee has been distributed to each Medical Staff member at least thirty (30) days in advance of such meeting. Amendments to be adopted must be approved by affirmative vote of a majority of the Medical Staff present after the existence of a quorum has been established. Any amendments to these Medical Staff Bylaws adopted by the Medical Staff shall become effective when approved by the Board of Directors.

   b. Amendment at Initiation of Board of Directors. These Medical Staff Bylaws may be amended by the Board of Directors at any regular or special meeting of the Board of Directors. A copy of any proposed amendment(s) to these Medical Staff Bylaws shall be distributed to each member of the Medical Staff at least thirty (30) days in advance of the meeting at which the Board of Directors proposes to take final action thereon. Any amendments approved by the Board of Directors also shall require approval by the Medical Staff as provided herein. Any amendments to these Medical Staff Bylaws adopted by the Board of Directors shall become effective when notice is given to the Medical Staff.

2. Major changes in the bylaws will necessitate a rewriting of the bylaws which will be distributed to the Medical Staff. Minor changes will be distributed with the “old” version along with the “new” version. This will be the duty of the Secretary of the Medical Staff.

3. Neither the Medical Staff nor the Governing Body shall unilaterally amend the Medical Staff Bylaws, Rules and Regulations.

4. REFERRED TO MEDICAL EXECUTIVE COMMITTEE
   a. All proposed amendments of these Bylaws initiated by the Medical Staff shall, as a matter of procedure, be referred to the Medical Executive Committee.

5. REPORT TO MEDICAL STAFF

a. The Medical Executive Committee shall report on them either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose.

6. VOTE BY MEDICAL STAFF AND ADOPTION
   a. They shall be voted upon at that meeting provided that they shall have been posted on the Medical Staff Bulletin Board, electronic or written at least 14 days prior to the meeting.

7. NOTICES TO MEDICAL STAFF
   a. Any notices to the Medical Staff required by this Article 13 shall be deemed effective when sent by mail or electronic transmission using the contact information currently on file in the Medical Staff Services Office at the time of the notice.

   b. TECHNICAL CORRECTIONS

      Corrections that are strictly limited to correcting typographical or inadvertent errors or updating references in the Medical Staff Bylaws, such as titles of positions or names of policies, that do not involve a substantive change may be made by the Medical Staff Services Office, with the approval of the Co-Chairs of the MEC, without the necessity of compliance with the procedures in this Article.

   c. PROHIBITION ON UNILATERAL ADOPTION OR AMENDMENT

      Neither the Medical Staff, the MEC, nor the Board of Directors may unilaterally adopt or amend these Medical Staff Bylaws.

   d. ADOPTION AND EFFECTIVE DATE

      These Bylaws and any amendments pursuant to this Article shall become effective only upon the date of approval by the Board of Directors. The Bylaws and any amendments shall replace and superseded all previous medical staff bylaws and be upheld by the Board of Directors. The Medical Staff, individual Members of the Medical Staff, and applicants for Medical Staff membership and/or clinical privileges shall comply with and enforce the Medical Staff Bylaws, which shall be distributed to Members and applicants.

ARTICLE XIV. PHYSICIAN HEALTH

The Medical Staff will implement a process to identify and manage matters of individual physician health that is separate from the Medical Staff disciplinary function. In general, this process is to provide education about physical health, address prevention of physical psychiatric or emotional illness and facilitate confidential diagnosis, treatment and rehabilitation of physicians who suffer from a potentially impairing condition.

The purpose of the process is assistance and rehabilitation, rather than discipline, to aid a physician in retaining or regaining optimal professional functioning, consistent with protection of patients. If at any time during the diagnosis, treatment, or rehabilitation phase of the process, it is determined that a physician is unable to safely perform the privileges he or she had been granted, the matter is forwarded to Medical Staff leadership for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.

Process design should include mechanisms for the following:

- Education of the Medical Staff and other organization staff about illness and impairment recognition issues specific to physicians;
- Self-referral by a physician and referral by other organization staff;
- Referral of the affected physician to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern;
- Maintenance of the confidentiality of the physician seeking referral or referred for assistance, except as limited by law, ethical obligation, or when the safety of a patient is threatened;
- Evaluation of the credibility of a complaint, allegation, or concern;
- Monitoring of the affected physician and the safety of patients until the rehabilitation or any disciplinary process is complete; and
- Reporting to the Medical Staff leadership instances in which a physician is providing unsafe treatment.

ADOPTED EFFECTIVE THIS 22nd DAY OF AUGUST, 2014.

_____

KIM FOREMAN, M.D., CHIEF OF STAFF

_____

TONY WAHL, CEO