

RULES AND REGULATIONS
Texas Spine and Joint Hospital, L.L.P.
Medical Staff

Pursuant to Section 12.1 of the Medical Staff Bylaws of Texas Spine and Joint Hospital, L.L.P. (“Hospital”), the following are adopted as the Rules and Regulations replacing all previous such Rules and Regulations subject to the approval and ultimate authority of the Board of Directors (“Board”) of the Hospital.

1. Admission and Discharge of Patients

1.1. A patient may be admitted to the Hospital and treated only by Physicians who have been duly appointed to membership on the Medical Staff, and granted clinical privileges by the Board.

1.2. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions and for transmitting reports of the condition of the patient to the referring Physician and to relatives of the patient with patient permission. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical records.

1.3. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency such statement shall be recorded within twenty four hours after admission of the patient.

1.4. Physicians admitting emergency cases shall be prepared to justify to the Medical Executive Committee (“MEC”) and the administration of the Hospital that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on the emergency basis and these findings must be recorded on the patient’s chart as soon as possible after admission, but within twenty four hours.

1.5. A patient who is to be admitted on an emergency basis that does not have a private Physician may select any consenting Physician in the applicable department or service to attend him. Where no such selection is made, a member of the Active or Provisional staff on duty in the department or service will be assigned to the patient, on a rotation basis, where possible. The chairman of each department shall provide a schedule for such assignments.

1.6. A patient who is to be admitted shall be admitted on the basis of the following orders of priorities and regulations;

(a) Emergency Admissions

Within twenty four hours following an emergency admission, the attending Physician shall document the need for this admission on patient’s medical records. History and physical examination shall suffice.

Failure to furnish this documentation, or evidence of willful or continued misuse of this category of admission, will be brought to the attention of the MEC for appropriate action.

(b) Pre-operative Admissions

Except in an emergency, patients scheduled for operations shall be instructed to appear for admission in the Hospital so as to allow time for pre-operative evaluation procedures. Patients scheduled for minor surgery may be admitted the day of surgery. Day surgery patients should be admitted at least two hours prior to their surgical procedure.

(c) Routine Admissions

1.7. Areas of restricted bed utilization and assignment of patients shall be in accordance with approved recommendations of the MEC and specified in Hospital policy. Patients may be admitted without regard to the above restrictions only after consultation with the service chief or his designee of the geographic area to which the patient is to be admitted. It is understood that when deviations are made from assigned areas, as indicated above, the admitting office will correct these assignments at the earliest possible moment, in keeping with transfer policies.

1.8. Patient transfers. Transfer priorities shall be as follows:

- (a) Emergency Room to appropriate patient bed;
- (b) From temporary placement in an appropriate geographic or a clinical service area to the appropriate area for that patient.

No patient will be transferred without such transfer being approved by the responsible Physician.

1.9. The admitting Physician shall be expected to give such information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever his patients might be a source of danger from any cause whatever.

1.10. For the protection of patients, the medical and nursing staffs and the Hospital, certain principles are to be met in the care of the potentially suicidal patient. Any patient developing suicidal intent after admission to the Hospital shall be transferred to the facility of their choice, as appropriate, where suitable facilities are available.

1.11. INTENTIONALLY LEFT BLANK

1.12. The attending Physician is required to document the need for continued hospitalization after specific periods of stay as identified by the Utilization Review Committee of this Hospital which is a section of the Hospital Performance Improvement Committee and Physician's Quality Improvement Committee, and approved by a particular clinical department and the MEC. This documentation must contain:

- (a) An adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.
- (b) The estimated period of time the patient will need to remain in the Hospital.
- (c) Plans for post-hospital care.

Upon request of the Utilization Review Committee, the attending Physician must provide written justification of the necessity for continued hospitalization of any patient hospitalized, including an estimate of the number of additional days of stay and the reason therefore. This report must be submitted within twenty four hours of receipt of such request. Failure of compliance with this policy will be brought to the attention of the MEC for action.

1.13. Patients shall be discharged only on order of the attending Physician. Should a patient leave the Hospital against the advice of the attending Physician, or without proper discharge, a notation of same shall be made in the patient's medical record.

1.14. To facilitate the orderly and efficient operation of the Hospital, it shall be the responsibility of the attending Physician to discharge his patients as soon as possible on the day of discharge.

1.15. Death. In the event of a death in any area of the Hospital, unless the Physician has knowledge that at the time of death there is incontrovertible and/or irreversible terminal disease, or one of the communicable diseases listed in 1.17, the Hospital's approved protocols for identifying potential organ and tissue donors as mandated by the Uniform Anatomical Gift Act and the Texas Anatomical Gift Act shall be adhered to.

1.16. In all cases, pronouncement of death shall be by the attending Physician, or his designee. The body shall not be released until an entry has been made and signed in the medical record by the Physician. Exceptions to this are instances as described above, or in 1.17, where the patient's care has been fully documented to within a few hours of death.

1.17. If a Physician has knowledge that a person had at the time of death one of the following diseases:

- (a) Acquired Immune Deficiency Syndrome
- (b) Anthrax
- (c) Viral Hepatitis
- (d) Plague

- (e) Rabies
- (f) Rocky Mountain Spotted Fever
- (g) Syphilis
- (h) Tuberculosis
- (i) Tularemia, or
- (j) Viral Hemorrhagic Fever,

the Physician shall affix, or cause to be affixed, a tag on the deceased, preferably on a great toe, that shall include the words "Communicable Disease, Blood/Body Fluid Precautions Required." Policies with respect to the application of tags to deceased patients, post mortem handling of the deceased patients, and the release of a body, regardless of cause of death, shall conform to local and state laws and regulations and the documentation of the funeral director's name and state issued identification number.

1.18. Autopsy. It shall be the duty of all staff members to secure autopsies whenever possible. An autopsy may be performed only with a written consent, signed in accordance with Texas law. All autopsies shall be performed by the Hospital consultant pathologist or the Physician delegated this responsibility. Provisional anatomic diagnoses shall be recorded on the medical record within seventy two (72) hours. The complete protocol should be made a part of the record within sixty (60) days unless exceptions for special studies are established by the MEC.

2. Medical **Records**

2.1. The attending Physician shall be responsible for the preparation of a complete medical record for each patient. The patient's medical record should be pertinent and current and may well contain such items as identification data, patient complaints, elements of personal history; family history; history of present illness; physical examination; special reports such as consultations, clinical laboratory and radiology services; and as well a provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; summary or discharge note; clinical resume; and the autopsy report when performed.

2.2. A complete history and physical examination shall be completed no more than thirty (30) days before or within twenty-four (24) hours after admission. When the exam has been completed within 30 days prior to admission, there should be a note documenting any changes in the patient's condition. A durable, typed copy of a complete history and physical examination done before the patient is admitted may be used in the Hospital record, providing the history and physical examination was done by a member of this Hospital's staff. When non physicians have documented aspects of a physician examination or gathered a patient's medical history, the responsible physician shall appropriately authenticate this information prior to the procedure. In elective surgery, the history and physical must be recorded and available for the medical record prior to surgery.

2.3. Prior to emergency surgery the admitting Physician should enter in the progress notes an admitting note to include indications for surgery and pertinent physical findings.

2.4. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least daily on critically ill patients and those where there is difficulty in diagnosis or management of the clinical problem.

2.5. Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports shall be dictated as soon as possible following surgery for outpatients as well as inpatients and the report promptly signed by the surgeon and made a part of the patient's current medical record.

Additionally, a summary of findings should be placed in the chart stating:

- a. Procedure performed;
- b. Any complications;
- c. Any blood loss;
- d. Specimens;
- e. Length of time of the procedure; and
- f. the Assistant Surgeon (if any).

2.6. Consultations shall show evidence of review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

2.7. All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated by signature or initials.

2.8. Symbols or abbreviations on the Do Not Use list cannot be used.

2.8.1. The use of a signature stamp is prohibited.

2.9. Final diagnoses shall be recorded in full, without the use of symbols or abbreviations by the responsible Physician at the time of discharge of all patients except those abbreviations on file with the Hospital Medical Records Office and only if such information is available. This will be deemed equally as important as the actual discharge order.

2.10. The discharge summary should summarize the reason for hospitalization; the significant findings; the procedures performed and treatment rendered; the condition of the patient on discharge; and any specific instructions given to the patient and/or family, as pertinent. Consideration should be given to instructions relating to physical activity, medication, diet, and follow-up care. A final progress note may be substituted for the discharge summary in the case of patients with problems of a minor nature who require less than a forty eight (48) hour period

of hospitalization and should include any instructions given to the patient and/or family.

2.11. All medical records are the property of the Hospital and may be removed from the jurisdiction of the Hospital only in accordance with a court order, subpoena or statute. In case of readmission of a patient, all previous records shall be available for the use of the current attending Physician. Unauthorized removal of charts from the Hospital is grounds for suspension of the Physician for a period to be determined by the MEC.

2.12. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

2.13. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the MEC before records can be studied. Subject to the discretion of the Administrator, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

2.14. A medical record shall not be permanently filed until it is completed by the responsible Physician or is ordered to be filed as complete by the Medical Record Committee. Incomplete medical records due to a Physician being deceased or Unavailable permanently or for a prolonged period of time, will be reviewed by the Medical Record Committee. The Medical Record Committee may declare the medical records complete for the purposes of filing. A statement to this effect must be signed by a physician member of the Medical Record Committee and filed with the chart.

2.15. A Physician's preprinted order, when indicated by the appropriate department or committee of the Medical Staff and submitted to the MEC for approval, may be formulated. All new preprinted orders, as well as changes, must be approved in the same manner. When applicable to a given patient, these preprinted orders shall be followed insofar as proper treatment of the patient will allow, and shall constitute the orders for treatment until specific orders are written for and signed by the attending Physician. Preprinted orders must be dated, timed, and authenticated within twenty four hours.

2.16. Medical records shall be completed as follows:

- (a) All deficiencies beyond 30 days of discharge date are considered delinquent. If the Physician has not completed his records by the end of the 30 days, his admitting privileges will be denied until his records are completed.
- b) Three (3) such suspensions of admitted privileges within any twelve (12) month period shall be sufficient cause for permanent suspension of privileges in the Hospital for that Physician.

3. General Conduct of Care

3.1. A general consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. The admitting officer should notify the attending Physician whenever such consent has been refused by the patient. When so notified, it shall, except in emergency situations, be the Physician's obligation to obtain proper consent before the patient is admitted to the Hospital. Specific information regarding any further special or surgical procedure and the risks associated with it must be disclosed to the patient, in order to allow the patient to give informed consent for the procedure specified.

3.2. Verbal orders are strongly discouraged. If necessary, a verbal order shall be considered to be in writing if dictated to a licensed certified personnel in the following areas: a licensed nurse, licensed dietitian, pharmacist, Physician Assistant, Nurse Practitioner, certified registered nurse anesthetist, radiology technician, occupational therapist, physical therapist, speech therapist, social worker, therapeutic recreational specialist and respiratory care practitioner. The above noted certified personnel will indicate Physician issuing the order and attending Physician shall authenticate such orders at next visit, and the failure to do so shall be brought to the attention of the MEC.

3.3. The Physician's orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the appropriate staff.

3.4 The Physician may transmit orders and instructions to a department/service of the Hospital by telefax (facsimile machine) when it is deemed the most practical method at the time and provided it contains all the proper elements otherwise required of a proper order and comes to the unit in good and legible form signed by the Physician. Any problem of legibility is Physician's responsibility. Any such transmission shall be maintained as a part of the medical record.

3.5. All previous orders are canceled when patients go to surgery.

3.6. All drugs and medications administered to patients shall be those listed in the latest edition of the United States Pharmacopoeia, the National Formulary, The American Hospital Formulary Service of the A.M.A. Drug Evaluations; or that have been approved by the Food and Drug Administration of the Texas Department of Health. Drugs for approved clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals, and all regulations of the Food and Drug Administration.

3.7. Drug orders to be filled by the Hospital pharmacy may be filled with generically equivalent drugs with equal bioavailability from the approved Limited Drug List, unless otherwise specified by the ordering Physician.

3.8. All non-emergency intravenous antibiotics, and other intravenous medications normally administered by intermittent intravenous infusion, will be mixed in the Pharmacy under a laminar flow hood, and will be prepared by using small volume “piggyback” bottles of solutions for injection, according to the standard dilutions shown in the Piggyback Dilution Chart. This policy will apply unless other directions for administration are prescribed by the Physician ordering the medication.

3.9. All medications for patients in the Hospital are supplied by the Hospital pharmacy. Any medications brought with the patient for continued use in the Hospital should be duly recorded by the Physician and placed in the custody of the pharmacy department until the patient is dismissed.

3.10. There is an automatic stop-order after five days for Schedule II controlled drugs, and ten days for Schedule III, IV and V drugs, anticoagulants, antibiotics, tranquilizers and cortisone preparations. All other drug orders shall expire on the fourteenth day thereafter. If medication is ototoxic, the order therefore will expire after twenty four (24) hours. In all cases, however, the ordering Physician will be notified prior to discontinuance of such medication and Physician will then discontinue or reorder the medication.

3.11. Any qualified Physician with clinical privileges in this Hospital can be called for consultation within his area of expertise.

3.12. A consultation shall not be complete or acceptable unless it includes an examination of the patient and the patient’s record and a written opinion signed by the consultant and attached to the record. When consultation is requested, the consultant shall be called by the attending Physician or designee.

3.13. The attending Physician is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant.

3.14. Except in an emergency, consultation is required in the following situations:

- (a) When the patient is not a good risk for operation or treatment;
- (b) Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;
- (c) Where there is doubt as to the choice of therapeutic measures to be utilized;
- (d) In unusually complicated situations where specified skills of other Physicians may be needed;
- (e) In instances in which the patient exhibits severe psychiatric symptoms;
- (f) When requested by the patient or his family;

- (g) If consultation is done primarily to fulfill Hospital policy, it should be undertaken free of charge to the patient.

3.15. If a nurse has any reason to doubt or question the care provided to any patient, or believes that appropriate consultation is needed and has not been obtained, the nurse shall call this to the attention of the supervisor, who in turn may refer the matter to the Director of Nurses or the Administrator, who may bring the matter to the attention of the Chief of Staff. If warranted, the Charge Nurse or Floor Supervisor may bring the matter to the attention of the chairman of the department wherein the Physician has clinical privileges. Where circumstances are such as to justify such action, the chairman of the department or any member of the Medical Staff may request a consultation.

3.16. All Physician's Assistants and Technicians (AHPs) who are either in the employ of a private Physician or whom he brings in for either teaching or assisting purposes are the direct responsibility of that individual Physician.

3.17. All clinical laboratory procedures ordered by the Physician shall be performed in the Hospital laboratory if such procedures are available. Laboratory procedures not available in the Hospital laboratory may be referred only to laboratories recommended by the Chairman of the Department of Pathology and approved by the MEC.

3.18. Diagnostic and therapeutic radiology services shall be maintained and directed by one or more qualified radiologists. Performance and interpretation of radiological examinations should be made by a qualified radiologist whose name shall be specified in the written order for the examination by the referring Physician except as otherwise provided herein. Privileges to perform specific limited interpretive diagnostic and monitoring radiological studies may be granted to staff Physicians who are not radiologists, but they should have special and particular qualifications, training and experience as to those studies, their interpretations and the use of the equipment used to make the studies as well as practice in a field of related diagnostic/therapeutic activities and particular privileges granted by the Medical Staff. Credentials files of all Physicians thus engaged shall reflect the training, experience and current competence required for the aspects of radiological services for which they are engaged. The reports made of any radiographic studies shall be made in triplicate, one copy to be attached to the patient's record, one sent to the attending Physician, and one filed in the Radiology Department. Only personnel designated as qualified by the medical staff may use radiation equipment (MRI, CT Scanners, X-ray equipment) and must do so in accordance with Hospital policies and procedures.

3.19. All requests by the attending Physician for radiographic examination shall contain a concise statement of reason for the examination.

3.20. Subjects for the educational programs shall be chosen by either the Continuing Education Committee or the MEC and may include clinical material of this Hospital. Either the record Administrator or quality improvement coordinator shall assist in the selection and preparation of cases to be presented either as clinical-pathological conferences or case studies.

3.21. Electrocardiography:

- (a) The ECG (electrocardiography) laboratory shall be operated under the direction of the Chief of Staff.
- (b) Interpretation of the tracings of an electrocardiogram is a privilege that may be granted to a Physician by the credentialing process prescribed by the Medical Staff Bylaws, which includes a written and oral examination.
- (c) Request for ECG examination shall include the selection of a Physician on the approved list to be the interpreter.
- (d) ECGs shall be read within twenty four (24) hours. If not read within twenty four (24) hours after performed, the ECG shall be placed in the Physician's box on ER/ECG rotation for that day.

3.22. INTENTIONALLY LEFT BLANK.

3.23. Any member of the Medical Staff, when unavailable to care for his patients due to absence from the city for whatever reason, shall designate another member of the staff to attend his patients during his absence. In case of failure to name such staff member, the Administrator of the Hospital shall notify the chairman of the appropriate service who shall have the authority to call in any staff member to attend such patients, should he consider it necessary.

3.24. Active and Provisional Staff members shall be required to attend a minimum of fifty (50%) percent of the departmental meetings unless specifically excused by the MEC. The written excuse shall be presented to the MEC within thirty days after said meeting.

3.25. Any Physician on the staff has a right to waive any rule of the Hospital if by so doing this act protects the best interest of the patient. At the same time, the Physician shall explain in the medical record, by the time the record is completed, why he waived the rule or rules concerned.

3.26. Non-staff physician referral for out-patient rehabilitation services shall be allowed but shall include the following stipulations:

- (a) When the therapist does not think that the treatment ordered is apropos, then the therapist may consult with the Chairman of the Medicine Department.
- (b) When any problem might arise with a patient undergoing physical therapy treatment on referral by a non-staff physician, the patient will be referred to the Hospital's emergency room Physician for appropriate care; i.e., codes, falls, etc.

4. General Rules Regarding Surgical Care

4.1. Written, signed, informed surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or an unconscious patient in which consent for surgery cannot be immediately obtained from patient, guardian, or next of kin, these circumstances should be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken, if time permits. It shall be the Physician's obligation to have the established informed consent form completed prior to surgery or other medical procedures requiring consent.

4.2. Except in severe emergencies, the preoperative diagnosis and pertinent laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. In any emergency, the Physician shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery. In elective surgery, the history and physical examination must be recorded prior to surgery.

4.3. A patient admitted for dental care is a dual responsibility involving the dentist (who is an allied health professional) and physician member.

(a) Dentists' responsibilities:

- (1) A detailed dental history justifying Hospital admission;
- (2) A detailed description of the examination of the oral cavity and a preoperative diagnosis;
- (3) A complete operative report, describing the finding and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed;
- (4) Progress notes as are pertinent to the oral condition;
- (5) Clinical resume (or summary statement);
- (6) Pertinent instructions to patient and/or family at time of discharge.

(b) Physicians' responsibilities:

- (1) Medical history pertinent to the patient's general health;
- (2) A physical examination to determine the patient's condition prior to anesthesia and surgery;

- (3) Supervision of the patient's general health status while hospitalized.
- (c) The discharge of the patient shall be on written order of the dentist member of the staff and he will be responsible for post-operative instructions.
- (d) Patients admitted to the Hospital for oral and maxillofacial surgery care shall receive the same basic medical appraisal as patients admitted for other services, whether the appraisals are performed by a physician member of the Medical Staff or an oral and maxillofacial surgeon qualified to complete an admission history and physical examination and assess medical risks of the procedure on the patient. A physician member of the Medical Staff shall be formally consulted in connection with the care of medical problems that may be present upon admission or that may arise during the hospitalization of the oral surgery patient.
- (e) Oral and maxillofacial surgeons must have documentation of successful completion of post-graduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body, approved by the United States Office of Education and the American Dental Association Commission on Dental Accreditation.

4.4. The anesthesiologist or nurse anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition.

4.5. In any surgical procedure when in the judgment of the surgeon in charge it is deemed the procedure deals with an unusual hazard to life, there must be a qualified assistant present and scrubbed.

4.6. Any specimen removed during an operation, except as provided below, and with the exception of that exempted in the Joint Commission on Accreditation of Healthcare Organizations Standards, shall be sent for macroscopic, and if necessary, microscopic examination. The pathologist shall make such examination as may be considered necessary to arrive at a tissue diagnosis. The authenticated report shall be made a part of the patient's medical record. The pathologist is responsible for verifying the receipt of tissues for examination. The Medical Staff may provide for further limited exceptions and exemptions from the provisions of this section requiring the examination by a pathologist. It is specified that the following are specifically exempt:

- (a) Specimens that by their nature or condition do not permit fruitful examination, such as a cataract, orthopedic appliance, foreign body, or portion of rib removed only to enhance operative exposure;

- (b) Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements;
- (c) Traumatically injured members that have been amputated and for which examination for either medical or legal reasons is not deemed necessary;
- (d) Foreign bodies (for example, bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives;
- (e) Specimens known to rarely, if ever, show pathological change, and removal of which is highly visible postoperatively, such as the foreskin from the circumcision of a newborn infant; and
- (f) Teeth provided the number, including fragments, is recorded in the medical record.

4.7. Surgeons must be in the operating room and ready to commence operation at the time scheduled and in no case will the operating room be held longer than fifteen minutes after the time scheduled.

5. **Contract and/or Emergency Services**

5.1. The Board and the Medical Staff may approve the use of a contract physician group to provide twenty-four hour coverage in various areas including, but not limited to, the Emergency Department for this area. Emergency room service, other than that provided by the emergency room contract Physicians, shall be provided by the specialist on call on a rotation basis. The patient who has a private Physician on the staff shall be the responsibility of that Physician and he or his designee will be notified if requested.

5.2. The duties and responsibilities of all personnel serving patients within the emergency area shall be defined in a procedure manual relating specifically to this outpatient facility.

5.3. Upon written request, staff members may be excused from the requirement of rotation on emergency room service:

- (a) Upon reaching their 55th birthday, with a minimum of five years of service on the staff of the Hospital;
- (b) Upon reaching their 60th birthday, with less than five years of service on the staff of the Hospital;
- (c) For health reasons; or
- (d) After twenty five years of service.

5.4. An appropriate medical record shall be kept for every patient receiving emergency service in accordance with current standards of The Joint Commission Accreditation Manual for Hospitals. This information shall be incorporated in the patient's Hospital record if patient is admitted to the Hospital.

5.5. Each patient's medical record shall be signed by the Physician in attendance that is responsible for its clinical accuracy.

6. Rules Regarding Allied Health Professionals (AHPs)

6.1. The purpose of these rules and regulations **is to encourage more effective** utilization of skills of Physicians by enabling them to employ certain qualified health care professionals as is consistent with the patient's health and welfare. The review and appointment of each non-physician professional shall be the direct responsibility of each employing Physician, in accordance with Article HI, Section 3.1 of the Medical Staff Bylaws of the Hospital.

6.2. Non-physician professionals individually employed by members of the Medical Staff may function as an aide to a Physician only in the area of specialty of the sponsoring member. They may not serve as a substitute for the Physician under any circumstances. They may perform duties which do not require the exercise of independent medical judgment as assigned by the supervising Physician who is responsible for the performance of such tasks and who retains direct control and supervision over them.

6.3. The procedure for evaluating non-physicians shall be:

- (a) Application shall be made to the appropriate service through the Medical Staff office and shall be approved by the appropriate department director, Credentials Committee, MEC and the Board.
- (b) The application shall include qualifications; including training, experience and current license or certification as appropriate.
- (c) Clinical duties and responsibilities shall be established by the service and shall be based on training and experience. The employing Physician member of the Medical Staff shall retain ultimate patient care responsibility.
- (d) The right to participate directly in the management of patients while under the supervision/direction of a member in good standing of the Medical Staff shall be granted in accordance with these guidelines.
- (e) These personnel shall function within the limits established by the service or division which shall be consistent with state practice acts and provide proof of malpractice insurance.

7. Use of Physical Restraints

The Medical Staff has developed written policies on the proper use of restraint in the Hospital. The Medical Staff continuously monitors these policies and updates them as appropriate. The Medical Staff insures that the policies meet all requisite standards of the Texas Department of Health and the JCAHO. The Medical Staff may delegate these duties to the Executive Committee or other standing or ad hoc committee of the Medical Staff.

8. Harassment/Disruptive Behavior

8.1 Purpose .To provide guidelines for the identification and management of harassment/disruptive Physician behavior.

8.2 Policy .It is the policy of the Hospital that all individuals be treated with courtesy, respect and dignity. The Hospital requires all employees, Physicians and other independent healthcare providers to conduct themselves in a professional and cooperative manner.

8.3 A Physician's behavior which is unusual, unorthodox or different is not sufficient to justify disciplinary action; however, unacceptable harassment/disruptive behavior can include, but is not limited to:

- (a) Attacks leveled at other appointees to the Medical Staff which are personal, irrelevant, or go beyond the bounds of fair professional comment.
- (b) Impertinent and inappropriate comments written (or inappropriate illustrations drawn) in patient medical records, or other official documents, impugning the quality of care in the Hospital, or attacking particular Physicians, nurses or Hospital policy.
- (c) Non-constructive criticism addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or to impute stupidity, or incompetence.
- (d) Foul language or use of expletives that are found offensive to those within hearing range.
- (e) Inappropriate loud and argumentative conversation.

8.4 Harassment is defined as follows:

- (a) The term "harassment" includes but is not limited to unwelcome slurs, jokes, verbal, graphic, or physical conduct relating to an individual's race, religion, sex, age, national origin, or disability.

- (b) Sexual harassment consists of unwelcome advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature where:
 - (1) Submission to such conduct is an explicit or implicit term or condition of employment.
 - (2) Employment decisions are based on an employee's submission to or rejection of such conduct; or
 - (3) Such conduct interferes with an individual's work performance or creates an intimidating, hostile, or offensive working environment.
- (c) The term "harassment" may also include conduct of employees, supervisors, vendors and/or customers who engage in verbal or physical harassing behavior which has the potential for humiliating or embarrassing an employee of the Hospital.

8.15 Documentation of Harassment/Disruptive Behavior

- (a) Documentation of harassment/disruptive behavior is critical since a pattern of behavior can usually be established only through proper documentation. Physicians, nurses, and other Hospital employees who observe behavior by a Physician which disrupts the smooth operation of the Hospital, or jeopardizes patient care, shall document the incident on a variance report.
- (b) Documentation may be written by the Director/Supervisor of complainant in an "as told to" fashion. The report or subsequent documentation shall include, if possible:
 - (1) The date and time of the questionable behavior; the name of the alleged harasser.
 - (2) If the behavior was in the presence of a patient, or it affected or involved a patient in any way, the name of the patient is needed.
 - (3) The circumstances which precipitated the situation.
 - (4) A description of the questionable behavior limited to factual, objective language as much as possible.
 - (5) The consequences, if any.
 - (6) The action taken including date, time, place, action, and name(s) of those intervening.
- (c) The report shall be marked "Confidential" and submitted to the Director of Medical Staff Services within two weeks of occurrence. The report shall be forwarded to the President of the Medical Staff.

- (d) The President of the Medical Staff shall notify the offending Physician within one week of receipt to Medical Staff Services and ask him/her to respond in writing to the report.
- (e) All documentation regarding these issues will be filed in the Physician's confidential file for consideration at time of reappointment.

8.16 Progressive Disciplinary Action .All reports of harassment/disruptive behavior will be dealt with in the following manner:

- (a) First Report
 - (1) When warranted, the Medical Staff Officers and the Administrator shall initiate a discussion and emphasize that such behavior is inappropriate.
 - (2) Informal meetings shall be documented.
 - (3) A follow-up noted to the Physician shall state that the Physician is required to behave professionally and cooperatively.
 - (4) The Physician shall be given a copy of this policy and will be notified that with the next offense, formal action will be taken.
 - (5) The initial approach should be collegial and designed to be helpful to the Physician.
 - (6) If the President of the Medical Staff feels he/she may not totally be unbiased, a designee may be selected to perform the duties.
- (b) Second Report of same or similar offenses. The Physician will be notified and the record of occurrences will be placed on the MEC agenda. A second report may result in a Formal Letter of Reprimand from the MEC.
- (c) Third Report of same or similar offenses. The Physician will be notified and the record of occurrences will be placed on the MEC agenda. A third report may result in suspension of Hospital privileges for 14 days if recommended by the MEC to the Board.
- (d) While this policy addresses several levels' of warnings and meetings with a Physician, it is possible that the behavior at issue is so unacceptable as to make alternatives inappropriate. Based on the misbehavior at issue, the steps in this policy may be truncated, as recommended by the Administrator and Medical Staff Officers to the MEC. If warranted, the MEC will forward a recommendation to the Board.
- (e) If there is a move to take disciplinary action against a Physician, the Physician may attend the meeting(s) to present his case or have the opportunity to answer the charges prior to a disciplinary decision being made.

Nothing in this policy is intended to alter the relationship between Hospital and the Medical Staff who are granted privileges to practice there. This policy is intended to assist the Medical Staff in recognizing and handling harassment or claims of harassment. Nothing herein shall make Hospital responsible for the actions of Physicians. Physicians are not employees, representatives, or agents of the Hospital, but rather are independent contractors.

FAIR HEARING PLAN

TEXAS SPINE AND JOINT HOSPITAL, L.L.P.

TYLER, TEXAS

TABLE OF CONTENTS

	<u>Page</u>
ARTICLE I: BASIS FOR HEARINGS.....	1
1.1 Applicability of Plan.....	1
1.2 Non-Applicability of Plan.....	1
ARTICLE II: EVIDENTIARY HEARING.....	3
2.1 Initiation of Evidentiary Hearing.....	3
2.1-1 Notice of Adverse Recommendation.....	3
2.1-2 Petition for Evidentiary Hearing.....	3
2.1-3 Appointment of Hearing Committee, Arbitrator, or Hearing Officer.....	3
2.1-4 Notice of Hearing, Committee Appointment, and Respondent’s Witnesses.....	3
2.2 Evidentiary Hearing Procedures.....	3
2.2-1 Respondent’s Representative.....	4
2.2-2 Petitioner’s Representative and Witnesses.....	4
2.2-3 Powers and Duties of Presiding Officer.....	4
2.2-4 Review of Evidence Prior to Hearing.....	4
2.2-5 Procedure and Evidence.....	4
2.2-6 Rights at Hearing.....	4
2.2-7 Burden of Proof.....	4
2.2-8 Postponements, Recesses, and Closing.....	4
2.2-9 Report.....	4
2.2-10 Respondent’s Final Recommendation.....	5
2.2-11 Decision.....	5
ARTICLE III: APPELLATE REVIEW.....	5
3.1 Initiation of Appellate Review.....	5
3.1-1 Petition For Appellate Review.....	5
3.1-2 Appointment of Appeals Committee.....	5
3.1-3 Notice of Appellate Review.....	5
3.2 Appellate Review Procedure.....	5
3.2-1 Written Statements.....	5
3.2-2 Powers.....	5
3.2-3 Matters Considered and Actions Taken.....	5
3.2-4 Closing.....	6
3.2-5 Recommendation and Decision.....	6
ARTICLE IV: MISCELLANEOUS.....	6
4.1 Summary Suspensions.....	6
4.2 Notices, Petitions, and Requests.....	6
4.3 Quorum and Action.....	6
4.4 Number of Reviews and Board Decision.....	6
4.5 Release.....	6
4.6 Waiver.....	7
4.7 Attorneys.....	7
4.8 Transcript and Record of Proceedings.....	7
4.9 Decorum.....	7
4.10 Joint Hearings and Appeals.....	7
ARTICLE V: EFFECTIVE DATE.....	8

FAIR HEARING PLAN

TEXAS SPINE AND JOINT HOSPITAL, L.L.P,

This Fair Hearing Plan (“Plan”) is established to provide a mechanism for confirming or modifying any Adverse Recommendation towards any applicant for or member of the Medical Staff. This Plan is intended to comply with the Health Care Quality Improvement Act of 1986 (the “Act”), as amended from time to time, and to provide full legal protection to individuals and entities acting on behalf of the Hospital on “professional review activities” or providing information to any Hospital “professional review body,” as those terms are defined in the Act. This Plan shall be amended as of the effective date of any amendment to the Act, to the extent that they offer new protections or expand present protections to individuals and entities.

Unless otherwise specified, capitalized terms used but not defined herein shall have the meanings ascribed in the Bylaws of the Medical Staff. All references to “days” shall mean calendar days. My deadline falling on a holiday, Saturday, or Sunday shall be extended to the next regular business thy. The term “Petitioner” means the Practitioner who is entitled to and requests a hearing and/or appeal. The term “Respondent” means the authority issuing the Adverse Recommendation (either the MEC or the Board). The Petitioner or Respondent may be referred to individually as a “Party” or collectively as “Parties.”

ARTICLE I: BASIS FOR HEARINGS

1.1 **Applicability of Plan.** Except as otherwise set forth in Section 1.2 of this Plan, the following Adverse Recommendations shall entitle the affected Practitioner to request an evidentiary hearing:

- 1.1-1 Denial of initial appointment or reappointment;
- 1.1-2 Termination of membership;
- 1.1-3 Denial of requested advancement, or unrequested reduction, in Medical Staff category;
- 1.1-4 Limitation of admitting privileges;
- 1.1-S Denial, reduction, or revocation of privileges;
- 1.1-6 Continuance of a summary suspension by the MEC;
- 1.1-7 Imposition of a period of non-voluntary probation; and
- 1.1-8 Requirement of non-voluntary consultation in the exercise of privileges.

1.2 **Non-Applicability of Plan.** The following shall not be considered an Adverse Action under the terms of the Bylaws and this Plan and shall not give rise to a right to a hearing or appellate review:

- 1.2-1 My action regarding an Allied Health Professional;
- 1.2-2 Denial, suspension, limitation, or revocation of temporary privileges;

- 1.2-3** A suspension or restriction of clinical privileges for a period of less than thirty (30) days, during which time an investigation is being conducted to determine the need for a professional review action;
- 1.2-4** Termination of a contract with a Medical Staff member or with an entity that employs or contracts with a Medical Staff member, or termination of a Medical Staff member's relationship with an entity that contracts with the Hospital, if so provided in the contract or the Bylaws;
- 1.2-5** The denial of or refusal to accept an application for initial appointment or reappointment to the medical staff (i) where the application is incomplete; (ii) where the application reflects that the applicant does not meet the minimum objective requirements for appointment or reappointment; or (iii) where the applicant is requesting clinical privileges in a department, subspecialty or service in which the number of medical staff appointees has been limited in accordance with the Bylaws;
- 1.2-6** Rejection of an application because the applicant does not meet the Hospital's licensure or insurance requirements;
- 1.2-7** A decision to retain a provisional Medical Staff member for one additional one year period on the provisional Medical Staff;
 - 1.2-8** An automatic corrective action taken pursuant to Section 6.3.3 or 6.3.4 of the Bylaws;
 - 1.2-9** A warning letter, a letter of admonition, or a letter of reprimand;
 - 1.2-10** Denial of requested privileges if those privileges are not granted to any Practitioner; and/or
 - 1.2-11** The appointment of an ad hoc investigation committee;
 - 1.2-12** The conduct of an investigation into any matter;
- 1.2-13** The formulation and presentation of any preliminary report of any ad hoc investigation committee to the President of the Hospital or to the officers of the Executive Committee;
- 1.2-14** The making of a request or issuance of a directive to an applicant or medical staff appointee to appear at an interview or conference before the Credentials Committee, any ad hoc investigation committee, the President of the Hospital, the Board or any other professional review body in connection with any investigation prior to a proposed adverse recommendation or action;
- 1.2-15** The appointment of a newly-appointed Medical Staff appointee to the Provisional Staff;
- 1.2-16** The imposition of supervision or observation on a Medical Staff appointee which supervision or observation does not restrict the clinical privileges of the Medical Staff appointee or the delivery of professional services to patients;
- 1.2-17** Corrective counseling;
- 1.2-18** A recommendation that the Medical Staff appointee be directed to obtain retraining, additional training, or continuing education;
- 1.2-19** The denial of a request for a waiver or reduction of the required minimum liability insurance coverage as provided in the Bylaws;

- 1.2-20** The following changes in Medical Staff category: (i) a change from Active Staff to Senior Active Staff upon attaining age 65; (ii) a change from Active Staff to Courtesy Staff for failure to meet the patient care requirements set forth in the Bylaws; or (iii) a change from Active Staff to Courtesy Staff for failure to meet the meeting attendance requirements set forth in the Bylaws; or (iv) any other change in category resulting from the failure of a Medical Staff appointee to meet the minimum objective criteria for a specific category;
- 1.2-21** My recommendation or action not “adversely affecting” [as such term is defined in Section 431 (1) of the Act] any applicant or Medical Staff appointee, or which is not based upon a subjective determination of the professional competency or conduct of the applicant or Medical Staff appointee; or
- 1.2-22** My other action specified in the Bylaws as not giving rise to a right to a hearing or appellate review.

ARTICLE II: EVIDENTIARY HEARING

2.1 Initiation of Evidentiary Hearing.

- 2.1-1 Notice of Adverse Recommendation. Before the Board confirms an Adverse Recommendation, the Administrator shall send written notice to the affected Practitioner. The notice shall specify the Adverse Recommendation, the right to request a hearing, the time limit of thirty (30) days to request the hearing, a summary of the Practitioner’s rights at the hearing, and a summary statement of the reasons for the Adverse Recommendation. The summary statement shall describe the acts or omissions, questioned cases, insufficiently substantiated elements, or unresolved questions concerning qualifications or other factors, in such a manner that the Practitioner will have reasonable notice of the basis for the Adverse Recommendation.
- 2.1-2 Petition for Evidentiary Hearing. Within thirty (30) days after receipt of the notice of Adverse Recommendation, the Practitioner may submit a written request for a hearing with the Administrator. Upon receipt of this request, the Administrator shall provide the Petitioner and the Respondent with a copy of this Plan. Failure to request a hearing as provided herein shall constitute a waiver of all rights to a hearing and appeal and an acquiescence to the Adverse Recommendation.
- 2.1-3 Appointment of Hearing Committee, Arbitrator, or Hearing Officer. When a hearing is requested, the Chairperson of the Medical Staff (“Chairperson”), in consultation with the Administrator, shall appoint an ad hoc hearing committee (“Hearing Committee”) composed of not less than three (3) members of the Medical Staff and shall designate a chairman. Members of the Hearing Committee may not have actively participated in the matter involved at any previous level (although basic knowledge of the matter shall not be grounds for disqualification) and may not be in direct economic competition with the Petitioner. In the event that a fully qualified Hearing Committee from the Medical Staff cannot be appointed, the Chairperson may appoint qualified outside Practitioners who are provided temporary privileges to serve on the Hearing Committee. In the event that a suitable Hearing Committee is unlikely to be chosen, the evidentiary hearing may be held before a special arbitrator mutually acceptable to the Petitioner and the Administrator or before a special hearing officer who is appointed by the Administrator and who is not in direct economic competition with the Petitioner.

2.1-4 Notice of Hearing, Committee Appointment, and Respondent's Witnesses. Within seven (7) days after the appointment of the Hearing Committee, the Administrator shall fix a place, time, and date for the hearing and shall send Special Notice thereof, together with the names of the members of the Hearing Committee, to the Petitioner, and the Respondent. The notice shall also include a list of witnesses, if any, expected to testify on behalf of the Respondent at the hearing (which may be updated or supplemented by written notice to the Petitioner up to seven (7) days before the hearing). The hearing shall be held not less than thirty (30) days nor more than sixty (60) days from the date of the notice.

2.2 Evidentiary Hearing.

2.2-1 Respondent's Representative. By written notice to the Administrator received at least seven (7) days prior to the hearing, the Respondent shall be entitled to designate a physician-representative to present and examine evidence at the evidentiary hearing.

2.2-2 Petitioner's Representative and Witnesses. By written notice to the Administrator received at least seven (7) days prior to the hearing, the Petitioner shall be entitled to designate a physician representative or other person of his choice to present and examine evidence at the hearing. The Petitioner shall also, in the same notice, provide the Administrator with a list of witnesses whom he expects will testify on his behalf at the hearing. Only those representatives and witnesses whose names are so provided may participate or testify at the hearing; provided, however, that if the Petitioner does not testify in his own behalf, he may be called and examined as if under cross examination. The Petitioner must be personally present during the hearing.

2.2-3 Powers and Duties of Presiding Officer. The presiding officer shall preside over the hearing. The presiding officer shall determine the order of procedure and relevancy of subject matter and shall make all rulings with respect to matters of procedure and admissibility of evidence. The presiding officer shall issue orders reasonably appropriate for maintaining decorum, ensuring the pace of the hearing, and for the presentation of evidence by the Parties.

2.2-4 Review of Evidence Prior to Hearing. Prior to the hearing, either Party may examine evidence in the possession of the other Party if deemed relevant by the presiding officer. The Party must present a written request to the presiding officer, to the other Party, and to the person in possession of the materials at least five (5) days prior to the time requested for examination. The place for examination shall be the Hospital unless otherwise ordered by the presiding officer, who shall also have the authority to issue orders relating to the production or the protection of such evidence.

2.2-5 Procedure and Evidence. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. The presiding officer may admit any relevant evidence regardless of its admissibility in a court of law; provided, however, that the presiding officer also has the discretion to halt any question or line of questioning deemed irrelevant. The presiding officer may order that oral evidence be taken only on oath or affirmation. The Hearing Committee shall be entitled to consider any material contained in the Petitioner's administrative file at the Hospital, his application and accompanying documents, and all information that could be considered in connection with applications for Medical Staff appointment or renewal appointment. The Hearing Committee may also take official notice of any generally accepted technical or scientific matter and of any generally accepted facts.

- 2.2-6** Rights at Hearing. The Parties shall have the following rights at the hearing: to present evidence deemed relevant by the presiding officer; to call, examine, and cross-examine witnesses; to impeach any witnesses; to rebut any evidence; to representation by a person of the Party's choice (provided, however, that an attorney may not examine or cross-examine witnesses, present evidence, or otherwise make any statements in front of the Hearing Committee); to have a record made of the proceedings as provided in Section 4.8 hereof; and to submit to the Hearing Committee a written statement within seven (7) days after adjournment of the hearing.
- 2.2-7** Burden of Proof. In all cases, the Respondent shall have the initial obligation to introduce evidence in support of its Adverse Recommendation, but the Petitioner shall thereafter have the obligation of supporting his challenge to the Adverse Recommendation by presenting clear and convincing evidence that the Adverse Recommendation is not based in fact, is not supported by the evidence, or is not reasonable in light of the evidence.
- 2.2-8** Postponements, Recesses, and Closing. The presiding officer may in his discretion postpone, recess, and reconvene the hearing from time to time. After all evidence is presented, the hearing shall be adjourned. The Hearing Committee may, at a time convenient to itself, conduct its deliberations outside the presence of the Parties. Upon conclusion of its deliberations, the hearing shall be declared closed.
- 2.2-9** Report. Within fourteen (14) days after the close of the hearing, the Hearing Committee shall deliver a written report of its recommendations, including a statement of the basis for the recommendations, to the Administrator, who shall promptly transmit copies to the Petitioner and Respondent. The report may recommend confirmation, modification, or rejection of the Respondent's original Adverse Recommendation.
- 2.2-10** Respondent's Final Recommendation. Within fourteen (14) days after receipt of the Hearing Committee report, the Respondent shall render a final written recommendation in the matter. In reaching its final recommendation, the Respondent may review the hearing record and the transcript, if available. The Respondent shall immediately forward its final written recommendation, including the basis for the final recommendation, to the Administrator. Within twenty days after the date of the final recommendation, the Administrator shall give Special Notice thereof to the Petitioner and the presiding officer of the Hearing Committee.
- 2.2-11** Decision. If the Respondent was the Board, then its final recommendation shall be the final decision in the matter, without appeal. In addition, if the Petitioner fails to seek appellate review as provided in Article III, the Board shall render a final decision in the matter, and the Administrator shall send Special Notice of the final decision, including the basis for the final decision, to the presiding officer of the Hearing Committee, the MEC, and the Petitioner, within twenty (20) days after the date of the final decision.

ARTICLE III: APPELLATE REVIEW

3.1 Initiation of Appellate Review. If the Respondent was the MEC, then the Petitioner may be entitled to an appellate review in accordance with this Article III.

- 3.1-1** Petition For Appellate Review. Within thirty (30) days after receipt of the notice of the final written recommendation of the MEC, the Petitioner may file with the Administrator a written petition for an appellate review. The Administrator shall then furnish a copy of the petition to the MEC and the Board. If a written petition for appellate review is not so filed, the Petitioner waives his right to appellate review and acquiesces in the final written recommendation of the MEC.

- 3.1-2** Appointment of Appeals Committee. Within fourteen (14) days after the petition for appellate review is received, the Chairman of the Board or his designee shall appoint an ad hoc appellate review committee (“Appeals Committee”) of at least three (3) members of the Board and shall designate the Chairman thereof. The Appeals Committee may consist of the Board acting as a committee of the whole. No member of the Appeals Committee may be in direct economic competition with the Petitioner or have previously been actively involved with the Adverse Recommendation.
- 3.1-3** Notice of Appellate Review. Within fourteen (14) days after the appointment of the Appeals Committee, the Administrator, with the advice of the Chairman of the Appeals Committee, shall fix a place, time, and date for the appellate review. The Administrator shall send Special Notice thereof, together with the names of the members of the Appeals Committee, to the Petitioner and the MEC. The date fixed for the appellate review shall not be less than thirty (30) days or more than sixty (60) days from the date of the notice.
- 3.2** Appellate Review Procedure.
- 3.2-1** Written Statements. The Petitioner shall have the right to submit a written statement to the Administrator no later than fourteen (14) days prior to the date fixed for the appellate review. The Administrator shall promptly provide the Appeals Committee and the MEC with a copy of the written statement. The MEC may submit a written statement in reply to the Administrator, with a copy to Petitioner, no later than seven (7) days before the appellate review.
- 3.2-2** Powers. The Appeals Committee and its Chairman shall also have all powers granted to the Hearing Committee and its presiding officer, and such additional powers as are reasonably appropriate to the discharge of its responsibilities.
- 3.2-3** Matters Considered and Actions Taken. The Appeals Committee shall act as an appellate body, reviewing the proceedings of the evidentiary hearing and the written statements. Only under unusual circumstances shall new matters or evidence be introduced at the appellate review. The Appeals Committee, in its sole discretion, may determine whether new matters will be considered or new evidence accepted. The Appeals Committee, in its sole discretion, may require that the Parties or their representatives appear personally, make oral statements in favor of their positions, and respond to questions of the Appeals Committee (neither Party shall be allowed to cross-examine the other). The Appeals Committee shall determine whether the report and recommendations of the Hearing Committee and the subsequent recommendations founded thereon were made (i) in the reasonable belief that the action was in furtherance of quality health care, (ii) after a reasonable effort to obtain the facts of the matter, (iii) after adequate notice and hearing procedures were afforded to the Petitioner, and (iv) in the reasonable belief that the action was warranted by the facts known. The Appeals Committee may affirm, modify, or reverse the recommendation of the MEC, or, in its discretion, remand the matter to the MEC for further review, recommendation, and return.
- 3.2-4** Closing. Upon conclusion of the review of the materials and the presentations by the Parties, if any, the appellate review shall be adjourned. The Appeals Committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the Petitioner and the MEC. Upon conclusion of the deliberations, the appellate review shall be declared closed.

- 3.2-5** Recommendation and Decision. The Appeals Committee shall forward its written recommendation to the Board within fourteen (14) days after the close of the appellate review, and the Board shall render a final decision within thirty (30) days thereafter. If the Board as a whole acted as the Appeals Committee, it shall render its final decision within thirty (30) days of the close of the appellate review. The Administrator shall send notice of the Board's final decision, including a statement of the basis for the decision and the recommendations of the Appeals Committee (if applicable) to the Chairman of the Appeals Committee, the MEC, and the Petitioner within twenty (20) days after the final decision. The Administrator shall also make other reports regarding any final Adverse Action in accordance with applicable law.

ARTICLE IV: MISCELLANEOUS

- 4.1** Summary Suspensions. In response to a written request by a Petitioner who has been summarily suspended, the Administrator shall use his best efforts to cause the hearing and appellate review to be held at the earliest possible time without regard to the limitations contained in Sections 2.1-4 and 3.1-3 hereof
- 4.2** Notices, Petitions, and Requests. All notices, petitions, and requests to or from the Petitioner required or permitted under this Plan shall be by Special Notice. Unless otherwise provided herein, notices, petitions, and requests shall become effective as of the date they are personally delivered to the addressee or to the office of the addressee or at the time that they are deposited in the United States mail, postage prepaid, addressed to the last known address of the addressee as shown on the records of the Hospital. Notices, materials, and other communications, other than those to and from the Petitioner, may be transmitted informally in whatever manner is reasonably expected to timely inform the recipient.
- 4.3** Quorum and Action. A simple majority (i.e., greater than 50%) of the members of the Hearing Committee or the Appeals Committee shall constitute a quorum of the respective committees. The action adopted by a majority of the members at a meeting at which a quorum is present shall constitute the action of the committee. Either committee may also act by written consent signed by a majority of the members of the committee. Members must be present during the entire evidentiary hearing or appellate review in order to vote. A tie vote shall constitute an affirmation of the Adverse Recommendation.
- 4.4** Number of Reviews and Board Decision. Notwithstanding any other provision of the Bylaws or this Plan, no applicant or member of the Staff shall be entitled to more than one evidentiary hearing and one appellate review with respect to an Adverse Recommendation.
- 4.5** Release. By petitioning for a hearing under this Plan:
- 4.5-1** Each Petitioner specifically authorizes and requests all persons with any information relating to the Adverse Recommendation to provide such information to the Hearing Committee and/or the Board directly or through authorized representatives of the Hospital and the Medical Staff;
- 4.5-2** Each Petitioner will use his best effort to cause, and assumes the burden of causing, all such information to be presented, and shall execute specific written requests and releases on forms adopted by the Board; and
- 4.5-3** Each Petitioner specifically releases from legal liability all individuals, review bodies, and organizations that submit or consider such information.

- 4.6** Waiver. If at any time the affected Practitioner fails to go forward, fails to discharge his obligations, or otherwise fails to comply with this Plan, the Practitioner shall be deemed to have acquiesced in the Adverse Recommendation and to have waived all prior procedural objections and all rights otherwise accruing to him under the Bylaws or this Plan with respect to the matters concerned.
- 4.7** Attorneys. These proceedings are for the purpose of intra-professional resolution of matters bearing on professional competency and conduct. The Petitioner is, however, entitled to be represented at the evidentiary hearing or appellate review by an attorney. If the Petitioner desires to be represented by an attorney at any hearing or review, he must notify the Administrator at least seven (7) days prior to the noticed hearing or appellate review date. If such a request is made by the Petitioner, the Respondent shall be authorized to be represented at the hearing or appellate review procedure by an attorney. Participation by the attorneys shall consist solely of providing private advice and counsel to their respective clients, and shall not include presenting evidence, examining or cross-examining witnesses, making statements directly to the committee, or otherwise participating directly in the proceedings. The presiding officer shall have the authority to ensure that all attorneys conduct themselves in accordance with these standards.
- 4.8** Transcript and Record of Proceedings. The Administrator shall cause to be prepared a transcript of the evidentiary hearing and oral argument, if any, during the appellate review. The Administrator shall also cause a record to be prepared of the evidentiary hearing and appellate review, and the Petitioner shall be entitled to a copy of the record upon payment of one-half the charges associated with its preparation. The evidentiary hearing record shall include documentation of the initial Adverse Recommendation, the notice of Adverse Recommendation, the Practitioner's petition for an evidentiary hearing, the notice of the hearing, the hearing transcript, all exhibits introduced at the hearing, the Petitioner's and Respondent's written statements, if any, the Hearing Committee's report and the final recommendation. The appellate review record shall include the Petitioner's request for appellate review, the notice of appellate review, the transcript of the oral argument, if any, of the appellate review, any written statements submitted prior to the appellate review, and notice of the final decision of the Appeals Committee. The record shall be maintained by the Administrator for a period of five (5) years after the conclusion of all proceedings.
- 4.9** Decorum. The evidentiary hearing and appellate review must be conducted in accordance with basic rules of decorum and orders of the presiding officer. The presiding officer may exclude or otherwise discipline any person who substantially, intentionally, or repeatedly violates these rules of decorum or orders or otherwise disrupts or interferes with the conduct of the proceeding. Any such conduct by the Petitioner or any representative of Petitioner may constitute a waiver by Petitioner of his right to a hearing or review, and the Petitioner shall be deemed to have acquiesced in any Adverse Recommendation.
- 4.10** Joint Hearings and Appeals. The Hearing Committee and/or the Appeals Committee may participate in joint hearings and/or appellate reviews with hearing committee(s) or appeals committee(s) of other System hospitals. In addition to any and all powers granted under this Plan and other applicable fair hearing plans, the presiding officer of the joint hearing committee and the chairman of the joint appeals committee shall have the authority to issue orders that best coordinates the provisions of the various fair hearing plans.

ARTICLE V: EFFECTIVE DATE

This Plan and any amendments hereto shall become immediately effective when adopted by the Medical Staff and approved by the Board.

ADOPTED by the Medical Staff
Effective _____, 2002.

Chairperson of the Medical Staff

APPROVED by the Board of Directors
Effective _____, 2002

President of the Board of Directors

Revised: January 21, 2011
Reviewed: August 15, 2014

