CHRISTUS MOTHER FRANCES HOSPITAL – SULPHUR SPRINGS MEDICAL STAFF BYLAWS

Table of Contents

ARTICLE I. NAME **2**
1.1 The name of this organization shall be: 2
ARTICLE II. PURPOSE **2**
2.1 The purpose of this organization is: 2
ARTICLE III. MEDICAL STAFF MEMBERSHIP **2**
3.1 Nature of Medical Staff Membership 2
3.2 Qualifications for Membership 3
3.3 Specific Qualifications 4
3.4 Waiver of Qualifications 4
3.5 Responsibilities of Medical Staff Membership 4
ARTICLE IV. CATEGORIES OF THE MEDICAL STAFF **5**
4.1 Active Medical Staff 5
4.2 Associate Medical Staff 6
4.6 Emeritus Medical Staff 6
4.7 Affiliated Medical Staff 7
ARTICLE V. PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT **7**
5.1 Conditions and Duration of Appointment 7
5.2 Application for Appointment 8
5.3 Continuing Education 10
5.4 Appointment Process 10
5.5 Reappointment Process 12
5.6 Notice of Licensure/Medical Privileges/Professional Liability Action 13
5.7 Leave of Absence 13
ARTICLE VI. CLINICAL PRIVILEGES **14**
6.1 Clinical Privileges 14
6.2 Temporary Privileges 14
6.3 Emergency Privileges 15
6.4 Disaster Privileges 15
6.5 Privileges (Special) 17
6.6 Medical History and Physician Examination Privileges 17
ARTICLE VII. ADVANCED PRACTICE CLINICIAN **19**
7.1 Advanced Practice Clinicians 19

7.2 Procedural Review and Notice 20
ARTICLE VIII. CORRECTIVE ACTION 22
8.1 Procedure 22
8.2 Summary Suspension 23
8.3 Automatic Suspension 23
8.4 Notice of Removal of a Physician 25
8.5 Report to Regulatory Entities 25
ARTICLE IX. HEARING AND APELLATE REVIEW PROCEDURE 25
9.1 Right to Hearing and to Appellate Review 25
9.2 Exception to Right to Hearing. 27
9.3 Notice of Adverse Recommendation or Decision 28
9.4 Request for Hearing 28
9.5 Waiver of Hearing 28
9.6 Notice of Hearing 28
9.7 Appointment of Hearing Committee and/or Hearing Officer 29
9.8 List of Witnesses 30
9.9 Conduct of Hearing 30
9.10 Hearing Committee Report 31
9.11 Action on Hearing Committee Report 32
9.12 Appeal to the Governing Body 32
9.13 Final Decision by Governing Body 34
ARTICLE X. OFFICERS 34
10.1 Officers of the Medical Staff 34
10.2 Qualifications of Officers 35
10.3 Conflict of Interest 35
10.4 Election of Officers 35
10.5 Term of Office 35
10.6 Removal of Officers 35
10.7 Vacancies in Office 37
10.8 Duties of Officers 37
ARTICLE XI. NONDEPARTMENTALIZED SERVICES 38
11.1 Organization of Services Non-Departmentalized 38
11.2 Qualifications, Selection and Tenure of Chiefs of Service 38
11.3 Functions of Chief of Service 39
11.4 Functions of Service Committee 39
11.5 Assignment to Services 40

11.6 General Practice and Family Practice ... 40
ARTICLE XII. COMMITTEES ... 40
12.1 Executive Committee of the Medical Staff ... 40
12.2 Service Specific Committees ... 42
12.3 Joint Conference Committee ... 42
ARTICLE XIII. MEDICAL STAFF MEETINGS ... 43
13.1 Regular Meetings ... 43
13.2 Special Meetings ... 43
13.3 Quorum ... 44
13.4 Attendance Requirements ... 44
ARTICLE XIV. COMMITTEE AND SERVICE MEETINGS ... 44
14.1 Regular Meetings ... 44
14.2 Special Meetings ... 44
14.3 Notice of Meetings ... 44
14.4 Quorum ... 44
14.5 Manner of Action ... 44
14.6 Rights of Ex-officio Members ... 45
14.7 Minutes ... 45
14.8 Attendance Requirements ... 45
ARTICLE XV. IMMUNITY FROM LIABILITY ... 45
ARTICLE XVI. RULES AND REGULATIONS ... 47
ARTICLE XVII. AMENDMENTS ... 47
17.1 Review Every Two Years ... 47
17.2 Proposed Amendments to Bylaws ... 47
17.3 Vote on Amendments or Changes in Rules and Regulations ... 47
17.3.1 MEC ... 47
17.3.2 General Medical Staff ... 47
17.3.3 Governing Board ... 48
ARTICLE XVIII. ADOPTION ... 48

CHRISTUS MOTHER FRANCES HOSPITAL – SULPHUR SPRINGS
MEDICAL STAFF BYLAWS

PREAMBLE

WHEREAS, CHRISTUS Mother Frances Hospital – Sulphur Springs is a general hospital owned and operated by CHRISTUS Hopkins Health Alliance; and

WHEREAS, its purpose is to serve as a general hospital providing patient care and education;

WHEREAS, it is recognized that the medical staff is responsible for the quality of medical care in the hospital and must accept and discharge this responsibility, subject to the ultimate authority of the hospital governing body, and that the cooperative efforts of the medical staff, the Chief Executive Officer (CEO) and the governing body are necessary to fulfill the hospital's obligations to its patients;

WHEREAS, the hospital board wishes to delegate to the clinical services, to the committees of the medical staff, and specifically to certain officers of the staff, chairmen of those services and members of those committees, the duty and responsibility to make recommendations to the board concerning an applicant's appointment or reappointment to the medical staff of the hospital and the clinical privileges such applicant shall enjoy in the hospital;

THEREFORE, the physicians, podiatrists and dentists practicing in this hospital hereby organize themselves into a medical staff in conformity with these bylaws. Neither the medical staff nor the governing body may unilaterally amend the medical staff bylaws, rules or regulations.

DEFINITIONS

The following definitions shall apply to terms used in these bylaws:

1. The term "Advanced Practice Clinician (APC)" means all independently licensed non-physician health care professionals who regularly care for patients in the hospital. Advanced Practice Registered Nurses (APRN) and Physician's Assistants (PA) are to be credentialed by the contracted Credentialing Verification Office (CVO).

2. The term "chief executive officer" or "CEO" means the individual appointed by the governing body to act in its behalf in the overall management of the hospital district.

3. The term "chief of service" means the medical staff member duly appointed or elected in accordance with these bylaws to serve as the head of a service.

4. The term "executive committee," medical executive committee or "MEC" means the executive committee of the Medical Staff unless specific reference is made to the executive committee of the governing body.

5. The term "governing body" or "board" means the Board of Directors of CHRISTUS Mother Frances Hospital – Sulphur Springs or authorized designee.

6. The term “medical staff” means those practitioners who have been appointed and are privileged to attend patients or to provide other diagnostic, therapeutic, teaching or research services at the hospital

7. The term “practitioner” means all privileged providers and applicants for privileges with an unlimited license.

8. The term “service” means that group of practitioners who have clinical privileges in one of the general areas of family medicine, surgery, obstetrics, pediatrics, anesthesiology and radiology.

9. Whenever a personal pronoun is used, it shall be interpreted to refer to persons of either gender.

ARTICLE I. NAME

1.1 The name of this organization shall be:

CHRISTUS Mother Frances Hospital – Sulphur Springs Medical Staff

ARTICLE II. PURPOSE

2.1 The purpose of this organization is:

To organize the activities of physicians and other clinical practitioners who practice at CHRISTUS Mother Frances Hospital – Sulphur Springs in order to carry out, in conformity with these bylaws, the functions delegated to the medical staff by the hospital board.

ARTICLE III. MEDICAL STAFF MEMBERSHIP

3.1 Nature of Medical Staff Membership

Membership on the medical staff of CHRISTUS Mother Frances Hospital – Sulphur Springs is a privilege which shall be extended only to professionally competent physicians, dentists, and other practitioners who continuously meet the qualifications, standards, and requirements set forth by these bylaws and associated policies of the medical staff and hospital.

No practitioner, including those in a medical administrative position, shall admit or provide medical or health-related services to patients in the hospital unless the practitioner is a member of the medical staff and has been granted clinical privileges in accordance with these bylaws or unless the practitioner has been granted temporary privileges in accordance with the procedures set forth in these bylaws. Appointment to the medical staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these bylaws.

No person shall be entitled to membership in the Medical Staff merely because that person holds a certain degree, is licensed to practice in this or in any other state, is a member of any

professional organization, is certified by any clinical board, or because such person had, or presently has, staff membership or clinical privileges at another health care facility.

No aspect of medical staff membership or particular privileges shall be denied on the basis of sex, race, age, creed, color, national origin, or physical or mental impairment that does not pose a threat to the quality of patient care.

3.2 Qualifications for Membership

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

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

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

Must:

a. Adhere to the ethics of their respective professions;
b. Be able to work cooperatively with others;
c. Be willing to participate in and properly discharge those responsibilities determined by the medical staff.

Must maintain in force professional liability insurance that:

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

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

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

3.3 Specific Qualifications

Physicians. An applicant for physician membership in the medical staff shall be a graduate of a medical school approved at the time of the issuance of such degree by the Texas Board of Medical Examiners for licensure, must have completed or be enrolled in an accredited residency program in the field for which privileges are requested, and must also hold a valid and unsuspended certificate to practice medicine issued by the State of Texas.

Dentists. An applicant for dental membership in the medical staff shall be a graduate of a dental school approved at the time of the issuance of such degree by the Texas State Board of Dental Examiners for licensure and must also hold a valid and unsuspended certificate to practice dentistry issued by the State of Texas.

Podiatrist. An applicant for podiatric membership in the medical staff shall hold a Doctor of Podiatric Medicine (DPM) degree conferred by a school approved at the time of issuance of such degree by the Council on Podiatric Medical Education of the American Podiatric Medical Association and must hold a valid and unsuspended license to practice podiatry by the State of Texas.

3.4 Waiver of Qualifications

Under special circumstances, in order to serve the best interests of the hospital and medical staff, one or more of the above qualification requirements may be waived at the discretion of the MEC on a case-by-case basis.

3.5 Responsibilities of Medical Staff Membership

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

a. Providing patients with the quality of care meeting the professional standards of the Medical Staff of this hospital;

b. Abiding by these bylaws and the rules and regulations of the Medical Staff;

c. Working cooperatively with medical Staff members, nurses, hospital administration and others;

d. Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership;

e. Abiding by applicable hospital bylaws, rules, policies and protocols;

f. Providing medical care to patients in emergency situations wherever and whenever needed regardless of the member’s category of appointment or the patient’s ability to pay;

g. Requesting consultation from other specialties as the needs of the patient require, and providing consultation to other medical staff members when requested;

h. Arranging for coverage at all times when not available by another member of the Medical Staff with the same clinical privileges.

i. Self-reporting any physician health matter, including impairment or substance abuse matters;

j. Self-reporting loss of professional liability insurance;

k. Self-reporting any investigation, recommendation, limitation, suspension or termination regarding:

    1. Privileges at any other health care facility; or
    2. License to practice by any state or federal agency as required by these bylaws.

l. Actively participating in the hospital's quality improvement and utilization review activities;

m. Performing other staff obligations as may be established from time to time by the medical staff;

n. Medical staff members may also be expected to discharge in a reasonable manner the following responsibilities:

    1. Serving on medical staff committees;
    2. Providing Emergency Department call coverage;
    3. Regularly attending Medical Staff meetings and Service Committee meetings as specified in these bylaws;
    4. Timely response to patients upon admission and ordering appropriate tests and basic treatments when given basic admitting privileges;
    5. Assuring appropriate communication with consultants. Emergent/urgent consults shall require both a STAT physician order as well as direct physician-to-physician communication. Routine consults shall require a physician order, physician-to-physician communication and be requested with the expectation that consultations will be seen within 24 hours, unless otherwise specified by the requesting physician.

ARTICLE IV. CATEGORIES OF THE MEDICAL STAFF

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

4.1 Active Medical Staff

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

Responsibilities.

- Make reasonable attempts to participate in meetings of the department and/or committees to which the member is appointed;
- Meet established continuing medical education requirements;
- Actively participate in quality assessment and improvement activities of the Medical Staff;
- Maintain accurate, legible, timely, and complete medical records; and
- Demonstrate the capability to provide continuous and timely care to the satisfaction of the MEC and Governing Board.

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

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

4.2 Associate Medical Staff

Qualifications. The Associate Staff shall consist of physicians, dentists and podiatrists who have twenty-five (25) or fewer patient care admissions in the hospital each year.

Responsibilities.

a. Make reasonable attempts to attend and participate in meetings of the Medical Staff;

b. Meet established continuing medical education requirements;

c. Actively participate in quality assessment and improvement activities of the Medical Staff; and

d. Maintain accurate, timely, complete medical records

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

4.6 Emeritus Medical Staff

Qualifications. Emeritus Staff members shall be physicians, dentists and podiatrists who have retired from active practice and have provided extensive and meritorious services to the Medical Staff, the hospital or the community over an extended period of time. To be eligible for

appointment to the Emeritus Staff, a practitioner must meet at least three (3) of the following criteria:

a. Fifteen (15) or more years in good standing on the Active Medical Staff of the hospital;

b. Service as a clinical Service Chairman;

c. Service as a Medical Staff officer;

d. Exemplary record of community service; or,

e. Recommendation by the MEC.

Prerogatives. Emeritus Medical Staff members may attend Medical Staff meetings, CME activities and Medical Staff social events. Emeritus Medical Staff members may participate as members of Medical Staff committees not otherwise limited to Active Medical Staff members if the Emeritus Medical staff member has been requested to do so by a clinical service or other committee chairperson and authorized to do so by the Chief of Staff.

Limitations. Emeritus Staff members are not eligible to hold clinical privileges at the hospital. Emeritus Staff member shall abide by all applicable laws, rules and regulations regarding confidentiality. Emeritus Medical Staff members shall not hold office nor vote in Medical Staff elections.

4.7 Affiliated Medical Staff

The Affiliated Medical Staff shall consist of physicians, dentists, podiatrists, and advanced practice clinicians who;

i. Are not eligible or are not requesting appointment to the Active or Associate Categories; **or**

ii. Will practice at the hospital exclusively from a remote location, such as telemedicine or similar means; **or**

iii. Are seeking membership without clinical privileges.

The Affiliated Staff members shall have no Hospital, department or committee responsibilities, and may not vote or hold office.

ARTICLE V. PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

5.1 Conditions and Duration of Membership and/or Clinical Privileges

Initial appointments and reappointments to the medical staff shall be made by the governing body. The governing body shall act on appointment, reappointments, or revocation of appointments only after there has been a recommendation from the Medical Staff as provided in these bylaws; provided that in the event of a delay of more than 90 days upon receipt of a completed application on the part of the Medical Staff, the governing body 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 medical staff.

Appointments and reappointments to the Medical Staff and/or clinical privileges shall be for a period established by the Governing Board up to a maximum of three (3) years. Membership and the granting of clinical privileges may initially be for a duration less than three (3) years as determined appropriate by the MEC or as appropriate to establish a uniform credentialing cycle for those applicants with medical staff membership or clinical privileges at one or more hospitals in the Health System. Appointment or Reappointment periods of less than three (3) years are not considered adverse actions as defined within the Corrective Action and Fair Hearing Plan.

Appointment to the Medical staff shall confer on the appointee only such clinical privileges as have been granted by the governing body, in accordance with these bylaws.

Temporary privileges may be granted by the CEO pending board approval.

Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every medical staff member's obligation to provide continuous care and supervision of his patients, to abide by the medical staff bylaws, rules and regulations, to accept committee assignments, and to participate in Emergency Department call coverage as established by MEC and Hospital consistent with the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA) unless specifically exempted upon recommendation of the medical staff. Participation in Emergency department call coverage is a responsibility of eligible practitioners and is not an assumed right of membership and/or clinical privilege.

5.2 Application for Appointment

Each application for appointment to the medical staff shall be in writing, and signed by the applicant on a form prescribed by the MEC, approved by the Board, and appended in the rules and regulations. The application shall be submitted to contracted Credentialing Verification Office and shall require detailed information concerning the following:

a. Applicant's professional qualifications and shall include the names of at least two practitioners 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, ethical character, and peer relationships. Peer recommendation includes written information regarding the practitioners current: medical/clinical knowledge, technical and clinical skills, clinical judgement, interpersonal skills, communication skills, and professionalism.

b. Information relevant to the applicant's professional education, professional experience, evidence of current licensures, proof of liability insurance and

Primary source verification of the National Practitioner Data Bank (NPDB) and query of the Office of Inspector General's List of Excluded Individuals and Entities (OIG LEIE) will be conducted by contracted Credentialing Verification Office;

c. History of license suspension, revocation or other alteration in licensure status;

d. History of disciplinary action by hospitals, professional societies and specialty boards;

e. Complete history of any past or current malpractice claims, or alteration in professional liability insurance coverages and contain a statement as to any high risk areas of practice;

f. Licensure requirements is contingent on physician specialty;

g. Any physician who changes his insurance carrier or renews his insurance within the three year appointment timeframe must submit this information to the Credentialing Liaison and contracted Credentialing Verification Office within 30 days of the change;

h. Information as to whether the applicant's membership status and/or clinical privileges have ever been revoked, suspended, reduced, or not renewed at any other hospital or institution, and whether his license to practice in any jurisdiction has ever been suspended, probated, or terminated;

i. Information as to whether the applicant's narcotics license has ever been suspended or revoked;

j. A statement from each of the two referring practitioners noted above, that the applicant is known by him to be free from substance addiction, and to have no mental or physical disabilities, which might impair the performance of the privileges, which he seeks.

All correspondence from this staff and hospital to sources named or implied above, pursuant to the acquisition of necessary information upon which to judge an applicant's fitness for staff membership and privileges, shall be accompanied by a release of liability signed by the applicant, approved by the medical staff upon recommendation of the MEC appended to the rules and regulations.

The applicant shall have the burden of producing adequate information for a proper evaluation of his competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications. The completed application shall be submitted to the Credentialing Verification Office for processing and verification. Once the contracted Credentialing Verification Office collects the references and other materials deemed pertinent, the completed file is then submitted to the local medical staff office for review and preparation for submission to the MEC.

By applying for appointment to the medical staff, each applicant thereby signifies his willingness to appear for interviews in regard to his applications, authorizes the hospital to consult with members of medical staff of other hospitals with which the applicant has been associated and

with others who may have information bearing on his competence, character and ethical qualifications, consents to the hospital's inspection of all records and documents that may be material to an evaluation of his professional qualifications and competence to carry out the clinical privileges he requests as well as of his moral and ethical qualifications for medical staff membership, releases from any liability all representatives of the hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his credentials and releases from any liability all individuals and organizations who provide information to the hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.

The application form shall include a statement that the applicant has read the bylaws and rules and regulations of the medical staff, and minimally acknowledges the availability of the bylaws of the board of directors to read. Furthermore, he agrees to be bound by the terms thereof if he is granted membership and/or clinical privileges, and to be bound by the terms thereof without regard to whether or not he is granted membership and/or clinical privileges in all matters relating to consideration of his application.

No applications shall be considered complete until all such information is supplied.

5.3 Continuing Education

As a basic element of professional practice, the Medical Staff are expected to complete continuing professional education as required by the Texas Administrative Code and the Texas Medical Board. Continuing education units are made available through staff participation in Morbidity and Mortality (M&M) Committee meetings and the physician peer review program facilitated by the Rural and Community Health Institute (RCHI).

5.4 Appointment Process

Within 90 days after receipt of the completed application for membership, the MEC shall make a written report of its assessment to the governing body, including its recommendation that the practitioner be appointed to the medical staff or be rejected for medical staff membership. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may, where appropriate, be qualified by probationary conditions.

Prior to making this report and recommendation, the MEC shall examine and deliberate upon all evidence obtained through information contained in references given by the practitioners, and from other sources available to the committee, including but not limited to the National Practitioner Data Bank (NPDB) and the Office of the Inspector General (OIG) and criminal history check. These deliberations must contain at a minimum, consideration of the applicant's training, licensure status and history, board certification status and history, disciplinary action, actions by other hospitals, professional societies, and specialty boards, professional liability insurance status and history, privileges and standings at other hospitals, high risk areas of practice, previous drug and alcohol problems, physical and mental health status (to include TB testing (this excluded all tele-med only practitioners and pathology), chest X-ray or risk assessment results), geographic location of the applicant, past peer and subordinate professional

relationships, ability of the hospital to provide adequate facilities and support services for the individual applicant for his patients, and patient care needs for additional staff members with the applicant's skills and training. Every clinical service in which an applicant seeks privileges, shall provide an appraisal as to whether the practitioner has established and meets all the necessary qualifications for the category of staff membership and the clinical privileges requested by him. In serious deliberations, the MEC may find, on a simple majority vote, that an applicant is unsuitable for staff membership based on any or all of the considerations above. The executive committee shall submit to the governing body, its majority recommendation together with its report, completed application and all other documents considered in arriving at its recommendation. Additionally, it shall submit its written recommendation specifically delineating clinical privileges based on the recommendations of every service committee in which the practitioner seeks privileges.

When the recommendation of the MEC is to defer the application for further consideration, it must be followed up within 30 days with a subsequent recommendation for appointment with specified clinical privileges, or for rejection for staff membership; provided, however, that the MEC shall submit a recommendation to the governing body within 90 days of the receipt of the practitioner's complete application.

When the recommendation of the MEC is favorable to the practitioner, the MEC shall promptly forward it, together with all supporting documentation, to the governing body.

When the recommendation of the MEC is adverse to the practitioner either in respect to appointment or clinical privileges, the CEO shall promptly so notify the practitioner by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the governing body until after the practitioner has exercised or has been deemed to have waived his right to a hearing as provided in Article IX of these bylaws.

Within sixty (60) days after receipt of a favorable recommendation, the governing body or its MEC shall act in the matter. The hospital must notify the applicant in writing of the decision not later than the twentieth (20) day after the date on which action is taken. If the governing body's decision is adverse to the practitioner in respect to either appointment or clinical privileges, the CEO shall notify him of such adverse decision by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the practitioner has exercised or has been deemed to have waived his rights under Article IX of these bylaws and until the joint conference committee has met as described in subsection i. below. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

At its next regular meeting after all of the practitioner's rights under Article IX have been exhausted or waived, the governing body or its duly authorized committee shall act in the matter not later than sixty (60) days after the date on which the recommendations of the MEC is received. The governing body's decision shall be conclusive, except that the governing body may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the governing body shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation, and new evidence in the matter, if any, the

governing body shall make a decision either to appoint the practitioner to the staff or to reject him for staff membership. All decisions to appoint shall include a delineation of the clinical privileges, which the practitioner may exercise.

Whenever the governing body's decision will be contrary to the recommendation to the MEC, the governing body shall submit the matter to a joint committee composed of the chief of the medical staff, Chiefs of the Service Committees and a similar delegation representing the governing body. The committee so composed shall review matters pertinent to the issue and make a recommendation, which the governing body shall consider before making its decision final.

When the governing body's decision is final, it shall send notice of such decision through the CEO to the chairman of the MEC, and to the chief of service concerned, and by certified mail, return receipt requested, to the practitioner.

5.5 Reappointment Process

Three months prior to expiration of the appointment a complete reappointment packet is sent to the applicant by contracted Credentialing Verification Office. The fully completed packet is to be returned to contracted Credentialing Verification Office within the ninety (90) days or staff privileges will be rescinded and a new application must be submitted.

Prior to the final scheduled governing body meeting in the medical staff year, each Chief of Service shall review all pertinent information available on each practitioner in their respective services who are scheduled for periodic appraisal, according to the schedule outlined in Article V, Section 1.c., for the purpose of determining its recommendations for reappointments to the medical staff in any category, and for the granting of privileges for the ensuing period, and shall transmit its recommendations, in writing, to the governing body. Where non-reappointment or a change in clinical privileges is recommended, the reason for such recommendations shall be stated and documented.

Membership and the clinical privileges to be granted upon reappointment shall be based upon such member's professional competence and clinical judgment in the treatment of patients, his ethics and conduct, his attendance at medical staff meetings and participation in staff affairs, his compliance with the hospital bylaws and the medical staff bylaws, rules and regulations, his cooperation with hospital personnel, his use of the hospital's facilities for his patients, his relations with other practitioners, and his general attitude toward patients, the hospital and the public.

Each staff member being considered for reappointment shall be responsible for maintaining his physical and mental health status as well as his freedom from substance abuse.

Each staff member being considered for reappointment shall report to the local medical staff office all professional liability action in the interval since his previous staff appointment or reappoint.

Thereafter, the procedure provided in Section 4 of this Article V relating to recommendations on applications for initial appointment shall be followed.

5.6 Notice of Licensure/Medical Privileges/Professional Liability Action

Each applicant for medical staff appointment or reappointment or for renewed or revised clinical privileges or each medical staff member within thirty (30) days of the occurrence must provide in writing to the MEC a synopsis regarding the following:

a. Challenge to any licensure or registration, or voluntary or in-voluntary relinquishment of such licensure or registration;

b. Voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges.

c. Information on final judgments or settlements in any professional liability action in which he is involved.

Information relative to the above three items shall be placed in each credentials file for members of the medical staff and others with clinical privileges as deemed appropriate by the MEC.

5.7 Leave of Absence

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

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

Reinstatement Following Leave. Prior to termination of a leave the practitioner must request reinstatement by completing a "Request for Return from Leave of Absence." The request shall include evidence of continued and current competence, a summary of relevant professional activities, if any, during the leave and evidence of a good physical and mental health, which shall be reviewed by the chief of service. If a medical leave of absence has been granted the practitioner must have a "Return to Work Statement" completed by his healthcare provider for the specific medical condition that resulted in the request for leave of absence.

Failure to Request Reinstatement. Failure to submit a request for reinstatement will be deemed a voluntary resignation of medical staff membership and clinical privileges at the end of the practitioner's current appointment. Termination of appointment and clinical privileges under these circumstances does not entitle the practitioner to the procedural rights afforded by the hearing and appeal process outlined in the bylaws process. If the medical staff appointment and

clinical privileges expire or are resigned, the practitioner will be required to submit an application and appropriate fees, which will be processed as an application for initial appointment. The medical staff member requesting reinstatement, reappointment or appointment must submit such information to the MEC and to the board of directors.

ARTICLE VI. CLINICAL PRIVILEGES

6.1 Clinical Privileges

Every application for staff appointment and reappointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence and judgment, clinical performance, references and other relevant information. Privilege determinations may also be based on an appraisal by the service in which such privileges are sought. The service shall have the prerogative of establishing its rules and regulations concerning the criteria on which to judge such competency.

Periodic re-determination and/or request for modification of clinical privileges shall be made by the MEC upon the recommendation of the service in which clinical privileges are held during the biennial reappointment process. Such re-determination of clinical privileges or the increase or curtailment of same shall be based upon the specific privileges desired by the applicant, direct observation of patient care provided, review of records of patients treated in this or other hospitals and in review of the records of the medical staff which document the evaluation of the member's participation in the delivery of medical care through quality review and monitoring activities which the medical staff deems appropriate. The MEC and the specific Service Committee are empowered to conduct the aforementioned patient records review.

All members of the Medical Staff shall exercise only such clinical privileges as are approved by the Governing Board upon the recommendation of the MEC acting upon the recommendation of the Service Committee in which such privileges are sought.

Privileges for Podiatrists and Dentists. Clinical privileges for podiatrists and dentists shall be granted on a case-by-case basis in accordance with licensure, education, training, current competence, experience and other qualifications deemed applicable.

There is no provision in these bylaws for independent patient care provided by other than physicians, dentists and podiatrists.

6.2 Temporary Privileges

Temporary privileges may be granted in two circumstances: (1) to fulfill an important patient care, treatment, and service need; or (2) when a new applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Staff and the Board.

a. Patient Care Need. Temporary clinical privileges may be granted on a case-by-case basis by the CEO or designee, upon recommendation of the Chief of Staff, to fulfill an important patient care need that mandates an immediate authorization to practice for a limited period of time, while the full credentials

information is verified and approved. When temporary privileges are granted to meet an important patient care need, the Chief of Staff shall verify the Practitioner's current licensure and current competence. Examples would include, but are not limited to situations where:

1. A member becomes ill or takes a leave of absence and a practitioner would need to cover his/her practice until s/he returns.
2. A specific practitioner has the necessary skills to provide care to a patient that no member currently privileged possesses.

b. New Applicants. When an applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Staff and the Board, the CEO or designee, upon positive recommendation of the Chief of Service and Chief of Staff, may grant the applicant temporary privileges for no more than 120 days

c. Special requirements of supervision and reporting may be imposed on any Practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the CEO or designee with concurrence of the Chief of Staff upon notice of any failure by the Practitioner to comply with such special conditions.

d. The CEO or designee, with concurrence of the Chief of Staff, may at any time terminate a Practitioner's temporary privileges effective upon discharge from the hospital of the Practitioner's patient(s). However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the Practitioner, the termination may be imposed by any person entitled to impose a summary suspension and shall be immediately effective. The Chief of Staff shall assign a member of the Medical Staff to assume responsibility for the care of such terminated Practitioner's patient(s) until they are discharged from the hospital. The wishes of the patient(s) shall be considered where feasible in selection of such substitute Practitioner.

6.3 Emergency Privileges

In the case of emergency, any physician, podiatrist or dentist member of the medical staff, to the degree permitted by his license and regardless of service or staff status or lack of it, shall be permitted and assigned to do everything possible to save the life of a patient using every facility of the hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such physician, podiatrist or dentist must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or he does not desire to request privileges, the patient shall be assigned to an appropriate member of the medical staff. For the purposes of this section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

6.4 Disaster Privileges

Disaster privileges may be granted upon activation of the Hospital's emergency operations plan. The CEO or Chief of Staff or his/her designee(s), on behalf of the Board, may grant disaster privileges in the event of a community-wide situation or declared emergency. The Medical Staff oversees the performance of those granted disaster privileges.

Disaster privileges may be granted to licensed independent practitioners upon presentation of a government issued photo identification (e.g., a driver's license or passport) and at least one of the following:

a. A current picture ID card from a health care organization that clearly identifies the practitioner's professional designation;

b. A current license to practice;

c. Primary source verification of licensure;

d. Identification indicating that the practitioner 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;

e. Identification indicating that the individual has been granted authority by a government entity to render patient care in emergency circumstances; or

f. Confirmation by current Medical Staff Member(s) with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

The CEO or Chief of Staff or his/her designee(s) are not required to grant disaster privileges to any individual requesting said privileges. Each decision will be made on a case-by-case basis. A denial of disaster privileges is not reportable to the National Practitioner Data Bank and does not give rise to procedural rights of review.

Primary source verification of licensure and credentials of individuals who receive disaster privileges will begin as soon as the immediate situation is under control and shall be completed within 72 hours from the time the volunteer practitioner presents to the organization. The CEO or Chief of Staff or his/her designee(s) will make a decision within 72 hours of the granting of disaster privileges related to the continuation of the disaster responsibilities initially assigned based on information obtained regarding professional practice. The privileging process will include:

a. Verification of licensure;

b. Verification of current clinical competence; and

c. Verification of current professional liability insurance coverage in an amount required by the Board of Directors.

A practitioner's disaster privileges will be immediately terminated in the event that any information received through the verification process indicates any adverse information or suggests the person is not capable of rendering services in an emergency.

Practitioners granted Disaster Privileges will wear appropriate identification in accordance with the Hospital's emergency operations plan.

The practitioner's privileges will be for the period needed during the duration of the disaster only and will automatically terminate at the end of the disaster.

Practitioners granted disaster privileges must comply with all routine activities to assure patient care including the completion of medical records.

6.5 Privileges (Special)

Privileges for special treatments and techniques not included under one of the clinical services would be applied for and granted in the same manner as core clinical privileges and shall be reviewed by the appropriate Chief of Service prior presentation to the MEC and board of directors for consideration.

6.6 Medical History and Physician Examination Privileges

The privilege to perform medical histories and physical examinations shall be granted to qualified applicants by the Board of Directors. A physical examination and medical history must be done no more than thirty (30) days before or twenty-four (24) hours after an admission for each patient by a physician or other qualified practitioner who has been granted these privileges by the medical staff. The medical history and physical examination shall be placed in the patient's medical record within twenty-four (24) hours after admission. When the medical history and physical examination are completed within the thirty (30) days before admission, an updated examination for any changes in the patient's condition must be completed and documented in the patient's medical record within twenty-four (24) hours after admission.

A medical history and physical examination shall be completed, documented and placed within the patient's medical record for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. Elective inpatient or outpatient surgery (to be performed under other than local anesthesia) will be cancelled or delayed until a pertinent history and physical examination is recorded in the medical record.

Podiatric outpatient history and physical examinations (ASA Class III and higher) may be completed by a non-credentialed provider, that is acting within his/her scope or practice under state law or regulations. The history and physical exam must be completed within 30 days of the scheduled procedure. The credentialed podiatric provider is responsible for reviewing the H&P and providing an update that is specific to their specialty. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

If a complete history has been recorded and a physical examination performed prior to the patient's admission to the hospital, not to exceed 30 days prior to admission, a reasonable durable, legible copy of these reports may be used in the patient's hospital medical record in lieu of the admission history and report of the physical examination, provided these reports were

recorded by a member of the medical staff unless otherwise stated. In such instances, or when the patient has a history and physical from previous hospitalization within the last 30 days for the same condition, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must be recorded within 24 hours after admission.

A temporary suspension in the form of withdrawal of all of attending physician's clinical and admitting privileges, effective until medical records are completed, shall be imposed automatically after warning of delinquency for failure to complete a History and Physical or Operative Report within twenty four hours and all other medical records within 14 days of patient discharge.
The HIM Director shall notify a practitioner of his delinquency status, with copies of the warning notice to the chief executive officer. The practitioner may be permitted one week in which to complete the delinquent records, History and Physical or Operative Report after receiving the delinquent warning. If the Chief, or his designee, of the medical staff does not intercede on his behalf within the stated time span, the delinquent practitioner's privileges must be temporarily suspended by the Chief Executive Officer.

6.7 Telemedicine Privileges

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

a. The Hospital uses the credentialing and privileging decision made by the distant-site to make a final privileging decision. For the medical staff to rely upon the credentialing and privileging decisions made by the distant-site hospital when making recommendation on privileges for the individual distant-site physicians and practitioners providing such services, the Hospital's governing body ensures, through its written agreement with the distant-site hospital, that all of the following provisions are met:

1. The distant site providing the telemedicine services is a Medicare-participating and Joint Commission-accredited hospital or ambulatory care organization,

2. The individual distant-site physician or practitioner is privileged at the distant-site providing the telemedicine services for those services to be provided at the originating site, and the distant site provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or ambulatory care organization,

3. The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the Hospital whose patients are receiving the telemedicine services is located,

4. Provide proof of malpractice insurance in the type, amount and duration required by the Hospital, and

5. With respect to a distant-site physician or practitioner, who holds current privileges at the hospital whose patients are receiving the telemedicine services (originating site), the hospital has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site hospital such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided by the distant-site physician or practitioner to the hospital's patients; and all complaints the hospital has received about the distant-site physician or practitioner.

b. The originating site privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission-accredited organization. Once the medical staff makes its recommendation regarding the privileging of the telemedicine provider, it then must go through the remainder of the credentialing process for a decision regarding approval by the Board.

c. The Hospital fully privileges and credentials the practitioner.

d. The Distant Site will attest that it has privileged the practitioner and the practitioner is licensed in Texas.

e. The services of the Distant Site practitioners shall be subject to Focused and Ongoing Professional Practice Evaluations, these Bylaws, Rules and Regulations and Hospital policies. Once there is approval of a recommendation for privileges from the medical staff, the governing body shall decide whether to grant privileges through the usual credentialing process.

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

ARTICLE VII. ADVANCED PRACTICE CLINICIAN

7.1 Advanced Practice Clinicians

The Advanced Practice Clinicians (APC) shall consist of independently licensed non-physician health care professionals who regularly care for patients in the hospital. Advanced Practice Clinicians who are employed by the hospital will be evaluated for employment through the Human Resource (HR) process. All Advanced Practice Clinicians will be credentialed by through the credentialing process. Such APCs are eligible for practice privileges if they:

a. Hold a license, certificate or other legal credential in a category of APCs which the board of directors has identified as eligible to apply for practice privileges;

b. Document their experience, background, training, demonstrated ability, judgment, and physical and mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency established by the hospital, and that they are qualified to exercise practice privileges within the hospital; and

c. Are determined, on the basis of documented references to adhere strictly to the ethics of their respective professionals; to work cooperatively with others in the hospital setting; and to be willing to commit to and regularly assist the hospital in fulfilling its obligations related to patient care, within the areas of their professional competence and credentials.

d. The board of directors upon recommendation of the MEC shall review and identify the categories of APCs, based upon occupation or profession, which shall be eligible to apply for practice privileges in the hospital. For each eligible APC category, the board of directors upon recommendation of the MEC shall identify the practice privileges and prerogatives that may be granted to qualified APCs in that category.

e. An APC must apply and qualify for practice privileges, and practitioners who desire to supervise or direct APCs who provide dependent services must apply and qualify for privileges to supervise approved APCs.

f. The privileges and responsibilities connected with an APC's providing patient care services within the hospital are detailed in the medical staff rules and regulations regarding APCs.

g. APCs will be voting members of the MEC. They may also attend M&M meetings and receive continuing education credit.

h. APCs who are employed by the hospital are governed by their terms of employment and are not subject to medical staff corrective action set forth in Article VIII. APCs are afforded access to the fair hearing and appeal processes.

7.2 Procedural Review and Notice

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

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

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

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

A Review Officer may or may not be a member of the Medical Staff, but shall be an individual not in direct economic competition with the APC, and may not have advised the Chief of Staff or the Administrator regarding the adverse recommendation or action. A Review Officer may or may not be an attorney at law. When a Review Officer is appointed in addition to a Review Committee, the Review Officer shall act as the presiding officer of the review, provide advice and counsel to the Review Committee, and attend and participate in deliberations, but may not vote.

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

Review Process.

a. The Review Committee shall conduct the review in the form of a dialogue and inquiry review format, not as an adversarial hearing.

b. The Review Committee shall present a written report, including a recommendation regarding the modification or revocation of the APC's privileges, to the Medical Staff. The Medical Staff shall, within thirty (30) days of the date of the review, forward the Review Committee's report to the Board of Directors along with (1) a recommendation in support of the Review Committee's findings, (2) a statement of disagreement with the Review Committee's findings, or (3) no comment.

c. The Board of Directors shall review the findings of the Review Committee and the recommendation of the Medical Staff, if any, and shall, within thirty (30) days of the receipt of the report and recommendation, make a final decision regarding the modification or revocation of the APC's privileges. The APC shall have no further rights to appeal the Board's decision.

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

Effect of this Section. This Section does not grant the APC the right to a hearing under Article IX of these Bylaws and does not affect the at-will employment status of an APC employed by the Hospital or by a member of the Medical Staff. This Section does not apply to an automatic suspension pursuant to Section 8.3 of these Bylaws. An APC whose privileges are terminated pursuant to the termination of the APC's sponsorship or employment by a member of the Medical Staff is not entitled to the rights of review provided by this section.

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

ARTICLE VIII. CORRECTIVE ACTION

8.1 Procedure

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

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

Within thirty (30) days after the MEC's receipt of the request for corrective action, the ad hoc committee shall make a report of its investigation to the MEC. Prior to the making of such report, the practitioner against whom corrective action has been requested shall have an opportunity for an interview with the ad hoc investigating committee. At such interview, he shall be informed of the general nature of the charges against him, and shall be invited to discuss, explain or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these bylaws with respect to hearings, shall apply thereto. A record of such interview shall be made by the ad hoc committee and included with its report to the MEC.

Following receipt of a report from an ad hoc committee following the ad hoc committee's investigation of a request for corrective action involving reduction or suspension of clinical privileges, the MEC shall take action upon the request. If the corrective action could involve a reduction or suspension of clinical privileges, or a suspension or expulsion from the medical staff, the affected practitioner shall be permitted to make an appearance before the MEC prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature and none of the procedural rules provided in these bylaws with respect to hearings shall apply thereto. A record of such appearance shall be made by the MEC.

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

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

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

8.2 Summary Suspension

Any one of the following:

a. Chief of the medical staff and one or more other members of the MEC;

b. A chief of service and one or more members of the MEC;

c. CEO and one or more members of the MEC of either the medical staff or the governing body,

shall have the authority, whenever failure to take such action may, in his/her opinion, result in an imminent danger to the health or safety of any individual may summarily suspend all or any portion of the clinical privileges of a practitioner or APC. Such summary suspension shall become effective immediately upon imposition.

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

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

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

8.3 Suspension

Incomplete Medical Records

a. A temporary suspension in the form of withdrawal of all of a practitioner's admitting and clinical privileges effective until medical records are completed, may be imposed after warning of delinquency for failure to complete medical records within fourteen (14) days of patient discharge.

Should a physician exceed three (3) suspensions for medical records delinquency in a rolling two (2) year period (with this matter being referred to the Chief of Staff), they will be removed from the medical staff and must reapply (which may be an occurrence reportable to the NPDB).

b. The HIM Director shall notify a practitioner of his or her delinquency status and provide a copy of the warning notice to the CEO. The HIM Director will also notify all Department Managers of the practitioner's suspension. The practitioner may be permitted one week in which to complete the delinquent record. If the medical records are not completed within one week, the practitioner will be automatically suspended.

c. The suspension is automatically terminated upon completion of delinquent records. The practitioner will notify the CEO or the HIM Director when the delinquent records have been completed.

Expirables

If a practitioner's licensure renewal or DEA certification is not completed by the expiration date of the issued medical license or DEA certification, the practitioner's clinical privileges are automatically suspended until proof of renewal is submitted to the credentialing liaison (HIM Director). The specified date of expiration assigned to the license will be the date considered when suspension is activated. Grace periods of licensing agencies will not be recognized as an extension of the licensing period for the purposes of these bylaws.

Upon expiration of professional liability insurance, the practitioner's clinical privileges are automatically suspended until proof of liability insurance is submitted to and verified by the contracted Credentialing Verification Office and communicated to the Credentialing Liaison (HIM Director). The specified date of expiration assigned to the policy will be the date considered when suspension is activated. Grace periods of insuring entities will not be recognized as an extension of the insured period for the purposes of these bylaws. Practitioners shall secure "prior acts coverage" for the uninsured period.

If a practitioner's participation in the Medicare or Medicaid programs is suspended or terminated, the practitioner's clinical privileges shall be automatically suspended.

Action by a licensing agency revoking or suspending a practitioner's license, or placing the practitioner on probation, shall automatically suspend all of the practitioner's clinical privileges.

No practitioner whose admitting privileges have been suspended shall have his or her patients admitted by another practitioner and then care for them himself. All privileges are lost while suspended.

If at any time an appointee is sanctioned by the Office of the Inspector General (OIG) the MEC will review and recommend further actions to be taken. Immediate steps may be taken by the Chief of the medical staff and the CEO to prevent errant billing and to maintain compliance with the Centers for Medicare and Medicaid Services Conditions of Participation.

It shall be the duty of the Chief of the medical staff to cooperate with the CEO in enforcing all automatic suspensions.

Whenever any of the actions specified in subsections b, c, d, or e above occur, the practitioner or APC must immediately report it to the CEO, who shall notify the Chief of Staff. In addition to the above referenced sections, a practitioner or APC must report, within 72 hours and in writing, any voluntary or involuntary termination of medical staff appointment, limitation, or reduction or loss of privileges at another hospital or health care entity. Failure to so report, without good cause, is grounds for automatic revocation of Medical Staff appointment and clinical privileges.

8.4 Notice of Removal of a Physician

The MEC shall draft a letter to be used to notify hospitalized patients of the removal of their attending physician's staff privileges and to honor the patient's wishes as regards a replacement. Immediately upon the removal of staff privileges of a member of the Medical Staff, the CEO or his designee shall utilize such letter to accomplish the above.

8.5 Report to Regulatory Entities

In the event a professional or review action, as hereinabove set forth, shall adversely affect the clinical privileges of the practitioner for a period of longer than thirty (30) days; or, in the alternative, in the event the hospital accepts the surrender of clinical privileges of a physician while the physician is under an investigation by the hospital relating to possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding, then the hospital shall report to the Texas Medical Board and the NPDB all of the following information:

a. The name of the practitioner involved.

b. A description of the acts or omissions, or other reasons, for the action or, if known, for the surrender.

c. Such other information respecting the circumstances of the action or surrender as the Texas Medical Board may deem appropriate.

ARTICLE IX. HEARING AND APELLATE REVIEW PROCEDURE

9.1 Right to Hearing and to Appellate Review

When any practitioner receives notice of a recommendation of the MEC that, if ratified by decision of the governing body, will adversely affect the practitioner's appointment to or status as a member of the medical staff or his exercise of clinical privileges for greater than 14 days, the practitioner shall be entitled to a hearing before an ad hoc committee of the medical staff. If the recommendation of the MEC following such hearing is still adverse to the affected practitioner, the practitioner shall be entitled to a fair hearing by the governing body before the governing body makes a final decision on the matter.

When any practitioner receives notice of a decision by the governing body that will affect the practitioner's appointment to or status as a member of the medical staff or his exercise of clinical privileges, and such decision is not based on a prior adverse recommendation by the MEC with respect to which the practitioner was entitled to a hearing and appellate review, the practitioner shall be entitled to a hearing by a committee appointed by the governing body, and if such hearing does not result in a favorable recommendation, to an appellate review by the governing body, before the governing body makes a final decision on the matter.

Events Giving Rise to Hearing Rights.

a. Actions or Recommended Actions. Subject to the exceptions below, the following actions or recommended actions, if deemed adverse, entitle the practitioner to a hearing upon timely and proper request:

   1. Denial of initial Staff appointment;
   2. Denial of reappointment;
   3. Suspension of appointment;
   4. Revocation of appointment;
   5. Denial of requested appointment to or advancement in Staff category;
   6. Reduction in Staff category;
   7. Special limitation of the right to admit patients not related to standard administrative or Medical Staff policies within the Hospital as a whole or within one or more specific Services;
   8. Denial or restriction of requested clinical privileges;
   9. Reduction in clinical privileges;
   10. Suspension of clinical privileges;
   11. Revocation of clinical privileges;
   12. Individual application of, or individual changes in, mandatory consultation or supervision requirement;
   13. Summary suspension of appointment or clinical privileges if more than fourteen (14) days.

b. When Deemed Adverse. Except as provided below, any action or recommended action listed above is deemed adverse to the practitioner only when it has been:

   1. Recommended by the medical staff; or
   2. Taken by the board under circumstances whe3re no prior right to request a hearing existed.

c. Exceptions to Hearing Rights.

1. Certain Actions or Recommended Actions. Notwithstanding any provision in the Medical Staff Bylaws to the contrary, the following actions or recommended actions do not entitle the practitioner to a hearing:
    a) The issuance of a verbal warning or formal letter of reprimand;
    b) The imposition of a monitoring or consultation requirement as a condition attached to the exercise of clinical privileges during a provisional period;
    c) The imposition of a probationary period involving review of cases but with no requirement either for direct, concurrent supervision or for mandatory consultation;
    d) The removal of a practitioner from a medico-administrative office within the Hospital unless a contract or employment arrangement provides otherwise; and
    e) Any other action or recommended action not listed above.
2. Other Situations. An action or recommended action listed in Section 8.1, paragraph one above does not entitle the practitioner to a hearing when it is:
    a) Voluntarily imposed or accepted by the practitioner unless such action is required to be reported to the National Practitioner Data Bank;
    b) Automatic pursuant to any provision of the Medical Staff Bylaws and related policies; or
    c) Taken or recommended with respect to temporary privileges unless a report to state or federal authorities is made, as in the case of limitation or termination of privileges in excess of 14 days.

9.2 Exception to Right to Hearing.

The clinical privileges and medical staff membership of members who are directly under contract with or provide services pursuant to an agreement with a contracting entity of the hospital shall be subject to termination in accordance with the terms of their contracts, and such medical staff member shall not be entitled to the procedural rights as specified in the bylaws or rules and regulations, except to the extent that the member's medical staff membership or clinical privileges which would otherwise exist independent of the contract are to be limited or terminated, or except where the limitation or termination is for reasons pertaining to the member's professional conduct which could be reasonably deemed to be a threat to patient safety or pertaining to the quality of care provided by the medical staff member. Whenever all of a contract practitioner's clinical privileges are terminated or suspended, that practitioner's medical staff membership shall be deemed terminated or suspended.

9.3 Notice of Adverse Recommendation or Decision

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

a. That a professional review action has been proposed to be taken against the practitioner.

b. The reasons for the proposed action.

c. That the practitioner has the right to request a hearing on the proposed action.

d. Any time limit of not less than thirty (30) days within in which to request a hearing.

e. A summary of the practitioner's rights in the hearing.

9.4 Request for Hearing

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

9.5 Waiver of Hearing

The failure of a practitioner to request a hearing to which he is entitled by these bylaws within the time and manner herein provided shall be deemed a waiver of the practitioner's right to such hearing and to any appellate review to which the practitioner might otherwise have been entitled on the matter.

When the waived hearing relates to an adverse recommendation of the MEC of the medical staff or of a hearing committee appointed by the governing body, the same shall thereupon become and remain effective against the practitioner pending the governing body's decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the governing body, the same shall thereupon become and remain effective against the practitioner in the same manner as a final decision of the governing body provided for in these Bylaws. In either of such events, the CEO shall promptly notify the affected practitioner of his status by certified mail, return receipt requested.

9.6 Notice of Hearing

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

request of the practitioner involved. The notice of the hearing may be supplemented at a later date.

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

9.7 Appointment of Hearing Committee and/or Hearing Officer

By Medical Staff. A hearing occasioned by an adverse Medical Staff recommendation shall be conducted by a hearing committee appointed by the Chief of Staff and composed of no less than two (2) nor more than four (4) Practitioners. The Chief of Staff shall designate one of the appointees as chair of the committee.

By the Board of Directors. A hearing occasioned by an adverse decision of the Board shall be conducted by a hearing committee appointed by the Chair of the Board of Directors and composed of no less than two (2) nor more than four (4) persons, including a Practitioner. The Board of Directors' Chair shall designate one appointee to serve as chairman of the committee.

Appointment of Hearing Officer. The use of a hearing officer is optional. A hearing officer may or may not be an attorney at law but must be experienced in and recognized for conducting hearings (e.g., arbitration proceedings, employee labor disputes and/or grievance procedures, administrative proceedings, military courts martial or like proceedings, and so on) in an orderly, efficient and non-partisan manner. The hearing officer shall not be any individual who is in direct economic competition with the individual requesting the hearing and shall not act as a prosecuting officer or as an advocate to either side at the hearing.

a. As Alternative to Hearing Committee. As an alternative to the hearing committee, the Chief of Staff may appoint a Hearing Officer to perform the functions that would otherwise be carried out by the hearing committee, including but not limited to making findings and recommendations. In the event a hearing officer is appointed instead of a hearing committee, all references in this Article to the "Hearing Committee" will be deemed to refer instead to the Hearing Officer.

b. As Presiding Officer of Hearing Committee. The Chief of Staff may appoint a Hearing Officer who may be an attorney to act as presiding officer of the Hearing Committee. The Hearing Officer shall not act as an advocate for either side at the hearing and shall not be entitled to vote. The Hearing Officer may participate in the private deliberations of the Hearing Panel and act as legal advisor to the Committee. If no Hearing Officer has been appointed, the Chair of the Hearing Committee shall serve as the presiding officer and shall be entitled to one vote. The presiding officer shall:

1. Allow the participants have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross examination;
2. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay;
3. Maintain decorum throughout the hearing; (d) Determine the order of procedure;
4. Rule on all matters of procedure and the admissibility of evidence; and
5. Allow argument by counsel on procedural points outside the presence of the Hearing Committee unless the Committee wishes to be present.

c. Service on the Hearing Committee. An individual shall not be disqualified from serving on a hearing committee merely because he or she has heard of the case or has knowledge of the facts involved or what he or she supposes the facts to be.

9.8 List of Witnesses

The witness lists shall be amended as soon as possible by the appropriate party when additional witnesses are identified. The hearing committee may permit a witness who has not been listed in accordance with this Section 9.8 to testify if it finds that the failure to list such witness was justified, that such failure did not prejudice the party entitled to receive such list, or that the testimony of such witness will materially assist the hearing committee in making its report and recommendation.

9.9 Conduct of Hearing

Following is the procedure for fair hearing:

a. An accurate record of the hearing must be kept by use of a court reporter unless all parties to the hearing agree on some other recording method. Copies of the record may be obtained by the practitioner upon payment of any reasonable charges associated with preparation thereof.

b. The personal presence of the practitioner for whom the hearing has been scheduled shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his rights and to have accepted the adverse recommendation or decision involved.

c. Postponement of hearings beyond the time set forth in these bylaws shall be made only with the approval of the ad hoc hearing committee. Granting of such postponements shall only be for good cause shown and in the sole discretion of the hearing committee.

d. The affected practitioner shall be entitled to be accompanied by and/or represented at the hearing by an attorney or other person of his choice. The MEC or Board, depending on whose recommendation or decision prompted the hearing, shall designate a person to support its recommendation

or decision and in addition may appoint an attorney to represent it during the hearing.

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

f. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rules, which might make evidence inadmissible over objection in civil or criminal action. The parties shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record.

g. The MEC must present appropriate evidence in support of the adverse recommendation or decision, but the affected practitioner shall thereafter be responsible for supporting his or her challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack of any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious.

h. The parties shall have the following rights: to call or examine witnesses, to introduce written evidence, to cross examine any witness on any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence. If the practitioner does not testify in his own behalf, he may be called and examined as if under cross examination. The hearing committee may order that oral evidence be taken only on oath or affirmation administered by any person entitled to notarize documents in the state where the hearing is held.

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

j. A member of the fair hearing committee shall not vote on any recommendations unless he has been in attendance for the entirety of all hearing meetings or read the transcript of the hearing during which he was absent.

9.10 Hearing Committee Report

Within a reasonable time after final adjournment of the hearing, not to exceed thirty (30) days the hearing committee shall make a written report and recommendation and shall forward the

same together with the hearing record and all other documentation to the MEC or to the Governing Board, whichever appointed it. The hearing committee shall similarly and promptly provide the involved practitioner with the same written report and recommendation by certified mail, return receipt requested. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the MEC or decision of the governing body. The written report will be filed within a reasonable time, but not more than thirty (30) days, following adjournment of the hearing.

9.11 Action on Hearing Committee Report

If, after the MEC has considered the report and recommendation of the hearing committee and the hearing record, the MEC's reconsidered recommendation is favorable to the practitioner, it shall be submitted to the governing body. If, however, such recommendation continues to be adverse, the CEO shall promptly so notify the practitioner, by certified mail, return receipt requested, and advise the practitioner of his/her right for appellate review. The CEO shall also forward such recommendation and documentation to the governing body, but the governing body shall not take any action thereon until after the practitioner has exercised or has been deemed to have waived his right to an appellate review.

9.12 Appeal to the Governing Body

Following is the process for appealing to the Governing Body:

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

b. If such appellate review is not requested within thirty (30) days, the affected practitioner shall be deemed to have waived practitioner's right to the same, and to have accepted such adverse recommendation or decision.

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

d. The appellate review shall be conducted by the governing body or by a duly appointed appellate review committee of the governing body of not less than three (3) members.

e. The affected practitioner shall have access to the report and record, and transcription, if any, of the ad hoc hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against the practitioner. The practitioner shall have thirty (30) days after receipt of the notice of appellate review to submit a written statement in the practitioner's own behalf, in which those factual and procedural matters with which the practitioner disagrees, and the reasons for such disagreement, shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Governing Body through the CEO at least ten (10) days prior to the scheduled date for the appellate review. A similar statement may be submitted by the MEC of the medical staff or by the governing body, and if submitted, the CEO shall provide a copy thereof to the practitioner at least ten (10) days prior to the date of such appellate review by certified mail, return receipt requested.

f. The governing body or its appointed review committee shall act as an appellate body. It shall review the record created in the proceedings, and shall consider the written statements submitted for the purpose of determining whether the adverse recommendation or decision against the affected practitioner was justified and was not arbitrary or capricious. If oral argument is requested as part of the review procedure, the affected practitioner shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him or her by any member of the appellate review body. The MEC or the governing body, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to him or her by a member of the appellate review body.

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

h. If the appellate review is conducted by the governing body, it may affirm, modify or reverse its prior decision, or, in its discretion, refer the matter back to the MEC for further review and recommendation within ten (10) days. Such referral may include a request that the MEC of the medical staff arrange for a further hearing to resolve specified dispute issues.

i. If the appellate review is conducted by a committee of the governing body, such committee shall, within thirty (30) days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the governing body affirm, modify or reverse its prior decision, or refer the matter back to the MEC for further review and recommendation within five (5) days. Such referral may include a request that the MEC of the medical staff arrange for a further hearing to resolve disputed issues. Within fifteen (15) days after receipt of such recommendation after referral, the committee shall make its recommendation to the governing body as above provided.

j. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in these Bylaws have been completed or waived. Where permitted by the hospital bylaws, all action required of the governing body may be taken by a committee of the governing body duly authorized to act.

9.13 Final Decision by Governing Body

Within thirty (30) days after the conclusion of the appellate review, the governing body shall make its final decision in the matter and shall send notice thereof to the MEC and, through the CEO, to the affected practitioner, by certified mail, return receipt requested. If this decision is in accordance with the MEC's last recommendation in the matter, it shall be immediately effective and final, and shall not be subject to further hearing or appellate review. If this decision is contrary to the MEC's last such recommendation, the governing body shall refer the matter to the Joint Conference Committee for further review and recommendation within fourteen (14) days, and shall include in such notice of its decision a statement that a final decision will not be made until the Joint Conference Committee's recommendation has been received. At its next meeting after receipt of the Joint Conference Committee's recommendation, the governing body shall make its final decision.

Notwithstanding any other provision of these bylaws, no practitioner shall be entitled a right to more than one hearing and appellate review on any matter which shall have been the subject of action by the MEC, or by the governing body, or by a duly authorized committee of the governing body, or by both.

A practitioner whose privileges have been revoked shall not be eligible to reapply for medical staff membership and privileges for a period of five (5) years.

ARTICLE X. OFFICERS

10.1 Officers of the Medical Staff

The officers of the medical staff shall be as follows:

a. Chief of Staff;

b. Vice Chief of the Medical Staff;
c. Immediate Past Chief of the Medical Staff (formerly Counselor);
d. Secretary-Treasurer.

10.2 Qualifications of Officers

Officers must be members of the active medical staff at the time of nomination and election 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.

10.3 Conflict of Interest

All nominees for election or appointment to medical staff offices and department chair positions (including those nominated by petition of the medical staff) shall, at least thirty (30) days prior to the date of election or appointment, disclose in writing to the MEC those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the medical staff. The MEC shall evaluate the significance of such disclosures and discuss any significant conflicts with the nominee. If a nominee with a significant conflict remains on the ballot, the nature of his conflict shall be disclosed in writing and circulated with the ballot.

10.4 Election of Officers

a. The regular election of medical staff officers will be held every other year at the annual meeting of the medical staff. Election will be by voice vote of voting members present unless secret ballot is requested, in writing, by any voting member at least seven (7) days prior to voting. All officers will require confirmation by the board of directors.
b. The nominating committee shall consist of members of the Active Medical Staff appointed by the Chief of the medical staff. This committee shall offer one or more nominees for each office.
c. Nominations may also be made from the floor at the time of the annual business meeting.

10.5 Term of Office

All officers shall serve a two year term from their election date or until a successor is elected. Officers shall take office on the first day of the medical staff year following his election. Each officer shall serve until the end of his term and until a successor is elected, unless he shall sooner resign or be removed from office.

10.6 Removal of Officers

All officers of the medical staff serve at the pleasure of the majority of the members of the medical staff as indicated by their election and in a similar manner may be removed when their service is no longer satisfactory to the medical staff.

Upon the presentation of a "Petition for the Removal of an Officer of the Medical Staff" signed by one-third (1/3) of the members of the active medical staff to the MEC at their regularly scheduled meeting, a vote on the petitioned removal of the officer shall be scheduled as the first item of business at the next regularly scheduled medical staff meeting.

The petition shall serve as the motion and second. Discussion of the removal shall be allowed, but two-thirds (2/3) of the active medical staff members present at the medical staff meeting may vote to close the discussion.

Chief of the medical staff shall preside over the discussion and vote to remove an officer of the Medical Staff except in instances where the petition is for the removal of the Chief of Staff. In that instance, the Vice Chief, Immediate Past Chief, or Secretary-Treasurer shall preside over the discussion and vote in that order of precedence unless it is a petition for their removal. In the instance in which there exist petitions for removal of all medical staff officers, the CEO of the hospital shall preside over that portion of the meeting concerned with removal, discussion, and votes.

Removal of an officer of the medical staff shall require a two-thirds (2/3) vote of all members of the active medical staff present at the meeting, shall be performed by secret ballot, and the vote tabulation shall be performed by an election judge elected by a majority of the members of the medical staff present at the meeting.

In the case of the removal of a medical staff officer or officers, the highest-ranking officer following the clearing of all petitions to remove, shall take charge of the meeting, and the next order of business shall be the election of replacement officers. Nominations shall be made from the floor, and a simple majority vote from the active medical staff members present at the meeting shall be required to fill the vacancy.

Removal of a general staff officer may be initiated by the board of directors acting upon its own recommendation. Permissible bases for removal of general staff officer include, without limitation:

a. Revocation of professional license by authorizing state agency;
b. Suspension from the medical staff (other than for delinquent medical records);
c. Failure to perform the required duties of the office;
d. Failure to adhere to professional ethics;
e. Failure to comply with or support enforcement of the hospital and medical staff bylaws, rules and regulations and policies;
f. Failure to maintain professional liability insurance;
g. Failure to maintain active staff status;
h. Physical or mental infirmity that renders the officer incapable of fulfilling the duties of his office;
i. Other conditions, as approved by the MEC.

10.7 Vacancies in Office

Vacancies in office during the medical staff year, except for the chief of the medical staff, shall be filled by the process described in section 10.6, paragraph six. If there is a vacancy in the office of the chief, the vice chief shall serve out the remaining term.

10.8 Duties of Officers

Chief of Staff. The chief of staff shall have the following responsibilities:

a. Act in coordination and cooperation with the CEO in all matters of mutual concern within the hospital.

b. Call, preside at, and be responsible for the agenda of all general meetings of the medical staff.

c. Serve on the medical staff MEC.

d. Serve as ex officio member of all other medical staff committees without vote and not counting toward a quorum.

e. Be responsible for the enforcement of medical staff bylaws, rules and regulations, 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 practitioner.

f. Appoint committee members to all standing, special, and multi-disciplinary medical staff committees except the MEC.

g. Represent the views, policies, needs and grievances of the medical staff to the governing body and to the CEO.

h. Be the spokesman for the medical staff in its external professional and public relations.

i. Attend regular and called meetings of the governing body and in the absence of a Joint Conference Committee, represent to the board the interest of the medical staff relating to pertinent actions taken or contemplated plans for future growth or problems that may arise during the normal course of hospital operations.

Vice Chief. In the absence of the chief of staff, the Vice Chief shall assume all the duties and have the authority of the chief of staff. The Vice Chief shall be a member of the MEC and of the Joint Conference Committee. The Vice Chief shall automatically succeed the chief of staff when the latter fails to serve for any reason.

Immediate Past Chief of Staff (formerly Counselor). The duties of the immediate past chief of staff shall be advisory in nature. The Immediate Past Chief of Staff shall be a member of the MEC with full voting privileges.

Secretary-Treasurer. The Secretary-Treasurer shall be a member of the MEC. The secretary shall keep accurate and complete minutes of all medical staff meetings, call medical staff

meetings on order of the chief, attend to all correspondence, and perform such other duties as ordinarily pertain to the office of secretary-treasurer.

ARTICLE XI. NONDEPARTMENTALIZED SERVICES

11.1 Organization of Services Non-Departmentalized

Because of the size of this hospital, the organization of the staff shall be non-departmentalized and shall be operated as an organization of services.

a. There shall be services of Surgical, Pediatric, Perinatal/Gynecology, Medicine (includes Family Medicine, Hospitalist Medicine, and Rehabilitation) and Emergency/Trauma Medicine.

b. Psychiatric care shall be the responsibility of the Medicine Service.

c. Clinical privileges in the newborn nursery shall be granted by the Pediatric Service.

d. Clinical privileges for obstetrics and gynecology shall be granted through the perinatal/gynecology service.

11.2 Qualifications, Selection and Tenure of Chiefs of Service

a. Each chief must be a member of the active medical staff, have privileges in the service, and frequently and regularly admit patients to that service.

b. Each chief of service shall be nominated by the nominating committee of the medical staff, be elected by a simple majority of the full active medical staff present at the annual medical staff meeting, and serve for two (2) years without limitation on succession.

c. Removal of a chief of service during this term of office may be initiated by a petition to remove by two-thirds (2/3) majority vote of all active medical staff members of the particular service. Such removal shall be effective upon the majority vote of the active medical staff and upon the ratification of the governing body. An interim chief of service shall be appointed by the chief of the medical staff, and shall serve until the next regular staff meeting at which time the medical staff shall nominate and elect by simple majority, a new chief of service.

d. The other two (2) members of the service committee shall be nominated, elected, and shall serve in a manner similar to the chief of service.

e. The other two (2) members of the service committee may be removed and replaced in a manner similar to that of the chief of service.

f. All nominees for election or appointment to medical staff offices and chief of service positions (including those nominated by petition of the medical staff) shall, at least thirty (30) days prior to the date of election or appointment, disclose in writing to the MEC those personal, professional, or financial affiliations or relationships of which they are reasonably aware that

could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the medical staff. The MEC shall evaluate the significance of such disclosures and discuss any significant conflicts with the nominee. If a nominee with a significant conflict remains on the ballot, the nature of his or her conflict shall be disclosed in writing and circulated with the ballot.

11.3 Functions of Chief of Service

Each chief of service shall:

a. Be accountable for all professional and administrative activities within the service.

b. Maintain continuing review of the professional performance of all practitioners with clinical privileges in the service, and report thereon as necessary to the MEC.

c. Biennially make specific recommendations as to the continuation, increase or decrease of service privileges for each practitioner in the service to the executive committee as an element of the reappointment process. Each recommendation shall be with the advice and consent of the service committee.

d. May appoint two (2) members of his service, one of whom may be the chief, to conduct the initial phase of patient care review when required by these bylaws.

e. Be responsible for enforcement of the hospital bylaws and of the medical staff bylaws, rules and regulations within the service.

f. Be responsible for implementation within the service of actions taken by the MEC.

g. Transmit to the MEC the service committee's recommendations concerning the staff classification and delineation of clinical privileges for all practitioners in the service at the time of initial appointment, or at any other time at the request of the MEC.

h. Be responsible for the teaching and education program in the service.

i. Participate in every phase of administration of the service through cooperation with the nursing service and the hospital administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques.

j. Assist in the preparation of such annual reports, including budgetary planning, pertaining to the service as may be required by the MEC, the chief officer or the governing body.

11.4 Functions of Service Committee

Each service committee shall conduct quality improvement activities as outlined in the hospital Quality Improvement (QI) Plan and conduct such business consistent with the rules and regulations pertaining to that service. Each clinical service committee shall recommend its own

rules and regulations, consistent with the policies of the medical staff and of the governing body for the conduct of the service committee and of the service, for the conduct of patient care within the service, and for the granting of clinical privileges and the review of same in the service. These rules and regulations, when approved by the medical staff and ratified by the governing body, shall be appended in the Medical Staff Rules & Regulations.

The service shall, at regular or called meetings, determine recommendations to be made to the MEC on hospital policy, as it affects that particular service.

A petition for resolution of a complaint against the Service Committee, signed by one-third (1/3) of the members of a particular clinical service shall, upon presentation to the MEC of the medical staff at its regularly scheduled meeting, require specific action by the MEC.

11.5 Assignment to Services

The MEC shall, after consideration of the recommendations of the clinical service committees, recommend initial service assignments for all medical staff members.

11.6 General Practice and Family Practice

General practitioners as well as family practitioners shall have clinical privileges granted through the Family Practice/Medical, in all areas of the medical staff endeavor in accordance with their education, training, experience and demonstrated competence. An exception to this shall be surgery performed in the

operative suite, which shall require joint appointment to the Surgical Service, subject to the rules of the Operative/Invasive Service Committee and to the jurisdiction of its chief of service and service committee in all matters pertaining to the conduct of surgery. Family practice staff members may request joint appointment to other services, may sit on service committees and serve as chief of service of other services.

ARTICLE XII. COMMITTEES

12.1 Executive Committee of the Medical Staff

Composition. The MEC shall be a standing committee and may include physicians and other licensed independent practitioners of any discipline or specialty. The majority of voting Medical Staff MEC members is fully licensed doctors of medicine or osteopathy actively practicing in the Hospital. The CEO of the hospital shall be an ex-officio member of this committee, without a vote and not counting towards a quorum. The MEC will meet at least ten times a year or as often as necessary to perform its function. A physician will be nominated/elected from each service (on a biennial basis) to serve on the MEC to include; Surgical, Pediatric, Perinatal/Gynecology, Medicine (includes ICU, Family Medicine, Hospitalist Medicine, and Rehabilitation) and Emergency/Trauma Medicine. The CMO of CHRISTUS Mother Frances Hospital-Sulphur Springs will serve as a non-voting member of the MEC. The election of officers will be conducted as outlined in section 10.4 of these bylaws. The primary function of the organized Medical Staff or MEC is to approve and amend Medical Staff Bylaws and to provide oversight

for the quality of care, treatment, and services provided by practitioners with privileges, and to define the structure of the Medical Staff.

Duties of the Executive Committee. The duties of the MEC include the following:

a. To represent and act on the behalf of the medical staff, between meetings of the medical staff, subject to such limitation as may be imposed by these bylaws.

b. To coordinate the activities and general policies of the various components of the medical staff.

c. To insure that the medical staff is kept abreast of the accreditation program and informed of the accreditation status of the hospital.

d. To carefully review the applications and credentials of all applicants and make recommendations for staff membership, denial of staff membership, termination, assignments of services, and delineation of clinical privileges.

e. To review periodically all information available regarding the clinical competence and performance of staff members and other practitioners with clinical privileges and as a result of such reviews to make recommendations for reappointment or non- reappointment to the medical staff; and continuation, augmentation, or reduction in clinical privileges.

f. To take reasonable steps to insure professional ethical conduct in competent clinical performance on the part of all members of the medical staff. This shall include the initiation of and/or participation in medical staff corrective or review/measures when warranted.

g. To provide liaison between the medical staff and the CEO and the governing body.

h. To recommend action to the CEO and CMO on matters of medico-administrative nature.

i. To make recommendations on hospital management matters (for example, long range planning) to governing body through the CEO and/or CMO.

j. To fulfill the medical staff's accountability to the governing body for medical care rendered to patients in the hospital and in the observations of the rules and regulations laid down in these bylaws by each individual medical staff member.

k. To provide preparation of all meeting programs, either directly or through delegation to a program chairman, or suitable agent.

l. To provide Professional Library Services. The committee shall be responsible for analysis of the changing needs of the hospital library services. These activities shall include deletion of outmoded material as well as acquisition of new material. A library chairman, who may not necessarily be a member of the MEC, may be appointed to perform this function.

m. To be responsible for making recommendations relating to revisions to and updating of the bylaws, rules and regulations of the medical staff.

n. To be responsible for insuring that the medical staff participates in the development and maintenance of methods for protection and care of hospital patients and others at the time of an internal or external disaster.

o. The chairman of the MEC shall be the chief of the medical staff.

p. The MEC is responsible to the board of directors for implementing the Quality Improvement Program within the medical staff through its organized service committees and departments.

q. To provide for ad hoc educational programs to the medical staff for quality improvement purposes, which may include presentations, discussions, case studies, case reviews, and case comparisons, according to the policies and procedures established to assure the protection of the medical committee privilege.

r. To provide oversight in the process of analyzing and improving patient satisfaction.

12.2 Service Specific Committees

Following are the designated medical staff service committees:

a. Family Practice/ICU/Medicine/Rehabilitation (Includes Diagnostic Radiology)

b. Perinatal/Pediatric

c. Operative/Invasive Procedures (Includes Interventional Radiology)

d. Emergency-Trauma Medicine

Committee responsibilities include but are not limited to the following:

a. May be convened at any time by the chief of service, on direction of the MEC or upon the request of the clinic directors within the service, Administration or another medical service committee;

b. Establish medically/clinically valid policies, procedures and criteria for the provision and assessment of patient care;

c. Review specific cases or matters referred from MEC, QIPS or other hospital or process improvement committees for evaluation of quality of service or patient safety;

d. The Trauma Committee, a sub-committee of the Emergency Medicine Committee, meets regularly to consider trauma-specific matters. The Trauma Committee may report directly to the MEC.

Medical service committee membership is outline in Attachment A.

12.3 Joint Conference Committee

The Joint Conference Committee shall be convened only as an ad hoc committee, and shall consist of an equal number of representatives from the governing body and from the Active Medical Staff. The representatives shall be President, Vice President and Secretary of the Board and the Chief of Staff, Vice Chief of Staff, and Secretary of the Medical Staff. The CEO of the hospital shall be an ex officio member of the committee without vote and not counting toward a quorum. A quorum shall be two-thirds (2/3) of the membership. The committee shall meet only as necessary to fulfill the requirements under Article IX below.

ARTICLE XIII. MEDICAL STAFF MEETINGS

13.1 Regular Meetings

Medical Staff meetings will be held annually to review and evaluate performance of the medical staff, to consider and act upon committee reports, and to deal with all matters pertaining to the medical staff.

The staff meeting preceding the end of each medical staff year shall be the annual staff meeting at which any elections of officers for the ensuing period shall be conducted.

The MEC shall, by standing resolution, designate the time and place for all regular staff meetings. Notice of the original resolution and any changes thereto shall be given to each member of the staff in the same manner as notice of a special meeting.

13.2 Special Meetings

The chief of the medical staff, the MEC, or not less than one- fourth (1/4) of the members of the active medical staff may at any time file a written request with the chief of staff that within seven (7) days of the filing of such request, a special meeting of the medical staff be called. The MEC of the medical staff shall designate the time and place of any such special meeting. A special meeting may be called for any purpose including as a forum for conflict resolution between the organized medical staff and the MEC.

Written or printed notice stating the place, day and hour of any special meeting of the medical staff shall be delivered, either personally, by mail, or electronically to each member of the active staff not less than two (2) nor more than seven (7) days before the date of such meeting, by or at the direction of the chief (or other persons authorized to call the meeting). If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each staff member at his address as it appears on the records of the hospital. Notice may also be sent to members of other medical staff groups who have so requested. The attendance of a member of the medical staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice called the meeting.

13.3 Quorum

A quorum consists of those members present.

ARTICLE XIV. COMMITTEE AND SERVICE MEETINGS

14.1 Regular Meetings

Committees may, by resolution, provide the time for holding regular meetings without notice.

14.2 Special Meetings

A special meeting of any committee or service may be called by or at the request of the chairman or chief thereof, by the chief of the medical staff, or by one-third (1/3) of the group's then members, but not less than two (2). Special meetings may be called for various reasons including for the purpose of resolving conflicts between the organized medical staff and the MEC.

14.3 Notice of Meetings

Written or oral notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the committee or service not less than two (2) days before the time of such meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at his address as it appears on the records of the hospital with postage thereon prepaid. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

14.4 Quorum

The presence of at least one (1) member of the active medical staff of committee or service shall constitute a quorum at any service committee or other committee meeting.

14.5 Manner of Action

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee or service. Action may be taken without a meeting by unanimous

consent in writing (setting forth the action so taken) signed by each member entitled to vote thereat.

14.6 Rights of Ex-officio Members

Persons serving under these bylaws as ex-officio members of a committee shall have, unless stated otherwise, all rights and privileges of regular members.

14.7 Minutes

Minutes of each regular and special meeting of a committee or service shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer and copies thereof shall be submitted to the attendees for approval, at the next regular meeting. Minutes shall be forwarded to the executive committee of the medical staff as appropriate. Each committee and service shall maintain a permanent file of the minutes of each meeting.

14.8 Attendance Requirements

Each active medical staff member is expected to attend and participate in all Medical Staff meetings and applicable department, service and committee meetings each year. Each MEC committee member shall be required to attend not less than fifty percent (50%) of all meetings in each year. The reasons provided for any absences and the action of the committee chairman thereon shall be shown in the minutes. The failure to meet the foregoing annual attendance requirements, unless excused by the committee chairman for good cause shown, shall be grounds for replacement of the committee member.

ARTICLE XV. IMMUNITY FROM LIABILITY

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

a. Any act, communication, report, recommendations, or disclosure, with respect to any such practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

b. Such privilege shall extend to members of the hospital's medical staff and of its governing body, its other practitioners, it's CEO and his representatives, and to third parties, who supply information to any of the foregoing authorized to receive, or act upon the same. For the purpose of this Article XV, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the governing body or of the medical staff.

c. There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

d. Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to:

1. Applications for clinical privileges;
2. Periodic reappraisals for appointment or clinical privilege;
3. Corrective action, including summary suspension;
4. Hearings and appellate review;
5. Medical care evaluations;
6. Utilization reviews;
7. Other hospital, service or committee activities related to quality patient care and inter- professional conduct.

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

f. In furtherance of the foregoing, each practitioner shall, upon request of the hospital, execute releases in accordance with the tenor and import of this Article XV in favor of the individuals and organizations specified in paragraph Second, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this state.

g. The consents, authorizations, releases, rights, privileges and immunities provided by these bylaws for the protection of this hospital's practitioners, other appropriate hospital officials and personnel, and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article XV.

h. The hospital and medical staff shall prepare an instrument in keeping with the provisions and spirit of the above article, which shall be entitled "Release of Liability in the Pursuit of Information for Medical Staff Membership and Credentialing." Such instrument shall be signed by an applicant for medical staff membership with the provision that a photocopy for the original shall bid in the same manner of the original, and a copy shall be included with each request for the information pertaining to an applicant's ability for staff membership and privileges. This instrument shall be recommended by the MEC, and will be considered in force when approved by the medical staff and governing body. It shall be included in the rules and regulations.

ARTICLE XVI. RULES AND REGULATIONS

The medical staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these bylaws, subject to the approval of the governing body. These shall relate to the proper conduct of medical staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the hospital. Such rules and regulations shall be a part of these bylaws, except that they may be amended or repealed by a simple majority of the MEC at any regular meeting at which a quorum is present and without previous notice. Such changes shall become effective when approved by the governing body. Rules and regulations may be organized in any manner suitable to the medical staff.

ARTICLE XVII. AMENDMENTS

17.1 Review Every Two Years

The chief of staff shall instruct the MEC to review the bylaws for any necessary or desired amendments on an as needed basis, but not less often than biennially. The MEC work will be handled by the MEC.

17.2 Proposed Amendments to Bylaws

A proposed amendment to the Bylaws or Rules and Regulations may be referred to the MEC by the medical staff, by the MEC, or by a service committee.

17.3 Vote on Amendments or Changes in Rules and Regulations

The MEC shall report proposed Bylaw amendments or rules and regulations to the medical staff committee at the next regular or called meeting. Proposed changes must be mailed to all Active Staff members prior to the medical staff meeting at which a vote is to be held. The three-step process to approval is as follows:

17.3.1 MEC

A vote will be taken by the MEC and requires (2/3) majority to pass and present to the general medical staff.

17.3.2 General Medical Staff

A vote by the general medical staff requires two-thirds (2/3) majority to pass and present to the governing board.

17.3.3 Governing Board

The governing board will vote and approve or disapprove by simple majority vote.

ARTICLE XVIII. ADOPTION

These bylaws shall be adopted by two-thirds (2/3) vote of those members present at any regular or special meeting of the active medical staff at which a quorum is present, shall replace any previous bylaws, and shall become effective when approved by the governing body of the hospital.

Last revision completed and approved by MEC, Medical Staff, and Governing Board on April 2025.