MEDICAL STAFF BYLAWS

PETERSON HEALTH

KERRVILLE, TEXAS

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TABLE OF CONTENTS

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PREAMBLE

The Medical Staff of Peterson Health (Medical Center) will organize the activities of qualified physicians, dentists, podiatrists, and Advanced Practice Providers in order to carry out the functions delegated to them. This organized Medical Staff will conform with the Bylaws and Rules and Regulations stated here and is ultimately subject to the authority of the Board of Directors of Peterson Health.

DEFINITIONS

1. An “Adverse Recommendation or Action” is a recommendation or action listed in Article IX.

2. The term “President” (formerly - "Chief Executive Officer”) means the individual appointed by the Board of Directors to act on its behalf in the overall management of the Medical Center and shall include his designee (the Chief Medical Officer) in his absence.

3. “Continuous Quality Improvement” refers to the Medical Center’s performance improvement program adopted annually by the Medical Executive Committee and the Board of Directors.

4. The term "he" or "him" or "his" includes both the masculine and feminine gender as well as both singular and plural.

5. The term “Investigation” for purpose of mandatory reporting to the National Practitioner Data Bank shall have the meaning set forth in Article XV.

6. The term “medical peer review” shall have the meaning set out in Article XV of these Bylaws.

7. “Medical Staff Bylaws” or “Bylaws” shall refer to these Bylaws and the Rules and Regulations unless the context clearly indicates otherwise. Any reference to an “Article” shall be to an Article in these Bylaws.

8. A “patient contact” is defined as the following with respect to a patient at the Medical Center: an admission for inpatient or observation status, a consultation involving examination of the patient, the performance of an outpatient procedure or procedure in the emergency department, a face-to-face evaluation in the emergency department, or the performance of a radiology, pathology or anesthesiology procedure or interpretation.

9. The term "Provider" means a licensed physician, dentist, podiatrist, or advanced practice provider.

10. “Chairman” is the chairman of the Board of Directors and includes a Vice Chair when the Chairman is not available.

11. The term “special notice” shall mean written notice delivered either by hand or certified mail, return receipt requested, and shall be considered delivered on the date received or refused.

12. The term "Staff" or “Medical Staff” means all Providers who have been granted membership on the Medical Staff of Peterson Health by the Board of Directors as provided in these Medical Staff Bylaws.

ARTICLE I: PURPOSE

The purposes of the Medical Staff are:

To promote a standard of high-quality patient care, treatment, and services based on best practice and evidence-based medicine, where available.

To recommend the scope of clinical privileges granted to Providers.

To provide for the ongoing evaluation (FPPE and OPPE) of the competency of Providers who are privileged.

To see that patient care is continuously reviewed and evaluated in accordance with the Medical Center’s performance improvement plan and these Bylaws, and provide leadership in performance improvement activities within the organization.

To offer advice, recommendations, and input to the President and the Board of Directors.

To initiate and maintain bylaws and rules and regulations for self-governance of the Staff.

To define the Medical Staff’s role within the context of the Medical Center setting and its responsibilities in the oversight of care, treatment and services, and create a system of rights and responsibilities between the Medical Staff and the Board of Directors and between the Medical Staff and its members.

ARTICLE II: MEMBERSHIP

Section 1. Nature of Membership

A. Membership on the Medical Staff is a privilege and not a right. It may be extended only to professionally competent Providers who continuously meet the qualifications, standards and requirements set forth in these Bylaws.

B. No Provider shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Medical Center merely by virtue of the fact that he is duly licensed to practice in this or in any other state, or that he is a member of any professional organization, or that he had in the past, or presently has, such privileges at another hospital.

C. Gender, race, creed, age, national origin, or other grounds not permitted by law are not used in making decisions regarding the granting or denying of Medical Staff membership or clinical privileges.

Section 2. Qualifications

A. Only those Providers licensed to practice in the State of Texas, who can document their background, experience and training, as well as demonstrate their current clinical competence, their adherence to the ethics of their profession, their good reputation, necessary health status and ability to fulfill the essential functions of Medical Staff membership and exercise the clinical privileges requested, and their ability and willingness to work personally and professionally in a non-disruptive manner with others in the delivery of quality health care, shall be eligible to be considered for membership on the Medical Staff.

B. The following general membership requirements for each applicant have been adopted:

1. Current, unrestricted Texas professional license.
2. Not on the Federal or Texas OIG exclusions lists.
3. Current, unrestricted Federal Drug Enforcement Agency (DEA) certification. Specialties not ordering or prescribing medications shall be exempt from this requirement.
4. Complete and accurate disclosure of any prior or current challenges or restrictions to licensure and DEA certification.
5. Active practice eighteen (18) months out of the last twenty-four (24) months in training, residency, or clinical practice.
6. Successful completion of an Accreditation Council on Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) approved residency training program consistent with privileges requested.
7. Current evidence of professional liability insurance coverage with a minimum coverage as determined by the Board of Directors.
8. Complete and accurate disclosure of current and past involvement in any professional liability action, its status and/or resolution.
9. Complete and accurate disclosure of any loss, restriction, or voluntarily/involuntary surrender of medical staff membership or clinical privileges at other health care entities.
10. Satisfaction of all professional criteria as established by the Service to which the applicant seeks admission.
11. No felony convictions.
12. Meet the CME requirements in the state of current practice.
13. As of January 1, 2013, all new staff members must be Board certified, in their primary specialty(ies) within the timeframe specified by their specialty board, but (*effective*

August 2020) only to a maximum timeframe of 5 years from completion of training. "Primary specialty" is defined, for the purpose of these Bylaws, as the specialty(ies) and/or sub-specialty(ies) in which the Provider practices; NOT the "primary" as defined by the ABMS. Board certification must be recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the American Board of Podiatric Specialties, as appropriate. All new staff members as of January 1, 2013 must also maintain board certification status to maintain medical staff privileges. If a Provider is reported as "Not Certified" by his/her certifying Board by virtue of having not completed Maintenance of Certification (MOC) requirements, the Provider must be in the process of addressing these requirements or have a plan to address these deficits with the goal of maintaining board certification by the next annual review subject to approval by the MEC and BOD. If board certification expires, due to extenuating circumstances, a request to maintain privileges and a plan for recertification within a reasonable period of time, may be submitted to the Credentials Committee. Alternative boards may be considered on a cases-by-case basis. The request must be submitted in writing to the Credentials Committee and be approved by the Medical Executive Committee and the Board of Directors. Providers on staff prior to January 1, 2013, are exempt from the requirement to maintain Board Certification.

Compliance with these minimum or threshold membership qualifications is required to apply for appointment or reappointment to the Medical Staff and to maintain that appointment once granted. For information regarding acceptable documentation and primary source verification, see Policy #7971, MS Qualifications for Medical Staff Appointment.

Section 3. Conditions and Duration of Appointment

A. Initial appointments and reappointments to the Medical Staff shall be made by the Board of Directors for up to a three (3) year period of time.

B. The Board of Directors shall act on appointments, reappointments, restrictions, or revocation of appointments only after there has been a recommendation from the Medical Executive Committee as provided in these Bylaws; provided, however, that in the event the Medical Executive Committee fails to act within ninety (90) days from the date that the fully completed application has been received by the Medical Executive Committee, the Board of Directors may act without such recommendation on the basis of documented evidence of the applicant's or Staff member's qualifications obtained from reliable sources other than the Medical Executive Committee.

C. Initial appointments for Providers seeking Medical Staff membership, if approved, shall be to one of the categories of the Medical Staff. The Provider will practice for a one (1) year period during which time the Provider shall be subject to focused professional practice evaluation (FPPE) in accordance with Medical Staff policy. Six (6) month and twelve (12) month evaluations of performance shall be conducted during the initial one year period. After the Provider has been on staff for twelve (12) months, the Provider will progress to an OPPE status if no issues have been identified while under FPPE status. Additional time

in FPPE status may be granted for a period of up to one (1) year in selected instances, if approved by the Medical Executive Committee and the Board of Directors.

D. Whenever a member of the Staff desires to change the category of his appointment or the extent or type of his privileges, he shall submit a letter to the Medical Staff Office, giving his specific reasons for making such requests. This request will be considered in the same manner and through the same procedures as are employed for appointments to the Staff.

E. It is the Provider's responsibility to keep all required licenses, certifications, and liability insurance current and documented with the Medical Staff Office. If not received by the Medical Staff Office by expiration date, the Provider will be subject to automatic action pursuant to Article VIII.

F. It is the Provider's responsibility to notify the Medical Staff Office as soon as possible and no later than seven (7) days after any of the following: official Board Order or Action issued to them by the Texas Medical Board, any changes to their DEA registration, including restriction, suspension or revocation; loss of professional liability insurance; any arrest or criminal conviction for misdemeanor or felony; exclusion from Federal Health Programs as a sanction for unlawful conduct; loss or suspension of privileges at another facility; or any investigation by any federal or state government agency including but not limited to CMS, OIG or DEA. Any loss or suspension of medical licensure or DEA registration requires immediate notification to the Medical Staff Office.

Section 4. Obligations of Appointment

Each Provider who submits an application for Medical Staff membership and each Provider who accepts appointment, reappointment, and/or clinical privileges agrees to review and abide by these Bylaws, Rules and Regulations, and any Medical Staff policies throughout any period of Medical Staff appointment and with the responsibilities of Medical Staff membership as such exist from time to time. More specifically and not in limitation, each Provider agrees to and shall during the term of his Medical Staff membership and/or any exercise of clinical privileges:

A. provide patients with quality care in accordance with accepted professional standards and the standards of the Medical Staff, comply with the ethical standards and professional guidelines of his profession, and conduct his professional practice with honesty and integrity;

B. provide for continuous care of the Provider's patients by personally attending those patients or by arranging for coverage for those patients by another member of the Medical Staff who holds the same or similar clinical privileges, as determined by the Medical Executive Committee with the approval of the Board of Directors, during any time that the Provider is not available;

C. abide by all Medical Center requirements, policies, and applicable legal and accreditation standards;

D. not delegate responsibility for diagnosis or care of any patient admitted to the Medical Center to a Provider who is not a member of the Medical Staff or to an allied health

professional who is not qualified to undertake this responsibility or who is not adequately supervised;

E. provide emergency call, seek consultation whenever necessary, and provide consultation within the scope of the Provider's capability and capacity, without regard to the patient's ability to pay, as may be further detailed in these Bylaws and the Rules and Regulations;

F. discharge in a responsible and cooperative manner the responsibilities and assignments associated with Medical Staff membership, including Medical Center and Medical Staff committee assignments, and participate professionally and cooperatively in medical peer review;

G. maintain in strictest confidence the records and proceedings of medical peer review and of all committees including, but not limited to, committees of the Medical Staff, the Medical Center, and the Board of Directors, as set forth in these Bylaws;

H. prepare and complete according to the Rules and Regulations, accurate, legible, and clinically pertinent medical records for all patients to whom the Provider provides care in the Medical Center;

I. comply with computerized physician order entry standards to support patient safety and to support the health system's pursuit of HIMSS 7 recognition;

J. cooperate with members, Medical Center staff and administration, and all others involved in the delivery of patient care in a respectful, courteous, and professional manner so as to promote the delivery of quality patient care and orderly operation of the Medical Center;

K. participate in continuing medical education as required by the Provider's professional licensing board and report such participation to the Medical Staff Office at the time of reappointment;

L. participate in a cooperative manner in any medical peer review activity and serve as a witness, hearing committee member, reviewer, consultant, or as otherwise requested by the Chief of Staff or the President; and

M. discharge such other Medical Staff responsibilities and obligations as may be established from time to time by the Medical Executive Committee or the Board of Directors.

N. agree to a health examination and/or cognitive testing when requested to do so in accordance with these Bylaws.

O. within reason and there is not good cause, appear before a standing committee or other meeting when requested to do so by the Chief of Staff, President/CEO, Board of Directors, or Medical Executive Committee.

P. agree to not misrepresent, misstate, or otherwise omit information on an application for initial appointment or reappointment, whether intentional or not. Judgment as to whether a

material misrepresentation, misstatement or omission has occurred rests solely on a determination by the Medical Executive Committee, subject to approval by the BOD.

Section 5. Leave of Absence

A. A member of the Medical Staff may, on written request to the Chief of Staff, be granted a leave of absence for military service, catastrophic illness, period of training, or other extenuating circumstances by the Board of Directors following consultation with the Medical Executive Committee. The leave of absence may be for a period not to exceed one (1) year or the end of the current term of appointment, whichever occurs first.

B. A Provider requesting to return from a leave of absence must file a written request for reinstatement with the Medical Staff Office at least thirty (30) days prior to the expected date of return and provide any requested information concerning his activities during the period of absence. The Provider may be restored to his prior Staff category and clinical privileges, if approved by the Medical Executive Committee and Board of Directors and/or may have conditions placed on his return if indicated. A Provider who does not meet the requirement in Section 2.B.5. above as a result of the approved leave of absence may be reinstated from the leave subject to a period of proctoring and/or other conditions.

Section 6. Provider Wellness

A. In documenting necessary health status and ability to fulfill the essential functions of Medical Staff membership and exercise the clinical privileges requested, a Provider may be required to submit to an examination and/or testing on request of the Chief of Staff, President, the CMO, or Chair of the Physician Wellness Committee. Failure to comply with required evaluation and/or testing shall be grounds for automatic suspension in accordance with Article VIII, Section 4. A request for examination and/or testing may also be made by the Credentials Committee in the case of an initial application for Medical Staff membership and failure to comply shall result in withdrawal of the application from consideration.

B. The Physician Wellness Committee shall operate pursuant to these Bylaws and written policy with a goal to aid a Provider in retaining or regaining optimal professional function, rather than discipline. Referrals to the committee may come from concerned individuals (peers, staff, office staff, family) or the Provider himself. Referrals can be made directly to a member of the Physician Wellness Committee or through the Physician Wellness Hotline. If at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that a Provider is unable to safely perform the privileges he has been granted, the matter shall be referred for appropriate corrective action including adherence to any state or federally mandated reporting requirements.

C. Provider applicants who are applying for initial Medical Staff membership and have been impaired by alcohol or drugs in the past must be alcohol/drug free for a two (2) year period, must submit proof of Alcoholic Anonymous or Narcotics Anonymous meeting attendance during this two (2) year period and any other requested information, must agree to a written contract with the Physician Wellness Committee in the form required by the committee,

and comply with any other requirements established by written policy.

Section 7. Dentists and Podiatrists

Unless otherwise required by the Board of Directors, dentists and podiatrists who are members of the Staff are not required to take emergency call for the Medical Center or comply with meeting attendance requirements.

ARTICLE III: PROFESSIONAL CODE OF CONDUCT

The Medical Staff will strive to maintain a professional environment in which to provide the best patient care possible. All patients, Providers, other health care team members, and visitors have a right to be treated with dignity, respect and courtesy at all times.

- Strive to promote a professional image among peers and colleagues
- Protect the professionalism and image of fellow Providers and health care team members
- Use positive, professional language that inspires confidence in the professional judgment, demeanor, training, and practice of staff
- Act in a way that protects the community investment in facilities and equipment
- Maintain the confidentiality of our colleagues, patients, and Medical Center business
- Conduct all personal interactions in a manner that respects each person's body, emotions, and spirit, and conforms with the highest standards of professional relationships at all times
- Maintain an appropriately positive public persona regarding the Medical Staff and its members, fellow health care team members, and the Medical Center
- Use the medical record to completely, honestly and solely document the required aspects of patient care activity
- Follow the methods described in the Bylaws to address concerns with issues associated with the Medical Staff, its members, and fellow health care team personnel
- Conduct professional practice in a manner consistent with the highest level of safety, infection control, documentation, and other relevant current and evolving standards.

As health care providers, we assume a position of high esteem and character. We each have an obligation to conduct ourselves with each other, with our patients and with our co-workers in a manner that is above reproach. When unprofessional or disruptive behavior is identified, it will be brought to the attention of the involved party with the expectation that such behavior not be repeated in accordance with written Medical Staff policy. Unprofessional or disruptive behavior may be reported to the appropriate committee for investigation and, if needed, corrective action according to Article VIII of these Bylaws. A single egregious incident may result in summary corrective action in accordance with Article VIII of these Bylaws.

ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

Section 1. The Medical Staff

The Medical Staff shall be divided into Active, Courtesy, Consultative, Community, Honorary, Advanced Practice Provider, and Advanced Practice Provider Community categories. A member of any category may participate in any continuing education programs offered by the Medical

Center. With the exception of Honorary Medical Staff members, all members shall be assigned to a Service.

Section 2. The Active Medical Staff

The Active Medical Staff shall consist of Providers who have regular patient contacts, provide continuous care to their patients and who assume all the functions and responsibilities of membership on the Active Medical Staff, including, where requested, emergency call and consultation assignments. Response to these duties, including emergency call, shall be in a timely fashion, as appropriate by specialty, and members of the Active Medical Staff must have their offices and residences within sufficient proximity of the Medical Center, as appropriate by specialty and as determined by the Medical Executive Committee and subject to the approval of the Board of Directors. Members of the Active Medical Staff shall be eligible to vote, to hold Staff and Service office, and to serve on and chair Medical Staff committees. Members of the Active Medical Staff during the first year as new members shall be eligible to vote, and to serve on Medical Staff committees, but not to hold Staff and Service office positions, or chair Medical Staff committees.

Members of the Active Medical Staff shall be required to attend fifty percent (50%) of the total regular Service and Staff meetings per year. However, attendance at any Staff committee to which a member has been appointed will be counted provided that attendance can be verified. Meeting attendance will be maintained in Provider files and reported on references and at reappointment review.

Section 3. The Courtesy Medical Staff

The Courtesy Medical Staff shall consist of Providers who are granted clinical privileges that may be exercised only while assuming call or shift coverage responsibilities for a member of the Active Medical Staff of the same specialty. When assuming call or shift coverage responsibilities pursuant to designation by the Active Medical Staff member, the Courtesy Medical Staff member shall respond to the Medical Center to attend the patient in person in a timely fashion as appropriate by specialty, as determined by the Medical Executive Committee and subject to the approval of the Board of Directors. When assuming call coverage responsibilities, the Provider shall have all of the other obligations of Active Medical Staff members, with the exception of meeting attendance. Courtesy Medical Staff members shall not hold office but may serve on Medical Staff committees and vote. Call coverage periods shall be restricted to a maximum of one-hundred-twenty (120) days of 24-hour call per term of appointment.

Section 4. The Consultative Medical Staff

The Consultative Medical Staff shall consist of Providers who act only as consultants by providing expertise in their area of training. Consultative Medical Staff members may not admit patients or perform invasive procedures in either the inpatient or outpatient setting. Consultative Medical Staff members may vote on any matter presented at meetings of the Staff, Service or committee of which they are a member when they are physically present, and may hold Service office or chair a committee, but are not eligible to serve as a Staff officer elected pursuant to Article X. ~~or to vote as provided in Article XVII.~~

A minimum of two (2) patient contacts per term of appointment is required for continued membership in this category; provided that, exceptions may be granted by the Board of Directors, following consultation with the Credentials Committee and the Medical Executive Committee, in areas of medical need. Consultative Medical Staff members shall have all of the obligations of Active Medical Staff members, with the exception of meeting requirements and emergency call; provided that, some areas of specialty may be required to submit an emergency call schedule at the discretion of the Medical Executive Committee, with the approval of the Board of Directors.

Section 5. The Community Medical Staff

The Community Medical Staff shall consist of Providers who do not have patient contacts and do not require clinical privileges, but who wish to be affiliated with the Medical Staff organization. The Community Medical Staff member must maintain an office in which professional services are provided that is located in the Medical Center's defined service area. Community Medical Staff members must comply with the general membership requirements in Article II, Section 2.b., with the exception of subsections 3, 5 and 7. They are not eligible for admitting or any other clinical privileges, but with the authorization of the patient or the patient's legally authorized representative may visit and review the patient's medical records during hospitalization.

Community Medical Staff members may serve on committees and vote on any matter presented at meetings of the Staff, Service or committees of which they are a member when they are physically present, and may hold Service office or chair a committee, but are not eligible to serve as a Staff officer. Community Medical Staff members shall have all of the obligations of Staff membership appropriate to their status but are not required to participate in emergency call or consultations since they do not hold clinical privileges. The Community Medical Staff meeting requirement shall be a minimum of two (2) Staff, Service, or committee meetings each year.

Section 6. The Honorary Medical Staff

The Honorary Medical Staff shall consist of Providers who are not active in the Medical Center and who are honored by emeritus status. These may be Providers who have retired from active practice or who are of outstanding reputation, not necessarily residing in the community. Honorary Staff members are not required to satisfy the requirements of Staff membership in Article II and shall not be eligible for admitting or any other clinical privileges, or to vote, hold office, or serve on committees.

Section 7. Advanced Practice Providers (APP)

Advanced Practice Providers (APP) are Providers affiliated with the Medical Staff for purposes of providing clinical services, consulting, teaching or other functions deemed necessary by the Medical Staff. Advanced Practice Providers must be sponsored by a physician member of the Medical Staff, unless allowed to practice independently as per state law.

If the APP loses their supervising physician, they have ninety (90) days to obtain a new supervising physician. The APP will be placed on administrative suspension until a new supervising physician is found or ninety (90) days have elapsed. Once the ninety (90) days have elapsed, the APP's membership will be terminated. There shall be no consequence to the APP

since the termination was an administrative one. The APP will have to reapply for membership in the future so long as they have a supervising physician.

Advanced Practice Providers may include individuals who practice independently within the scope of their licensure and are authorized to perform clinical service in a field allied to medicine but who do not hold a license to practice medicine, dentistry, psychiatry or podiatry.

Advanced Practice Providers shall consist of the following specialties:

- Physician Assistant
- Advanced Practice Registered Nurse – Certified Nurse Midwife
- Advanced Practice Registered Nurse – Certified Nurse Practitioner
- Advanced Practice Registered Nurse – Certified Registered Nurse Anesthetist
- Advanced Practice Registered Nurse – Clinical Nurse Specialist
- Psychologist or Licensed Counselor (PhD or LPC)
- Audiologist

While Advanced Practice Providers are considered members of the medical staff, they do not have the rights afforded to other members of the Medical Staff set forth in Article IX of the Bylaws. They shall be allowed to vote and serve on committees but may not hold office or chair committees.

Section 8. Advanced Practice Providers Community (APPC)

Advanced Practice Providers Community (APPC) are Providers who are working with a Community Medical Staff member in the clinic only and do not require clinical privileges but wish to be affiliated with the Medical Staff organization. The Advanced Practice Provider Community member must provide professional services in an office that is located in the Medical Center's defined service area and must comply with the general membership requirements in Article II, as applicable. They are not eligible for clinical privileges, but with the authorization of the patient or the patient's legally authorized representative may visit and review the patient's medical records during hospitalization. Advanced Practice Providers must be sponsored by a physician member of the Medical Staff, unless allowed to practice independently as per state law.

If the APP loses their supervising physician, they have ninety (90) days to obtain a new supervising physician. The APP will be placed on administrative suspension until a new supervising physician is found or ninety (90) days have elapsed. Once the ninety (90) days have elapsed, the APP's membership will be terminated. There shall be no consequence to the APP since the termination was an administrative one. The APP will have to reapply for membership in the future so long as they have a supervising physician.

Advanced Practice Providers Community shall consist of the following specialties:

- Physician Assistant
- Advanced Practice Registered Nurse – Certified Nurse Practitioner
- Advanced Practice Registered Nurse – Clinical Nurse Specialist
- Psychologist or Licensed Counselor (PhD or LPC)
- Audiologist

While Advanced Practice Providers are considered members of the medical staff, they do not have the rights afforded to other members of the Medical Staff set forth in Article IX of the Bylaws. They shall be allowed to vote and serve on committees but may not hold office or chair committees.

ARTICLE V: CATEGORIES OF OTHER STAFF (NON-MEMBERS)

Section 1. Telemedicine

Providers providing patient care services solely through electronic means such as telemedicine must apply for and be granted clinical privileges, but are not eligible for Staff membership. In developing a list of approved telemedicine clinical privileges, the Services shall recommend to the Medical Executive Committee and the Board of Directors which clinical services may be appropriately delivered via telemedicine. In credentialing and privileging Providers for telemedicine clinical privileges, the Medical Executive Committee and the Board of Directors may use the credentialing information provided by the distant site (the site where the Provider providing the services is located) if the distant site meets telemedicine requirements of the hospital's accrediting agency. Credentialing by Proxy (CBP) may be utilized as outlined in policy when a written agreement is entered into by Peterson Health and a Distant Site Hospital (DSH) or Distant Site Telemedicine Entity (DSTE) for Telemedicine Providers.

Section 2. APP Telemedicine

Advanced Practice Providers providing patient care services solely through electronic means such as telemedicine must apply for and be granted clinical privileges but are not eligible for Staff membership. Advanced Practice Providers must be sponsored by a supervising physician, unless allowed to practice independently as per state law.

If the APP loses their supervising physician, they have ninety (90) days to obtain a new supervising physician. The APP will be placed on administrative suspension until a new supervising physician is found or ninety (90) days have elapsed. Once the ninety (90) days have elapsed, the APP's membership will be terminated. There shall be no consequence to the APP since the termination was an administrative one. The APP will have to reapply for membership in the future so long as they have a supervising physician.

Advanced Practice Providers practicing via telemedicine shall consist of the following specialties:

- Physician Assistant
- Advanced Practice Registered Nurse – Certified Nurse Practitioner
- Advanced Practice Registered Nurse – Clinical Nurse Specialist

In developing a list of approved telemedicine clinical privileges, the Services shall recommend to the Medical Executive Committee and the Board of Directors which clinical services may be appropriately delivered via telemedicine. In credentialing and privileging Advanced Practice Providers for telemedicine clinical privileges, the Medical Executive Committee and the Board of

Directors may use the credentialing information provided by the distant site (the site where the Advanced Practice Provider providing the services is located) if the distant site meets telemedicine requirements of the hospital's accrediting agency. Credentialing by Proxy (CBP) may be utilized as outlined in policy when a written agreement is entered into by Peterson Health and a Distant Site Hospital (DSH) or Distant Site Telemedicine Entity (DSTE) for Telemedicine Advanced Practice Providers.

Section 3. Allied Health Professionals

Certain health professionals who are not Providers may be authorized to provide patient care services in the Medical Center in the capacity of Allied Health Professionals. Allied Health Professionals shall include those health professionals who are not eligible for clinical privileges but practice pursuant to a scope of practice authorization. They participate directly in the management of patients under the delegation, supervision and/or direction of a member of the Medical Staff. If the AHP loses their sponsoring physician, they will automatically be terminated. The AHP will have to reapply for membership in the future so long as they have a sponsoring provider.

Allied Health Professionals approval process shall consist of review and recommendation by the respective Service Chief and the Chief of Staff with ultimate approval being granted by a representative of the Board of Directors (President/CEO) but shall not be entitled to the rights of Medical Staff members or applicants, including but not limited to the procedural rights of review in Article IX. Eligibility shall be based on individual training, experience, and clinical competence and shall include:

- First Assistant (FA)
- Registered Dental Assistant (RDA)
- RNs (assisting a member of the Medical Staff, Research RN)
- Scrub Tech
- Surgical Tech
- Scribe

Allied Health Professionals shall be individually assigned to an appropriate Service and shall carry out their activities subject to Service policies and procedures.

ARTICLE VI: PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

Section 1. Application Procedure

A All applications for appointment to the Medical Staff shall be in writing using an approved application from the Medical Staff Office. The application shall require detailed information as necessary to verify compliance with the qualifications for Medical Staff membership as set forth in Article II, Section 2. The applicant shall also provide evidence of his ability to perform requested privileges and to execute his responsibilities to his patients if accepted for Staff membership. A statement from a physician attesting to ability to perform requested privileges may be accepted as proof of necessary health status and ability. Peer recommendations shall be required for all applicants which shall include medical/clinical

knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.

B. Requests for verification of education and hospital affiliation, references and any other information needed by the Medical Staff Office, or a committee will be sent out from the Medical Staff Office. The process shall include a query to the National Practitioner Data Bank and receipt of a response. Until all requested information is received, the application is considered incomplete and may not be processed. If the requested information is not received within three (3) weeks of request, a second notice will be sent. If not received within three (3) weeks of the second notice, the applicant will be given special notice that his application is incomplete, why it is incomplete, that it is his responsibility to ensure that the Medical Center receives the requested information within the stated time period if he desires continued processing of application, and that his application will be withdrawn from further processing if the information is not received within thirty (30) days. The applicant shall have thirty (30) days from the date of receipt of the special notice to complete the application; otherwise, the application will be withdrawn from further processing and returned to the applicant. Thereafter, if an applicant still wishes to pursue an appointment to the Medical Staff, they will have to begin the new application process anew.

C. The applicant shall always have the burden of proving and producing adequate information for a proper evaluation of his competence, character, ethics and other qualifications, and for resolving any questions about such qualifications.

D. Any omission, misrepresentation or misstatement in connection with an application for appointment, reappointment, and/or clinical privileges shall be grounds to withdraw the application from processing or, if Staff membership or clinical privileges have already been granted based on the omission, misrepresentation or misstatement, for corrective action pursuant to Article VIII.

E. By applying for appointment to the Medical Staff and/or clinical privileges, each applicant thereby:

1. signifies the accuracy and completeness of the application and his willingness to appear for application interviews;
2. authorizes the Medical Center to consult with members of medical staffs or administrations of other hospitals and health care entities with which the applicant has been associated, and with others who may have information regarding his qualifications for Medical Staff membership and clinical privileges;
3. consents to the Medical Center's inspection of all records and documents that may be material to an evaluation of his qualifications for Medical Staff membership and clinical privileges; and
4. releases from liability and extends absolute immunity to the Medical Center, the Board of Directors, the Medical Staff and its members, and Medical Center employees, agents and representatives for any actions in connection with consideration of the application for appointment, reappointment, and/or clinical privileges and to any third parties for providing information to the Medical Center, as further detailed in Article XV.

Every application for Staff appointment shall be signed and dated by the applicant and shall include acknowledgement of the above.

Section 2. Appointment Process

A. Service Review. Once the Medical Staff Office deems the application complete from its standpoint, the Chief of Service or Chief of Service-Elect shall review the application and delineation of privileges requested and determine whether the Provider meets all the necessary qualifications for Staff membership and the clinical privileges requested. They may consult, as deemed appropriate, the appropriate members of the specialty or sub-specialty in which privileges are being sought. All recommendations for appointment must also specifically recommend the clinical privileges that are being granted. These privileges may be qualified by probationary or other conditions. The conditions, if any, should be stated in specific terms with a statement of the reason for the conditions. After receipt of the completed application for Staff membership and privileges, the Service Chief or Chief-elect in his absence shall forward a written recommendation to the Credentials Committee prior to its regularly scheduled meeting or if not possible, shall attend the Credentials Committee meeting in person to review the application and supply the written recommendation to the Committee. Any recommendation for conditions or not to grant Staff membership or privileges shall be accompanied by a written statement of the reasons for the recommendation.

B. Credentials Committee. The Credentials Committee shall examine and review the qualifications of the applicant and determine whether the applicant meets all of the necessary qualifications for the category of Staff membership and for the clinical privileges requested by the applicant. Within ninety (90) days after receipt of the completed application for Staff membership and privileges, the Credentials Committee shall make a written recommendation to the Medical Executive Committee. Any recommendation for conditions or not to grant Staff membership or privileges shall be accompanied by a written statement of the reasons for the recommendation.

C. Medical Executive Committee. The Medical Executive Committee shall review the recommendation of the Credentials Committee and the application within thirty (30) days of receipt and recommend one of the following:

1. That the Provider be appointed to the Medical Staff upon such terms as the Medical Executive Committee states;
2. That the Provider be rejected for Medical Staff membership and/or clinical privileges; or
3. That the application be deferred for further consideration.

D. When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed up within sixty (60) days with a subsequent recommendation for appointment with specified clinical privileges, or for rejection for Staff membership.

E. When the recommendation of the Medical Executive Committee is not an Adverse

Recommendation or Action, the President shall promptly forward it to the Board of Directors.

F. When the recommendation of the Medical Executive Committee is an Adverse Recommendation or Action, the President shall promptly notify the applicant by special notice and all further procedures shall be as set forth in Article IX of these Bylaws.

G. The Board of Directors or its Executive Committee shall act on the matter no later than sixty (60) days after receipt of a recommendation from the Medical Executive Committee pursuant to subsection e. above. If the Board of Directors' final decision is an Adverse Recommendation or Action, the President shall promptly notify the applicant of such decision by special notice and all further procedures shall be as set forth in Article IX of the Bylaws.

H. If the Board of Directors' decision is not an Adverse Recommendation or Action, it shall be final, except that the Board of Directors may defer final determination by referring back to the Medical Executive Committee for further reconsideration. Any such referral shall state the reasons and set a time limit within which a subsequent recommendation to the Board of Directors shall be made. At its next regular meeting after receipt of such subsequent recommendation, the Board of Directors shall make a decision either to appoint the Provider to the Staff contingent upon such terms as the Board of Directors states, or to reject him for Staff membership. If the decision after deferral is an Adverse Recommendation or Action, it shall be handled as set forth in subsection g. above. All decisions to appoint shall include a delineation of the clinical privileges which the Provider may exercise.

I. Whenever the Board of Directors' preliminary decision is contrary to the recommendation of the Medical Executive Committee, the Board of Directors shall submit the matter to the Joint Conference Committee for review and recommendation before making its decision final.

J. Within twenty (20) days of a final decision, the Board of Directors shall send notice of the final decision through the President to the Chief of Staff and by special notice to the applicant, informing him of the decision.

Section 3. Reappointment Process

A. Reappointments for each Provider shall be for up to a three (3) year period of time. Reappointment application and processing must be completed prior to the three (3) year expiration date. If the Medical Executive Committee or Board of Directors requires additional information which cannot be obtained before expiration of the current term of appointment, the Provider may be conditionally reappointed one (1) time only for a term of up to ninety (90) days to allow for the information to be received and reviewed. If the reappointment application cannot be processed before expiration of the conditional reappointment term, the Provider will be required to file an initial application for Staff appointment.

B. Each recommendation concerning the reappointment of a Medical Staff member, and the clinical privileges to be granted upon reappointment, shall be based upon the member's professional competence and clinical judgment in the treatment of patients and other qualifications. This includes, but is not limited to:

1. use of the Medical Center's facilities for his patients;
2. a review of the results of ongoing, outcome-oriented evaluation of the clinical performance of the Provider (OPPE) and the recommendation of the Chief of Service based on the performance of the Provider at the Medical Center;
3. ethics and conduct;
4. participation in Staff affairs;
5. compliance with the Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Medical Center requirements and policies;
6. interpersonal skills in working with Medical Center personnel and colleagues;
7. documentation of or attestation to continuing medical education; and
8. general attitude and sense of responsibility toward patients, the Medical Center, and the public.

C. The procedures provided in Section 2. of this Article VI for processing applications for initial appointment shall apply to the reappointment process.

ARTICLE VII: PRIVILEGES

Section 1. Clinical Privileges

A. Every Provider shall be entitled to exercise only those clinical privileges specifically granted to him by the Board of Directors, except as provided in Sections 2-4 of this Article VII.

B. Every initial application for staff appointment 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, references, and any other relevant information.

C. Threshold or minimum objective criteria for the granting of clinical privileges in Services and/or special care areas of the Medical Center may be established, subject to the approval of the Medical Executive Committee and the Board of Directors. A Provider who cannot document satisfaction of approved criteria is not eligible to be considered for those privileges. The applicant shall always have the burden of establishing his clinical competence and other qualifications for the clinical privileges he requests.

D. Clinical privileges may be increased or restricted based upon the direct observations of care provided, review of the records of patients treated in this or other hospitals, review of the records of the Medical Staff which document the evaluation of the member's participation in the delivery of medical care, including a review of the results of ongoing, outcome oriented evaluation of the clinical performance of the Provider, and/or any other relevant information.

E. Applications for additional clinical privileges must be in writing. The type of clinical

privileges desired and the applicant's recent relevant training and/or experience must be stated. Such applications will be processed in the same manner as applications for initial appointment. All grants of initial clinical privileges shall be subject to focused professional practice evaluation in accordance with Medical Staff policy.

F. Privileges granted to dentists and podiatrists, as well as Advanced Practice Providers, shall be based on their training, experience, and demonstrated competence and judgment. The scope and extent of surgical procedures that each may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. A physician member of the Staff, secured by the dental or podiatric member of the Staff, shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization for each patient admitted by a dental or podiatric member.

G. As further detailed in the Rules and Regulations, a complete admission history and physical examination shall be dictated and placed in the medical record within twenty-four (24) hours of admission and before any surgery or procedure involving anesthesia**,** except in life threatening emergencies. If a complete history and physical examination has been recorded within thirty (30) days prior to admission, it may be used in the medical record as a preliminary history and physical examination; provided (i) it was recorded by a member of the Medical Staff, and (ii) an updated note is documented within twenty four (24) hours of admission and before any surgery or procedure involving anesthesia that includes any changes or additions to the physical examination or a note that there are no changes in the examination. Histories and physical examinations may only be performed by those who have been granted the clinical privileges to do so.

Section 2. Temporary Privileges

A. At the request of a member of the Medical Staff and with the approval of the Chief of Service concerned or the Chief of Staff, the President (or the CMO as his designee) may grant temporary privileges to a Provider serving as a locum tenens for a member of the Medical Staff or a visiting consultant to attend patients without applying for membership on the Medical Staff for a period not to exceed six (6) months to meet an important patient care need. Before granting temporary privileges, the following must be obtained and/or verified: education; current licensure; copy of DEA (unless not required due to specialty); queries and evaluations of the NPDB, AMA/AOA, and OIG Medicare/Medicaid Exclusions information; required professional liability insurance; clinical competence through at least two (2) peer reference(s) and/or other sources; background check; and NPI number.

B. Temporary privileges for new applicants for Staff membership with a complete application may be granted after recommendation from the Credentials Committee and while awaiting review and approval by the Medical Executive Committee and Board of Directors upon verification of the following: all qualifications of membership and the requested clinical privileges; a query and evaluation of the NPDB information; no current or previously successful challenge to licensure or registration; no involuntary termination of medical staff membership at another organization; and no involuntary limitation, reduction, denial, or loss of clinical privileges. Before granting temporary privileges, which may include

admitting privileges, the President (or the CMO as his designee) must have the concurrence of the appropriate Chief of Service and of the Chief of Staff. Temporary privileges for new applicants are not to exceed one hundred twenty (120) days.

C. At the request of the attending physician, consulting physician, or the Chief of Staff, temporary clinical privileges may be granted by the President (or the CMO as his designee) to a Provider who is not an applicant for Staff membership for the care of a specific patient to meet an important patient care need. Before granting temporary privileges, the items listed under subsection a. above must be obtained and/or verified and there must be concurrence of the appropriate Chief of Service and the Chief of Staff. Such temporary privileges shall be restricted to the treatment of not more than four (4) patients in any one year by any Provider. An exception being that Providers serving as proctors for robotic surgery are allowed to proctor the appropriate number of patients required for the privileging of the proctored Provider.

D. Special requirements of supervision and reporting may be imposed by the appropriate Chief of Service on any Provider granted temporary privileges.

E. Temporary privileges shall be immediately terminated by the President (or the CMO as his designee) upon notice of any failure by the Provider to comply with such special conditions. Additionally, the President (or the CMO as his designee) may at any time, upon the recommendation of the Chief of Staff or the appropriate Chief of Service, terminate a Provider's temporary privileges. The appropriate Chief of Service or, in his absence, the Chief of Staff, shall assist the patients of the terminated Provider's patients to select a member of the Medical Staff to assume responsibility for their care until they are discharged from the Hospital.

Section 3. Emergency Privileges

In the case of an emergency, any qualified member of the Medical Staff, to the degree permitted by his license shall be permitted to do everything possible to save the life of a patient using every facility of the Medical Center necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, the member must request the privileges necessary to continue to treat the patient. In the event such privileges are denied, or the member does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff. For the purpose of this section, an "emergency" is defined as a condition in which imminent and 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 or risk of imminent and serious permanent harm.

Section 4. Disaster Privileges

Disaster privileges are granted only when the Medical Center's emergency management plan has been activated and the Medical Center is unable to meet immediate patient care needs. The Chief of Staff or President (or CMO as his designee) shall determine when additional Providers are required to handle immediate patient care needs and initiate the granting of privileges on a case-by-case basis in accordance with the procedures described in the Disaster Privileging policy.

ARTICLE VIII: PERFORMANCE IMPROVEMENT, ~~AND~~ INTERVENTION, & CORRECTIVE ACTION

Section 1. Professional Practice Evaluation

A. **Ongoing Professional Practice Evaluation.** Each Provider exercising clinical privileges shall be monitored and evaluated on a regular basis to identify professional practice trends that have an impact on the quality of patient care. Evaluation results are used in privileging, system improvement, and when warranted, corrective action. In addition to ongoing professional practice evaluation (OPPE), reported concerns regarding the professional competence or conduct of a member or other individual with clinical privileges are evaluated through focused professional practice evaluation (FPPE). As noted above, all new providers with the exception of Community and APP Community will be in an FPPE status for the entire first year of their Medical Staff membership. If providers have very low or no volume during the first year, they will remain on FPPE status until such time as there is enough data to review performance by QMC.

1. **OPPE Criteria.** The Medical Staff, clinical services, and committees shall develop and routinely update peer review criteria based on current practices and standards of care, which shall be used in evaluating those applying for membership and privileges and the performance of members and privileges holders. Included in the clinical service peer review criteria are the types of data to be collected for evaluation. Medical Staff clinical services and committees shall routinely assess and/or update specific criteria to further (i) assess the quality and uniformity of the standard of patient care, treatment, and services, and patient safety; (ii) evaluate the results of professional practice evaluations of members and others with clinical privileges, including, but not limited to, verification that members and others are practicing within the scope of their clinical privileges; (iii) determine if improvement is indicated and communicate the findings to the appropriate individuals and committees; and (iv) enable the members and others with clinical privileges to implement changes through individual or focused performance improvement programs.

2. **OPPE Results.** Information resulting from ongoing peer review of members according to the Medical Executive Committee approved criteria shall be analyzed and acted upon. The findings of peer review and any recommendations pertaining to the member shall be included in the member's credentials file.

B. **Focused Professional Practice Evaluation (FPPE).** The Medical Staff is responsible for developing a focused professional practice evaluation process that will be used to evaluate a Provider's competence in performing specific Privileges or performance of other responsibilities of Medical Staff membership.

1. **Initial FPPE.** All initial granting of privileges shall be subject to an initial FPPE/proctoring (if needed or required) under these Bylaws as described in Section 1.A. above and otherwise reviewed for compliance with the relevant peer review criteria described above.

2. **FPPE Based on Concerns.** Focused Professional Practice Evaluations shall also

be conducted when a question arises regarding a currently privileged Provider's ability to provide safe, high quality patient care. The Medical Staff through its relevant committees shall define the circumstances giving rise to the FPPE; the methods used to conduct the focused evaluation; the duration of the evaluation period, including the criteria for extensions of the evaluation period; and how the information gathered during the evaluation period will be utilized. FPPE methods include but are not limited to: chart review (concurrent or retrospective), proctoring or other form of direct observation; external review; and/or discussion with other caregivers involved in the care of the patient. As a part of the medical peer review process, the Medical Executive Committee or other standing committee may require the Provider to appear before the committee to discuss a case or issue being reviewed by that committee and it is expected that the Provider make such an appearance where reasonable to do so. An FPPE by itself shall not constitute an investigation and shall not constitute a restriction of Privileges or grounds for any formal hearing or appeal rights as described in Article IX of these Bylaws.

3. **Resources.** OPPE and FPPE evaluation may utilize resources available on the Medical Center Medical Staff, other Medical Center personnel, or other individuals or organizations outside the Medical Center, including external clinical reviewers and other outside consultants. All external/internal individuals or organizations performing ongoing and focused professional practice evaluation activities are doing so on behalf of the Medical Center and its leaders. Referral to the Physician Wellness Committee shall be used when appropriate, also in accordance with Medical Staff policy.

Section 2. Routine Monitoring, Education & Intervention. The Medical Staff clinical services and committees are responsible for carrying out delegated review and quality improvement functions. They may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent proctoring or monitoring in the course of carrying out their duties, without initiating formal corrective action. Comments, suggestions, and warnings may be issued orally or in writing. The Provider may be given an opportunity to respond in writing and may be given an opportunity to meet with the clinical service or committee. Any such informal actions shall be documented in the Provider's file. Medical Executive Committee approval is not required for such actions, although the actions shall be reported to the Medical Executive Committee. The actions shall not constitute a restriction of Privileges, nor shall they be grounds for any hearing or appeal rights under Article IX of these Bylaws.

Section 3. Corrective Action

A. **Criteria for Initiation.**

1. Any person may provide information to the Medical Staff about the conduct, performance, or competence of its Members. When reliable information indicates that a Provider may have exhibited acts, demeanor, or conduct either within or outside of the Hospital that are reasonably likely to fit the below criteria, a recommendation for corrective action investigation may be initiated.

    a) Actions detrimental to patient safety or to the delivery of quality patient care within the hospital;

b) Unethical conduct;

c) Actions contrary to the Medical Staff Bylaws or Rules and Regulations;

d) Actions in violation of state or Federal laws or regulations;

e) Conduct below applicable professional standards;

f) Behavior disruptive of Medical Staff or Hospital operation; or

g) An improper utilization of Hospital resources adversely affecting quality as determined by the Medical Staff.

2. Additionally, if a Provider has sustained a summary suspension or limitation of Privileges at another hospital for medical disciplinary cause or reason, a request for an investigation of or action against such Provider should be brought to the attention of the Chief of Staff, any other officer of the Medical Staff, any Chief of Service, the Chair of any standing committee of the Medical Staff, the CEO (or the CMO as designee), or the Board of Directors, as appropriate.

3. A recommendation for corrective action may also be initiated by any Medical Staff or Service Line committee, with respect to activities, conduct, or performance within the scope of authority of that committee. Such recommendation shall be recorded in the minutes of that committee and shall be reported to the Chief of Staff and the Medical Executive Committee through the committee's Chair and/or the minutes.

B. **Request for Investigation for Corrective Action.**

1. Whenever activities or conduct described in Article VIII Section 3 A. are brought to the attention of any official named in the above section 3 A., the Chief of Staff shall be notified. The Chief of Staff shall notify the CEO (or CMO as the designee) and the Medical Executive Committee and shall continue to keep them fully informed of all action taken. In addition, the Chief of Staff shall immediately forward all necessary information to the investigating body; provided however, that the Chief of Staff or Medical Executive Committee may dispense with further investigation of matters deemed to have been adequately investigated by a committee, pursuant to Article VIII Section 3 A. or otherwise.

C. **Expedited Review.**

1. Whenever information suggests that corrective action may be warranted, the Chief of Staff or his designee shall inform the service Chief, and may on behalf of the Medical Executive Committee, immediately investigate and conduct whatever interviews may be indicated. The information developed during this initial review shall be presented to the Medical Executive Committee, which shall decide whether to initiate a corrective action or investigation.

2. In cases of complaints of harassment or discrimination involving a Medical Staff

Provider, an expedited review shall be conducted by the Chief of Staff, or his designee, with the CEO (or CMO as designee). The information gathered from that review may be referred to the Medical Executive Committee if it is determined that corrective action may be indicated against a Medical Staff Provider, and all further review would be conducted during Medical Staff Proceedings.

D. **Investigation.** The Medical Executive Committee shall review the request and determine whether to initiate an Investigation for purposes of possible corrective action.

1. If the Medical Executive Committee concludes that action is indicated but that no further investigation is necessary, it may proceed to take action without further investigation.

2. If the Medical Executive Committee concludes that a formal investigation is warranted, it shall direct an investigation to be undertaken. The investigation may be conducted by the Medical Executive Committee or an ad hoc committee appointed by the Medical Executive Committee. Alternatively, the Medical Executive Committee may request that the Provider's Chief of Service appoint an ad hoc committee to investigate the matter (hereinafter referred to as the "investigating committee"). An attorney may be appointed as a member of the investigating committee, without voting privileges, and impartial Providers who are not members of the Staff may be appointed by the Medical Executive Committee or Chief of Service to serve on the investigating committee, as long as the majority of the members of the committee are Staff members. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary action.

3. If the Medical Executive Committee initiates an investigation, it shall notify the Provider of the filing of the request for corrective action investigation, the general nature of the request or charges, and the initiation of the investigation, by special notice within five (5) days of the decision to initiate the investigation.

4. The Medical Executive Committee shall assure that the Provider was given an opportunity to provide information in a manner and upon such terms as the Medical Executive Committee, investigating body, or reviewing committee deems appropriate. The investigating body or reviewing body may, but is not obligated to, interview persons involved, however, such an interview shall not constitute a "hearing" as that term is used in Article IX, nor shall the hearings or appeals rules apply.

    a) If the opportunity for a meeting is afforded, the Investigating Committee or Individual shall provide Special Notice to the Provider at least seven (7) days prior to the meeting. The notice shall advise the Provider of the time, place and date of the meeting.

5. Within Sixty (60) days of initiation of an Investigation, unless the Chief of Staff in

consultation with the Hospital CEO grants an extension for good cause, the investigating committee shall make a report of its investigation shall forward it to the Medical Executive Committee. The report of the investigation shall include a record or summary of the interview with the Provider.

E. **Medical Executive Committee Action.**

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

2. **Medical Executive Committee Decision.** As soon as possible after the conclusion of the investigation, the Medical Executive Committee shall take action which may include without limitation:

    a) Determining no corrective action be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the Provider's file;

    b) Deferring action for a reasonable time where circumstances warrant;

    c) Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude clinical service heads from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file;

    d) Taking special measures to monitor the Provider's exercise of privileges on a non-restrictive basis;

    e) Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including without limitation, requirements for co-admissions, mandatory consultation or restrictive proctoring;

    f) Recommending reduction, modification, suspension or revocation of clinical privileges; such actions may be time limited;

    g) Recommending reductions of membership status or limitation of prerogatives directly related to the member's delivery of patient care; such actions may be time limited;

    h) Recommending suspension, revocation or probation of Medical Staff

membership. If suspension is recommended, the duration and terms of suspension, as well as the conditions precedent to its termination, shall be stated; and

i) Taking other actions deemed appropriate under the circumstances.

3. **Adverse Recommendation or Action.** If the Medical Executive Committee makes an Adverse Recommendation or Action as defined in Article IX of these Bylaws, all further procedures shall be as set forth in Article IX.

4. **Recommendation that is not Adverse.** If the Medical Executive Committee makes a recommendation that is not an Adverse Recommendation or Action, its report shall be forwarded to the Board of Directors for a final decision. The decision shall be in writing and set forth the bases or reasons for the decision.

   a) If the decision of the Board of Directors is not an Adverse Recommendation or Action, it shall be the final decision. The Hospital CEO shall send Special Notice of the final decision to the Provider within twenty (20) days of issuance of the decision.

   b) If the decision of the Board of Directors is an Adverse Recommendation or Action, all further procedures shall be as set forth in Article IX.

Section 4. Summary Corrective Action

A. **Grounds.** At least two of the following individuals upon agreement (provided one is a member of the Medical Staff) shall have the authority to restrict all or any portion of a Provider's Clinical Privileges, effective immediately, whenever failure to take such action may result in imminent danger to the health and/or safety of any individual: the Hospital President/CEO (or CMO as designee), Chief of Staff, Assistant Chief of Staff (in absence of Chief of Staff), a Chief of Service or Chairman of the Board of Directors.

B. **Privileges**. Immediately upon the imposition of a summary action, if the Provider is no longer able to exercise privileges restricted to care for his patients in the Medical Center by the summary action, the Chief of Staff or appropriate Chief of Service shall have authority and obligation to assist those patients to secure alternative medical coverage.

C. **Reporting.** The individuals imposing the Summary Corrective Action shall report the action immediately to the Medical Executive Committee, the Hospital President/CEO, and Chief of Staff, and the action shall remain in effect unless modified by the Medical Executive Committee.

D. **Notification.** The affected Provider shall immediately be notified, orally if possible and in writing by special notice, of the imposition of the summary action and the reasons for the action. The summary action shall become effective immediately upon imposition.

E. **MEC Review.** The Medical Executive Committee shall meet to review any summary action within a reasonable time, not to exceed ten (10) days of imposition. Upon request, the

affected Provider may attend that meeting and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee shall impose. The review by the Medical Executive Committee shall not constitute a hearing under Article IX and none of the procedural rules in that Article shall apply, nor shall an attorney be permitted to attend the meeting with the Provider.

F. The Medical Executive Committee may recommend modification, continuance or termination of the summary action. If the Medical Executive Committee terminates the summary action, the Medical Executive Committee may also refer the matter for additional investigation under Section 3 D. The recommendation of the Medical Executive Committee shall be effective immediately.

G. If, as a result of the review, the Medical Executive Committee does not recommend immediate termination of the summary action and the summary action is an Adverse Recommendation or Action, it shall entitle the affected Provider to the rights provided in Article IX of these Bylaws, and all further procedures shall be as set forth in that Article. The terms of the summary action shall remain in effect pending the procedures in Article IX.

H. If the Medical Executive Committee continues the summary action, but the action is not an Adverse Recommendation or Action, the action shall be forwarded to the Board of Directors for approval. The review by the Board of Directors shall not constitute a hearing under Article IX and none of the procedural rules in that Article shall apply.

1. If the Board of Directors approves or modifies the summary action and it is not an Adverse Recommendation or Action, or if the Board of Directors terminates the action, it shall be final, and the President shall provide the Provider with special notice of the final decision within seven (7) days of the decision.

2. If the Board of Directors modifies the summary action and the result is an Adverse Recommendation or Action, the matter shall first be referred to the Joint Conference Committee for review and recommendation. If, after considering the Joint Conference Committee's recommendation, the Board of Directors issues an Adverse Recommendation or Action, it shall entitle the affected Provider to the rights provided in Article IX of these Bylaws, and all further procedures shall be as set forth in that Article. The summary action as modified by the Board of Directors shall remain in effect pending the procedures in Article IX.

Section 5. Precautionary Suspension or Restriction of Clinical Privileges

A. **Grounds.** Any two of the following individuals upon agreement (provided one is a member of the Medical Staff) has the authority to impose a precautionary summary suspension or restriction of, or condition on, the Clinical Privileges of a Provider that will not last longer than fourteen (14) days: The Hospital President/CEO (or CMO as designee), Chief of Staff, Assistant Chief of Staff (in absence of Chief of Staff), a Chief of Service or Chairman of the Board of Directors. During this time a review or evaluation is conducted to determine the

need for further action.

B. **Notice to Provider.** The precautionary summary suspension is effective on imposition, and the Hospital President/CEO shall notify the Provider orally of the action and the reasons for the action as soon as possible. Oral notice shall be followed by Special Notice of the action and a general statement of the reasons for the action.

C. **Termination and nature of action.** A precautionary suspension or restriction shall automatically expire after the fourteenth (14th) day if not previously terminated by the individuals who imposed it. A precautionary suspension or restriction shall be taken in the course of medical peer review and professional review activity but is not considered a corrective action.

Section 6. Voluntary Agreement

A. **Grounds.** Whenever the activities or professional conduct of any Provider are such that, in the assessment of the Chief of Staff, further evaluation of the activities or professional conduct is necessary, the President (or the CMO as his designee) may ask the Provider to voluntarily refrain from utilizing all or certain clinical privileges or to voluntarily agree to some condition on those privileges for an agreed upon period of time while further evaluation is performed and a decision is made as to whether further action (such as initiation of an Investigation for purposes of possible corrective action) is indicated.

B. **Nature of action**. A voluntary agreement pursuant to this section, while taken in the course of medical peer review and professional review activity, is not a surrender or suspension of clinical privileges, is not considered corrective action, and may be terminated by the Provider on the giving of three (3) days prior written notice to the President (or the CMO as his designee). Nothing in this section prohibits a Provider from renewing a voluntary agreement one (1) or more times.

Section 7. Automatic Action

A. **Nature of action.** On notice to the Hospital of occurrence of any of the following, automatic action as detailed below shall result, in addition to any other automatic actions set out elsewhere in these Bylaws. An automatic action is not considered an Adverse Recommendation or Action or Corrective Action, does not entitle the Provider to any procedural rights of review under these Bylaws or otherwise, and does not require any action by the Medical Executive Committee or the Board of Directors. The occurrence of automatic action does not prevent the imposition of Corrective Action for the same or related grounds pursuant to the procedures in Article VIII.

1. **Medical Records.** An automatic suspension of a Provider's privileges will be imposed for noncompliance with Rules and Regulations regarding medical records delinquency. If the Provider continues on suspension for more than thirty (30) days due to failure to correct the medical records delinquencies, the automatic suspension shall result in an automatic termination of all clinical privileges and membership on the Medical Staff. Any Provider subject to three (3) automatic suspensions within a calendar year shall be referred to the Medical

Executive Committee for consideration of corrective action in accordance with Section 2 above.

2. **License.** Action by a Provider's state professional licensing agency revoking a Provider's license shall automatically terminate the Provider's Staff membership and all clinical privileges. Action by a Provider's state professional licensing agency suspending a Provider's license shall automatically suspend the Provider's clinical privileges. Except as provided below, if the state professional licensing agency imposes a restriction or limitation, that restriction or limitation shall be automatically applicable to the Provider's clinical privileges. Nothing shall preclude the Medical Executive Committee and/or the Board of Directors from taking further corrective action in accordance with this Article VIII as a result of the agency's action, including but not limited to termination of Staff membership and/or clinical privileges.

3. **Controlled Drugs.** Providers whose DEA certification or any other required permit to prescribe or administer narcotics and dangerous drugs, has been revoked or suspended will have their privileges to prescribe controlled substances automatically suspended until proof of reinstatement is established.

4. **Liability Insurance.** Loss of professional liability insurance as required by the Bylaws shall result in automatic suspension of clinical privileges. If the Provider fails to secure the required insurance within thirty (30) days of suspension, including insurance for any gaps in coverage, the Provider's clinical privileges and Medical Staff membership shall be automatically terminated.

5. **Criminal Convictions.** Conviction of any felony or of any misdemeanor involving violations of law pertaining to controlled substances, illegal drugs, Medicare, Medicaid, or insurance fraud or abuse, or a plea of guilty or nolo contendere to charges pertaining to the same shall result in automatic relinquishment of Medical Staff membership and privileges.

6. **Exclusion from Federal Health Programs.** Whenever a Provider is excluded from participation in Medicare, Medicaid, or any other state or Federal health care program as a sanction for unlawful conduct, Medical Staff membership and Clinical Privileges shall be automatically and immediately suspended as of the effective date of the exclusion, pending final action by the Board of Directors, based upon the recommendation of the Medical Executive Committee, which final action may include lifting the suspension following official reinstatement of eligibility to participate in the federal health care program. OIG exclusion of a Provider shall result in automatic termination of the Provider's Medical Staff membership and clinical privileges. Upon termination of the exclusion period the Provider must file an application for initial appointment and the grounds for the exclusion may be a basis for denial.

7. **Health Examination.** Failure of a Provider to agree to health examination or testing when requested in accordance with these Bylaws shall result in automatic

suspension of the Provider's clinical privileges until the examination or testing is conducted or corrective action in accordance with this Article VIII is taken.

8. **Failure to Satisfy Special Appearance Requirement.** Members are expected to cooperate with Medical Staff committees and representatives in the discharge of their official functions. This includes responding promptly and appropriately to correspondence, providing requested information, and appearing at appropriately announced meetings regarding quality-of-care issues, utilization management issues, Medical Staff administrative issues, and other issues that may arise in the conduct of Medical Staff affairs. It also includes submitting to mental or physical examinations, as requested by the Chief of Staff or the Medical Executive Committee, for the purpose of resolving issues of fitness to perform mental or physical functions associated with the practitioner's privileges or other related issues of reasonable accommodation.

   Failure to comply may constitute grounds for the Chief of Staff to suspend the Member's clinical privileges or take other appropriate action until a response is provided which is satisfactory to the requesting party. Any such suspension or action shall remain in effect until the Member is expressly notified that it is rescinded. A Provider who fails without good cause to appear and satisfy the requirements of Article VIII Section B. 2. shall automatically be suspended from exercising his or her Clinical Privileges, for a period of at least two weeks, or such longer period as the Medical Executive Committee shall determine. A suspension for two weeks shall, in all cases, be deemed administrative and not "medical disciplinary," regardless of the facts giving rise to the special appearance requirements; suspensions in excess of two weeks may or may not be "medical disciplinary," depending upon the facts and circumstances.

9. **Failure to Report**. Failure to report, as required in Article VIII Section 1 B. 2. within seven (7) days will result in an automatic suspension of Privileges.

10. **Misrepresentation, Misstatement or Omission.** As provided in Article II Section 2., a determination by the Medical Executive Committee, subject to the approval of the Board of Directors, that a Provider has a significant or material misrepresentation, misstatement or omission on an application for Medical Staff membership and/or Clinical Privileges, whether intentional or not, shall result in automatic withdrawal of the application from further processing. If the application has already been processed and the membership and/or Clinical Privileges granted, the Provider's Medical Staff membership and all Clinical Privileges shall be automatically terminated.

B. **Notice of Automatic Action.** The Provider shall be provided with Special Notice of imposition of automatic action.

C. **Allegation of Error.** If a Provider believes an error has been made and that there is no basis for the automatic action, within seven (7) days of receipt of notice of the automatic

action, the Provider must notify the Medical Executive Committee and provide written evidence of the error. The Medical Executive Committee shall rescind any automatic action if the basis for the action was in error. The Board of Directors shall be notified of each such rescission.

D. **Termination.** Except for automatic suspension based upon delinquent medical records, if after six (6) months the Provider remains suspended, his or her membership shall be automatically terminated. Thereafter, reinstatement to the Medical Staff shall require an application and compliance with ARTICLE VI Sections 1-2.

ARTICLE IX: HEARING AND APPELLATE REVIEW PROCEDURE

Section 1. Adverse Recommendation or Action

A. **Philosophy.** The intent in adopting these hearing and appellate review procedures is to provide for a fair review of decisions that adversely affect applicants and Providers, and at the same time to protect the peer review participants from liability. It is further the intent to establish flexible procedures that do not create burdens that will discourage the Medical Staff and Board from carrying out peer review. Accordingly, discretion is granted to the Medical Staff and Board to create a hearing process that provides for the least burdensome level of formality in the process and yet still provides a fair review, and this Fair Hearing Plan shall be interpreted in this context. Further, technical, insignificant, or non-prejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken.

B. **General.** When any Provider receives notice of an Adverse recommendation or action from the Medical Executive Committee that constitutes grounds for a hearing under Article IX, he is entitled to request a hearing under Article IX. If the recommendation following such hearing is still adverse to the Provider, he or she will then be entitled to request appellate review by a committee of the Board under Section 9 below. A Provider is entitled to the procedural rights of review set out below whenever an action is taken.

C. **Adverse Recommendation or Action.** Only the following recommendations or actions, when recommended by the Medical Executive Committee (or by the Board of Directors after a recommendation by the Medical Executive Committee that was not itself an Adverse Recommendation or Action), shall be considered an Adverse Recommendation or Action:

1. Denial of appointment;

2. Denial of clinical privileges;

3. Denial of reappointment

4. Termination or revocation of appointment or Staff membership;

5. Termination or revocation of clinical privileges based on professional competence or conduct;

6. Suspension of Staff membership or clinical privileges for more than fourteen (14) days based on professional competence or conduct which affects or could affect adversely the health and welfare of a patient or patients;

7. Imposition of a mandatory concurring consultation requirement;

8. Imposition of a proctoring or supervision requirement in which the proctor or supervisor must concur or approve before the Provider may exercise his or her clinical privileges;

9. Imposition of education, training, evaluation, or a counseling requirement that must be satisfied prior to exercising Clinical Privileges; or

10. Imposition of any other action that will result in reporting to the Texas Medical Board or the National Practitioner Data Bank.

D. **Exceptions.** The following recommendations or actions, and any others listed in the Bylaws, shall not be considered an Adverse Recommendation or Action:

1. Failure to process or consider an application for appointment, reappointment, or clinical privileges or failure to process a request for reinstatement from a leave of absence due to: (a) failure of the application or request to be complete, (b) failure to provide requested information or submit to requested health evaluation and/or testing, (c) failure to document satisfaction of any minimum criteria for clinical privileges as provided in Article VII, Section 1, including but not limited to any utilization or clinical activity requirements, or (d) the existence of an exclusive contract, which shall also include the inability to exercise clinical privileges already granted due to the existence of the exclusive contract;

2. Failure to grant or extend temporary, emergency, or disaster clinical privileges, placement of any conditions or limitations on the exercise of those clinical privileges, or termination of those clinical privileges;

3. Automatic action pursuant to Article VIII;

4. Precautionary suspension or restriction of clinical privileges as provided in Article VIII, Section 5;

5. Probation, any type of review, or another requirement that does not limit or restrict the Provider's exercise of clinical privileges, including focused review or a requirement to obtain consultation or have an observer or proctor that does not require that the consultant, observer, or proctor approve the Provider's exercise of clinical privileges;

6. Any limitation or restriction imposed equally on all Providers in a Staff category or equally on all Providers holding certain clinical privileges, including but not limited to

proctoring and other requirements imposed during the provisional period and/or proctoring associated with the granting of new privileges, or extension of the provisional period beyond the first year (or denial of such an extension);

7. Issuance of: (a) a quality variance rating or any agreement reached with the Provider in the course of medical peer review, (b) an oral warning, educational letter, or letter of warning or reprimand; (c) a requirement to obtain additional education, training, or experience, or to obtain health treatment, rehabilitation, or counseling that does not limit the Provider's ability to exercise clinical privileges, or (d) a requirement to be examined or evaluated to verify necessary health status, including but not limited to testing of bodily tissue or fluids;

8. Actions pursuant to a professional services contract or removal from elected or appointed Medical Staff office or committee membership or chairmanship; and

9. Failure to be considered for Consultative Medical Staff status under Article IV, Section 4, due to lack of required patient contacts and/or denial of an exception to the requirement.

10. Denial of appointment or reappointment to the Affiliate Staff or denial or termination of Honorary recognition/Honorary Medical Staff status; and

11. Denial of a requested change in Staff category, or lack of eligibility for or transfer to a Staff Category due to Patient Contacts or reassignment of Staff category at the time of reappointment as provided in Article IV and VI.

Section 2. Notice of Right to Hearing

A. The Provider who is subject to an Adverse Recommendation or Action as set out above shall be provided with special notice by the President within five (5) business days of the action. The notice shall:

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

2. Advise the Provider of the Provider's right to request a hearing;

3. Specify that the hearing must be requested within thirty (30) days of the date of the Provider's receipt of the notice, by submitting a written request to the Hospital President by Special Notice; and;

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

5. Summarize the Provider's rights during the hearing as specified below in and include a copy of this Article IX including;

   a) the right to be represented by an attorney or other person of his own choice,

   b) to have a record made of the hearing proceedings by the Medical Center and to obtain a copy of the hearing proceedings, upon payment of any reasonable charges associated with the making the copy,

   c) the right to call, examine, and cross-examine witnesses,

   d) the right to present evidence determined to be relevant by the presiding officer, regardless of its admissibility in a court of law,

   e) the right to submit a written statement at the close of the hearing, and

   f) the right to receive the written recommendation of the Hearing Committee (see Section 5 below), including a statement of the basis for the recommendation, and the written decision of the Board of Directors, including a statement of the basis for the decision.

6. If the Adverse Recommendation or Action includes a Summary Action, state that the Provider may request that the hearing be expedited to the extent reasonably possible; and

~~7.~~ That upon receipt of a properly filed request, a hearing will be scheduled and the Provider given special notice at least thirty (30) days in advance of the place, time, and date of the hearing, and a list of witnesses which may testify at the hearing in support of the Adverse Recommendation or Action.

Section 3. Waiver of Right to Hearing

A. The failure of a Provider to request a hearing in thirty (30) days as required shall be deemed a waiver of his right to the hearing and to any other procedural rights of review to which he might otherwise have been entitled on the matter, pursuant to these Bylaws or otherwise.

B. When the waived hearing relates to an Adverse Recommendation or Action of the Medical Executive Committee, the same shall thereupon become and remain effective against the Provider pending the Board of Directors' decision on the matter. When the waived hearing relates to an Adverse Recommendation or Action by the Board of Directors, the same shall thereupon become and remain effective against the Provider as a final decision of the Board of Directors as provided for in Section 10 below. In either of such events, the President shall promptly notify the affected Provider of his status by special notice.

Section 4. Request for Hearing and Notice of Date of Hearing

A. **Request for Hearing.** The Provider must request the hearing in writing and deliver the request to the Hospital President/CEO or CMO by Special Notice within thirty (30) days of the Provider's receipt of the notice of the right to the hearing under Article IX, Section 2 above. Prior to or in conjunction with requesting a hearing, the Provider may request mediation in accordance with Article IX, Section 11 below.

B. **Notice of Scheduling.** Following receipt of a proper request for a hearing the Hospital President/CEO or CMO shall schedule the hearing as provided below and provide Special Notice to the Provider of:

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

2. the list of witnesses expected to testify on behalf of the Medical Executive Committee or the Board of Directors (whichever initiated the Adverse Recommendation or Action) as provided in Section 2. A.7. above;

3. notice that the Provider is required to provide, at least ten (10) days prior to the date of the hearing, a list of the witnesses that the Provider expects to present at the hearing;

4. a list of the specific or representative patient records and/or other documents (if any) that are being relied on by the Medical Executive Committee or Board of Directors and that will be presented during the hearing; and the names and specialties or subspecialties of the member(s) of the Hearing Committee, a brief description of any contractual relationships between the member(s) and the Medical Center, and the procedures for asking questions and filing objections to the Hearing Committee members as set forth in Section 5. C. below.

C. **Rescheduling.** The hearing date may be rescheduled upon mutual agreement of the parties or upon a showing of good cause, as determined by the Presiding Officer of the hearing (see Section 5. F. below).

D. **Failure to Set Hearing Date.** Regardless of the Provider's request for a hearing under the Bylaws, if the Provider does not in good faith cooperate with the Hospital's scheduled hearing date and, as a result, a hearing has not been scheduled after a period of 90 days from the date of the Hospital's scheduled hearing date, the Provider shall be deemed to have waived the right to a hearing and to have accepted the Adverse Recommendation or Action, unless both parties agree to a delayed hearing date. The effect of the waiver shall be the same as in Section 3 above.

Section 5. Composition of Hearing Committee

A. **Hearing Committee.** When a hearing relates to an Adverse Recommendation or Action of the Medical Executive Committee, the hearing shall be conducted by an ad hoc hearing committee ("Hearing Committee") of not less than three (3) Providers, at least a majority of whom are members of the Medical Staff, appointed by the President in consultation with the Chief of Staff. One of the members so appointed shall be designated as chair. No Provider who has actively participated in the consideration of the Adverse Recommendation or Action shall be appointed a member of the Hearing Committee. No member of the committee shall be in direct economic competition or have other conflict of interests with the Provider involved.

B. **Alternate.** When using a Hearing Committee, at least one alternate shall be appointed. The alternate shall be released from any further obligation once the appointed members are present, and the hearing has been started.

C. **Hearing Officer.** With the approval of the Chief of Staff and the President, alternatively, the hearing may be conducted before a hearing officer who may be a Provider in the same discipline as the affected Provider, but who is not a member of the Medical Staff and not a direct economic competitor of the Provider. The hearing officer may be an attorney at law if the basis for the Adverse Recommendation or Action does not involve professional competence. (For purposes of the remainder of this Article, references to the "Hearing Committee" shall include the hearing officer unless the context clearly indicates otherwise.)

D. **Objections.** Any questions from the Provider to the members of the Hearing Committee in order to determine if there are objections must be directed through the President. The Provider must file any objections to the members, with a specific statement of the reason or basis of the objections, by special notice within ten (10) days of receipt of the Section 4 notice above. The President shall make any decisions on the objections and replacement of a member of the Hearing Committee; provided that, any objections that arise after commencement of the hearing shall be ruled on by the presiding officer. Failure to file objections as required shall constitute the Provider's acceptance of the impartiality and objectivity of the Hearing Committee members and a waiver of any further right to object. After objections have been made, the decision of the President is final.

E. **Representative.** The Medical Executive Committee or the Board of Directors, whichever initiated the Adverse Recommendation or Action, shall appoint an individual or individuals to serve as the representative ("Representative") for purposes of the hearing and any appellate review. The Representative shall have the same rights as the Provider and shall utilize Hospital legal counsel or outside counsel appointed by the Hospital President, but may not testify in the proceedings.

F. **Presiding Officer.** At the discretion of the President, an attorney may be appointed to serve as a Presiding Officer at the hearing and counsel to Hearing Committee. The attorney may not have provided legal advice on the matter that is the subject of the hearing. The attorney shall not have any right to vote, but may be present during deliberations solely for the purpose of providing legal advice to the Hearing Committee and assisting

with preparation of the hearing report.

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

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

Section 6. Witnesses and Exchange of Documents

A. As provided in Section 4 above, the Medical Executive Committee or the Board of Directors (whichever initiated the Adverse Recommendation or Action) is required to list any expected witnesses in the notice to the Provider of the date of the hearing. The Provider is required to notify the President in writing of his expected witnesses at least ten (10) days before the date of the hearing. Each party is solely responsible for arranging for the attendance of its witnesses. A witness list may be amended by special notice to the other party as soon as possible after a change in witnesses is identified. The Hearing Committee may permit a witness who has not been listed to testify if it finds that the failure to list the witness was justified, that the failure did not prejudice the party entitled to receive such list, or that the testimony of the witness will materially assist the Hearing Committee in making its report and recommendation.

B. Prior to the hearing, the Provider shall, upon written request to the President, be given an opportunity to review the patient records and other documents listed in the Section 4 notice of the date of the hearing. The Provider is not entitled to access any other documents except as specifically provided in this Article or to any rights of discovery in preparation for the hearing. Under no circumstances may a Provider access Medical Center or Medical Staff records of other Providers, including but not limited to any medical peer review records and proceedings regarding other Providers.

C. At least ten (10) days prior to the start of the hearing, each party must each provide the other with a list or index of the documents intended to be presented during the hearing and with a copy of those documents unless they have been previously provided. Any objections to these documents must be made by special notice to the other party (and the presiding officer if one has been appointed) at least five (5) days prior to the start of the hearing.

D. If additional documents need to be presented or are requested during the hearing and their need could not have been reasonably anticipated so as to comply with this Section, they

may be utilized in the hearing if the other party is given copies in advance and an opportunity to review them for purposes of objecting.

E. If any expert is to be presented as a witness by either party, the expert must be identified in accordance with Section 4. A. above and the other party provided with the following in accordance with subsection A. above:

1. a copy of the expert's curriculum vitae;

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

3. a copy of all documents or other information provided by the party to the expert for review.

No expert witness may be called by a party, nor testimony, opinions, or documents submitted for consideration in the hearing, unless disclosed in accordance with Section 4. A. & B. and this subsection or the presiding officer determines that the failure to disclose was unavoidable.

Section 7. Burden of Proof and Hearing Conduct

A. **Initial Obligation of Representative.** During the hearing, the Representative shall first present evidence in support of the Adverse Recommendation or Action. The Hearing Committee and the Provider may question any witnesses that the Representative presents. The Representative may not testify.

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

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

2. that the Provider possesses the necessary qualifications and competence for the Clinical Privileges and/or membership on the Staff, and

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

C. **Rights.** The Provider and the Representative shall have the following rights during the hearing:

1. Be present at the hearing;

2. Be accompanied by an attorney or another person of the party's choice to offer advice;

3. Have the Hospital make a record of the hearing as provided in this Section below;

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

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

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

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

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

D. **Majority Present.** There shall be at least a majority of the members of the Hearing Committee present when the hearing takes place, and no member may vote by proxy. If a member is absent for a portion of the hearing, the member may participate in the deliberations only after reading the transcript of the portion during which he or she was absent.

E. **Accurate Record.** An accurate record of the hearing shall be kept by a court reporter retained by the President. The cost of attendance of the reporter shall be the responsibility of the Medical Center, but the cost of obtaining a copy of the transcript shall be the responsibility of the requesting party.

F. **Waiver.** The personal presence of the Provider for whom the hearing has been scheduled shall be required. A Provider who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his rights in the same manner as provided in Section 3 of this Article IX and to have accepted the Adverse Recommendation or Action involved, which shall thereupon become and remain in effect as provided in that Section 3.

G. **No Strict Adherence.** The hearing need not be conducted strictly in accordance 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 rule which might make evidence inadmissible over objection in civil or criminal action.

H. **Right to Cross.** If the Provider does not testify in his own behalf, he may be called and examined as if under cross-examination.

I. **Findings and Recommendations.** The Hearing Committee may, in its sole discretion, 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. Upon conclusion of the presentation of oral and written evidence, including the submission of any written statements, the hearing shall be closed. The Hearing Committee may

thereupon, at a time convenient to itself, conduct its deliberations outside the presence of all participants other than the Presiding Officer. By majority vote, the Hearing Committee shall make findings of fact regarding each evidentiary point established by the Representative and Provider. Each finding should either support or refute the basis of the Adverse Recommendation or Action. The recommendation or action will either be affirmed, modified or reversed. The Hearing Committee's decision will be stated in objective terms which relate to the evidentiary points made by the Representative and Provider. Upon completing the deliberations and reaching a decision or recommendation, (which shall be accomplished within fourteen (14) days of closing the hearing), the hearing shall be adjourned.

J. **Written Report.** Within fourteen (14) days of adjournment of the hearing, the Hearing Committee shall issue a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the President. The report may recommend confirmation, modification, or rejection of the original Adverse Recommendation or Action. The President shall promptly forward a copy of the Hearing Committee's report and recommendation to the Provider by special notice and to the Medical Executive Committee or Board of Directors, whichever issued the Adverse Recommendation or Action.

Section 8. Consideration of Hearing Committee Report

A. Within thirty (30) days of receipt of the Hearing Committee's report, the Medical Executive Committee or the Board of Directors shall review the report and issue a recommendation to either affirm, reverse or modify its original Adverse Recommendation or Action.

1. If the recommendation by the Medical Executive Committee continues to be an Adverse Recommendation or Action, the Provider shall be entitled to request appellate review as provided below before a final decision by the Board of Directors.

2. If the recommendation by the Medical Executive Committee is not an Adverse Recommendation or Action, it shall be forwarded to the Board of Directors for a final decision within thirty (30) days of receipt by the Board of Directors.

3. If the decision by the Board of Directors is not an Adverse Recommendation or Action, it shall be the final decision. The Hospital President shall provide the Provider with Special Notice of the final decision within twenty (20) days of the final decision, with a statement of the basis of the decision.

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

Section 9. Appeal to the Board of Directors

A. **Notice of Right to Appellate Review.** If the Provider is entitled to appellate review, the Hospital President shall provide the Provider with Special Notice within ten (10) days of the decision, such notice to include:

1. A statement that the Provider is entitled to request appellate review of the Adverse Recommendation or Action by filing a written request by Special Notice with the Hospital President within twenty (20) days of the Provider's receipt of the Special Notice.

2. A statement that the Provider's request for appellate review must include a statement of all of the grounds for appeal as set out below, and the specific facts or circumstances which justify further review as they relate to each of the grounds for appeal;

3. A statement that failure to include in the appellate review request the required elements below will result in waiver of the Provider's right to appellate review; and

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

B. If the Provider wants to appeal, he must deliver a written request to the President within twenty (20) days of the Provider's receipt of the Special Notice as required by Section 9. A. 1. above. The request must include:

1. A statement of all the specific grounds for appeal under Section 9. D. below;

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

3. Whether the appellate review be held only on the written record on which the Adverse Recommendation or Action is based, as supported by the Provider's written statement provided for below, or that it be held on both the written record and that oral argument be permitted as part of the appellate review. The Board of Directors shall have the sole discretion to grant or deny a request for oral argument. Failure to request the opportunity in the request to make an oral statement waives the right to make an oral argument.

C. If such appellate review is not requested within twenty (20) days or if the Provider fails to submit the written statement as required below, the affected Provider shall be deemed to have waived his right to the appeal, and to have accepted such Adverse Recommendation or Action. The Adverse Recommendation or Action shall become effective immediately as provided in Section 3 of this Article IX.

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

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

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

3. There was not a reasonable belief that the Adverse Recommendation or Action was warranted by the known facts;

4. The Adverse Recommendation or Action was arbitrary or capricious;

5. The Adverse Recommendation or Action was not supported by sufficient evidence based on the hearing record or such additional information as may be permitted as set forth below; and/or

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

E. Within thirty (30) days after receipt of a proper request for appellate review, the President shall schedule a date for such review, including a date, time, and place for oral argument if such has been requested and granted. The President shall provide special notice to the affected Provider of the same. The date of the appellate review shall be at least fifteen (15) days but not more than forty-five (45) days from the date of the notice to the Provider of the date of the appellate review, except that when the Provider requesting the review is under a summary action, such review shall be scheduled as soon as the arrangements for it may reasonably be made, if the Provider waives the fifteen (15) days advance notice in writing.

F. The appellate review shall be conducted by the Board of Directors or by a duly appointed appellate review committee of not less than three (3) members of the Board of Directors. The Medical Executive Committee or the Board of Directors, whichever issued the Adverse Recommendation or Action pursuant to Section 8 above, shall appoint a representative to submit any written statements and make any oral arguments on its behalf for purposes of the appellate review ("Representative").

G. The affected Provider shall have access to any material, favorable or unfavorable, that was considered under Section 8 by the Medical Executive Committee or the Board of Directors. At least ten (10) days prior to the date of the appellate review, the Provider may submit to the President an updated written statement in which all those factual and procedural matters with which he disagrees, and his reasons for such disagreement shall be specified. This written statement shall cover any complaints of the Provider concerning any matter to which the appeal is related, and legal counsel may assist in its preparation. Upon receipt, the President shall provide a copy of the Provider's written statement to the Representative who may submit a written statement in rebuttal to the President at least three (3) days prior to the scheduled date for the appellate review. If submitted, the President shall provide a copy of the Representative's statement by special notice to the Provider prior to the appellate review.

H. The Board of Directors or its appointed appellate review committee shall act as an appellate body (the Board of Directors or the appointed appellate review committee shall be referred to as the "Review Committee"). Legal counsel may assist the Review Committee with conducting the appeal. The Review Committee shall be provided with the record created in the proceedings; to include the Hearing Committee report and transcript

and any materials considered under Section 8 and shall consider the written statements submitted pursuant to Section 7 subsection E above. If oral argument is a part of the appellate review procedure, the affected Provider and the Representative shall be present at such appellate review, shall be permitted to speak against the Adverse Recommendation or Action and shall answer questions put to them by any member of the appellate review body. The Provider and the Representative may be accompanied by an attorney in the appellate review, and the oral argument may be presented by the Provider and the Representative or attorneys.

I. The Review Committee may limit the time for the oral statements, and presentation of witnesses or other evidence is not permitted. New or additional matters not raised during the original hearing or in the Hearing Committee report or at the time of the Section 8 reconsideration, or not otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances, and the Review Committee shall, in its sole discretion, determine whether such new or additional matters shall be accepted.

J. In conducting the appellate review, Review Committee shall determine and make written findings as to:

1. whether there has been substantial compliance with the procedures in this Article IX;

2. whether there is sufficient evidence to support the Adverse Recommendation or Action issued pursuant to Section 8;

3. whether the Adverse Recommendation or Action was made:

   a) in the reasonable belief that it was in furtherance of quality health care,

   b) after a reasonable effort to obtain the facts of the matter, and

   c) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and the affording of notice and hearing pursuant to this Article IX; and

4. whether the Adverse Recommendation or Action is arbitrary, capricious, or unreasonable.

K. If the appellate review is conducted by the Board of Directors, it may affirm, modify, or reverse its prior decision, which shall be a final decision as provided in Section 10 below. Alternatively, in its discretion, the Board of Directors may refer the matter back to the Medical Executive Committee or Hearing Committee for further review and recommendation within thirty (30) days after referral. Such referral may include a request for a further hearing to resolve specified disputed issues.

L. If the appellate review is conducted by a committee of the Board of Directors, such committee shall, within fifteen (15) days after completion of the appellate review, either make a written report recommending that the Board of Directors affirm, modify, or reverse

its prior decision, or refer the matter back to the Medical Executive Committee or Hearing Committee for further review and recommendation within thirty (30) days after referral. Such referral may include a request for a further hearing to resolve disputed issues. Within seven (7) days after receipt of such recommendation after referral, the committee shall make its recommendation to the Board of Directors as above provided.

M. The appellate review shall not be deemed to be concluded until all have been completed or waived. Unless otherwise provided in the Bylaws governing the Board of Directors, any action required of the Board of Directors may be taken by a committee of the Board of Directors duly authorized to act.

Section 10. Final Decision by the Board of Directors

A. Within thirty (30) days of receipt of the written report of an appellate review committee after the conclusion of the appellate review, the Board of Directors shall make its final decision in the matter. This time may be extended to sixty (60) days if the matter is referred to the Joint Conference Committee under subsection B below.

B. The President shall send notice of the final decision of the Board of Directors to the Medical Executive Committee and, except as provided below, by special notice to the affected Provider. If this decision is in accordance with the Medical Executive Committee's last recommendation in the matter, it shall be immediately effective and final and shall not be subject to further hearing or appellate review. If this decision is contrary to the Medical Executive Committee's last such recommendation, prior to sending the decision to the Provider, the Board of Directors shall refer the matter to the Joint Conference Committee for further review and recommendation within ten (10) days. At its next meeting after receipt of the Joint Conference Committee's recommendation, the Board of Directors shall make its final decision with like effect and notice as first above provided in this Section 10.

C. Notwithstanding any other provision of these Bylaws, no Provider shall be entitled as a right to more than one (1) hearing and one (1) appellate review on any matter that is the subject of action by the Medical Executive Committee or by the Board of Directors, or by a duly authorized committee of the Board of Directors, or by both.

D. Following a final decision by the Board of Directors that is an Adverse Recommendation or Action, whether or not the Provider exercised the hearing and appellate review rights provided for in this Article, the interval of one (1) year must lapse before a new application concerning Medical Staff membership and/or the privileges that were the subject of the Adverse Recommendation or Action will be accepted for consideration.

Section 11. Mediation

A. A Provider who requests mediation pursuant to Section 241.101(d) of the Texas Health & Safety Code based on: (i) being subject to an Adverse Recommendation or Action by the MEC or Board of Directors as provided in Article IX; or (ii) a belief that the Credentials Committee has not acted on a complete application for appointment or reappointment within ninety (90) days of its receipt, shall be provided with an opportunity for mediation as

set forth in this Article IX. The Provider requesting statutory mediation shall be referred to as an "Eligible Provider" for purposes of this Section 11. Nothing in these Bylaws requires the Medical Center or the Medical Staff to notify an Eligible Provider of his right under Section 241.101(d) of the Texas Health & Safety Code to request mediation, to offer mediation to Providers who are not Eligible Providers, or to afford any other right of mediation other than that required by this statute.

B. The Eligible Provider must submit a request for mediation pursuant to Section 241.101(d) of the Texas Health & Safety Code by special notice to the President within fourteen (14) days of: (i) receipt of the notice of an Adverse Recommendation or Action; or (ii) the ninetieth (90th) day from the Credentials Committee's receipt of a complete application. Submission of a request in accordance with subsection (i) above temporarily suspends any hearing time lines in this Article IX. The mediation must be scheduled and completed within sixty (60) days of receipt of the request and, in the case of an Adverse Recommendation or Action, before a hearing is scheduled. If the Eligible Provider has waived his hearing rights as provided in the Section 3 above, mediation must be scheduled before the Adverse Recommendation or Action is submitted to the Board of Directors for a final decision.

C. The Eligible Provider and the Hospital will share the costs of the mediator equally and the mediator will be selected by mutual agreement of the Eligible Provider and the President. The mediator must be qualified as required by Section 241.101(d) of the Texas Health & Safety Code, unless the parties mutually agree in writing to use a mediator not meeting such requirements. The mediation shall occur either at the Medical Center or the mediator's office and shall be limited to a full day of mediation, unless otherwise agreed by the President.

D. The Medical Center shall be represented in the mediation by at least: (i) the President and the Chief of Staff (or their designees), if the Medical Executive Committee has initiated the Adverse Recommendation or Action, (ii) the President and the Chief of Staff or the Chairman (or their designees) if the Board of Directors has initiated the Adverse Recommendation or Action, or (iii) by the President and the Chair of the Credentials Committee (or their designees) if the Credentials Committee has allegedly failed to act on a complete application. Attorneys for the parties may attend and participate in the mediation; however, the personal presence of the Eligible Provider is required.

E. Unless otherwise provided by the Board of Directors, the representatives at the mediation shall not have the authority to bind the Medical Center to any agreement with the Eligible Provider reached in the mediation. Any agreement acceptable to the Eligible Provider and the Medical Center's representatives must be approved by the Board of Directors before it is binding on the Medical Center. Once approved, the mediation agreement shall be in writing, signed by the Eligible Provider and the Hospital's representatives (and their attorneys if participating), and shall be binding and final. Execution of a mediation agreement shall constitute a waiver of all of the Eligible Provider's rights under the Bylaws and otherwise if the mediation was requested as the result of an Adverse Recommendation or Action. Under no circumstances may the mediation agreement require any action not permitted by law or require the Medical Center, the Medical Staff, or the Board of Directors to violate any legal or accreditation requirement.

F. If the parties do not reach an agreement in the mediation, the Eligible Provider does not have any further rights to mediation and the hearing, if properly requested by the Eligible Provider, shall be scheduled as provided in this Article IX. Notwithstanding any other provision of these Bylaws, an Eligible Provider is only entitled to one (1) mediation in connection with a matter that is the subject of an Adverse Recommendation or Action or failure to act on an application. The fact that an Adverse Recommendation or Action that was the subject of an unsuccessful mediation is subsequently modified does not entitle the Provider to another mediation.

Section 12. Time Periods

Any time periods within which an action is to be taken under Article IX, unless the time period is requested by law, are intended as guidelines and not to create a righr of the Provider to have an action taken within the time period. A Provider may request waiver of one or more of the time frames specified in this Article for good cause by written submission to the Hospital President. The time periods for action in this Article IX may be modified by the Hospital President for good cause.

ARTICLE X: OFFICERS

Section 1. Officers of the Medical Staff

The officers of the Medical Staff shall be the Chief of Staff and Assistant Chief of Staff.

Section 2. Qualification of Officers

A. Officers must have been members of the Medical Staff for at least three (3) years at the time of nomination and election and must remain members during their term of office. Failure to maintain Medical Staff status or being subject to corrective action pursuant to these Bylaws or any restriction on his professional practice by a licensing or other governmental licensing agency during the term of office shall result in automatic removal from office immediately, creating a vacancy in the office involved. The Chief of Staff must be a physician.

B. In addition to the provisions in subsection A. above, an officer may be removed for good cause during his term of office by the Medical Staff members on a mail ballot, but no such removal shall be effective unless and until it has been ratified by the Board of Directors. “Good cause” shall include, without limitation, incompetence, repeated absence or neglect of duty, illness or other conditions such that the officer should be removed.

1. A petition requesting removal signed by at least ten percent (10%) of the voting members of the Medical Staff must be filed in the Medical Staff Office to compel a mail ballot under this section.
2. The mail ballot, sent to the Medical Staff members, shall be deemed delivered:
   a) when deposited in the U. S. mail with postage prepaid (or when deposited with an authorized mail delivery service),

b) when deposited in the Medical Center's internal mail distribution if the member is on the distribution list,
c) when sent by electronic mail which shall be deemed delivered upon read- receipt from an internet server, addressed to the member at the member's address as it appears of record in the Medical Staff Office, or
d) when hand delivered to the member or the member's office.

3. Removal shall require an affirmative two-thirds (2/3rds) vote of the ballots returned within twenty-one (21) days of the date of mailing or electronic delivery or hand delivery.

Section 3. Election of Officers

A. Officers shall be elected at the last quarterly meeting of the Medical Staff in the calendar year. Officers will be elected by a show of hands and subject to approval by the Board of Directors.

B. The Nominating Committee shall consist of at least three (3) members of the Medical Staff appointed by the Chief of Staff. This committee shall offer one (1) or more nominees for each office. Nominations of qualified members may also be made from the floor at the time of the meeting.

Section 4. Term of Office

The term of office is two (2) years, and an officer may be elected for consecutive terms. Officers shall take office on January 1st.

Section 5. Vacancies in Office

If there is a vacancy in the office of the Chief of Staff, the Assistant Chief of Staff shall serve out the remaining term. If there is a vacancy in the office of Assistant Chief of Staff, it shall be filled by the nominee of the Medical Executive Committee, subject to the approval of the Board of Directors.

Section 6. Duties of Officers

A. Chief of Staff: The Chief of Staff shall serve as the chief administrative officer of the Medical Staff to:

1. Act in coordination and cooperation with the President in all matters of mutual concern within the Medical Center;
2. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
3. Serve as a voting member and chair of the Medical Executive Committee;
4. Be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, and Medical Staff policies, 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 Provider;
5. Unless otherwise provided in these Bylaws, appoint committee members to all

standing, special, and multi-disciplinary Medical Staff committees;
6. Represent the views, policies, needs, and grievances of the Medical Staff to the President and to the Board of Directors;
7. Receive and interpret the policies of the Board of Directors and/or the Medical Center to the Medical Staff;
8. Report to the Board of Directors on the performance improvement activities of the Medical Staff;
9. Be the spokesman for the Medical Staff in its external professional and public relations; and
10. Serve as an ex-officio member of the Board of Directors, without voting rights.

B. Assistant Chief of Staff: The Assistant Chief of Staff shall be a member of the Medical Executive Committee, and it is recommended that the Assistant Chief of Staff have experience on both the Quality Monitoring Committee and the Credentials Committee. In the absence of the Chief of Staff, the Assistant Chief of Staff may temporarily assume the authority of the Chief of Staff.

Section 7. Membership Dues

A. Each member of the voting staff shall be required to pay annual dues assessed by the Medical Executive Committee in January of each year for the purpose of compensating the Chief of Staff. The dues are not to exceed $300. These dues shall be payable within thirty (30) days of the notice of assessment and will be deposited in a separate account solely for this purpose. Failure to pay the assessed dues will result in temporary suspension of privileges until dues are paid. The dues will be matched by funds from the hospital to pay for Medical Staff leadership training and to support compensation of the Medical Staff officers.

1. Dues shall be used to compensate the Chief of Staff for duties performed as listed above. The amount of compensation paid shall be established biennially, in writing, by the Medical Executive Committee and the Board prior to the election of officers.

ARTICLE XI: SERVICES

Section 1. Organization of Services

There shall be two Services of the Medical Staff: Medical and Surgical. Each Service shall be headed by a Chief of Service and a Chief of Service-Elect and shall function subject to the authority of the Medical Executive Committee. For organizational purposes, the specialties will be placed as follows.

A. Medical:
Allergy
Dermatology
Emergency Medicine
Family Medicine
Hospitalists
Internal Medicine (and its sub-specialties, with the exception of Gastroenterology)

Neurology
Psychiatry
Pediatrics
Physical Medicine and Rehabilitation
Radiology

B. Surgical:
Anesthesiology
Dentistry
Gastroenterology
General Surgery
Obstetrics and Gynecology
Ophthalmology
Oral Surgery
Orthopedic Surgery
Otolaryngology
Pathology
Plastic Surgery
Podiatry
Urology
Vascular Surgery

Section 2. Service Officers

A. Each Service officer must be a member of the Active or Consultative Medical Staff qualified by training, experience, and demonstrated ability for the position at the time of nomination and during all times of service. Each Chief of Service must be either: (1) board certified in a specialty recognized by the American Board of Medical Specialties (ABMS) or the Bureau of Osteopathic Specialists; or (2) have affirmatively established, as determined by the Medical Executive Committee with the approval of the Board of Directors, comparable competence through the credentialing process and served on the Medical Staff a minimum of three (3) years prior to being eligible for Chief of Service.

B. Each Chief of Service and Chief of Service-Elect shall be elected by majority vote of the voting members of their respective Services at the last meeting of the Service before January 1. The Chief of Service-Elect will automatically become Chief of Service if qualified and only a Chief of Service-Elect will be elected unless both offices are vacant. Terms are for 2-years.

C. A Service officer may be removed during his term of office on an affirmative vote of two-thirds (2/3) of the voting members of the Service on a mail ballot, but no such removal shall be effective unless and until it has been ratified by the Medical Executive Committee and by the Board of Directors.

1. A petition requesting removal signed by at least ten percent (10%) of the voting members of the Service must be filed in the Medical Staff Office to compel a mail ballot

under this section.

2. The mail ballot shall be sent to all voting members of the Service and deemed delivered:
   a) when deposited in the U. S. mail with postage prepaid (or when deposited with an authorized mail delivery service),
   b) when deposited in the Medical Center's internal mail distribution if the member is on the distribution list,
   c) when sent by electronic mail which shall be deemed delivered upon read- receipt from an internet server, addressed to the member at the member's address as it appears of record in the Medical Staff Office, or
   d) when hand delivered to the member or the member's office.
3. Removal shall require a simple majority of the ballots returned within twenty- one (21) days of the date of mailing or electronic delivery or hand delivery.

D. If there is a vacancy in the Chief of Service role, the Chief of Service-Elect shall serve out the remaining term. A vacancy of the Chief of Service-Elect role shall be filled by an election in that Service.

Section 3. Functions of Chiefs of Service

A. Each Chief of Service shall be responsible for:

1. All clinically related activities of the Service and administratively related activities of the Service unless otherwise provided by the Medical Center;
2. Integrating the Service into the primary functions of the Medical Center;
3. Coordination and integration of services between and within Services;
4. Developing and implementing policies and procedures that guide and support the provision of care, treatment, and services within the Service;
5. Recommending to the President a sufficient number of qualified and competent persons to provide care, treatment, and services within the Service;
6. Continuing surveillance, in accordance with these Bylaws and the Medical Center's performance improvement plan, of the professional performance of all individuals in the Service who have clinical privileges;
7. Recommending to the Medical Executive Committee the criteria for privileges within the Service that have been recommended by the Service;
8. Recommending clinical privileges for each Provider assigned to the Service;
9. Determining the qualifications and competence of Service personnel who are not credentialed through the Medical Staff process and provide patient care, treatment, and services;
10. Continually assessing and improving patient satisfaction and quality of care, treatment, and services in accordance with these Bylaws and the Medical Center's performance improvement plan;
11. Maintaining safety and quality control programs;
12. Providing for orientation and continuing education of Providers assigned to the Service and other Service personnel; and
13. Recommending space and any other resources needed in the Service, to include assessing and recommending off-site sources for needed patient care, treatment, and

services not provided by the Service or the Medical Center.

B. The Chief of Service-Elect shall assume the responsibilities of the Chief of Service in the Chief of Service's absence and perform such other duties as assigned by the Chief of Service.

Section 4. Functions of Services

Each Service shall establish its own criteria, consistent with the policies of the Medical Staff and of the Board of Directors, for the granting of clinical privileges in the Service. In the case of overlapping privileges, the Chief of Service of the Service in which the overlapping occurs will be required to review and sign the application of the individual involved. Conflicts between Services as to privileges of a Medical Staff member which cannot be resolved at the Service level shall be referred to the Medical Executive Committee. If such conflict cannot be settled at that level to the satisfaction of both parties, that matter will be referred to the Staff and then subject to the approval of the Board of Directors. At its meetings, each Service shall consider the findings, if any, pertaining to the monitoring and evaluation of care provided to Medical Center patients.

Section 5. Assignment to Services

A. The Medical Executive Committee shall make initial Service assignments for all Medical Staff members, and for all other approved Providers with clinical privileges, consistent with their training and experience.

B. A member of the Medical Staff may vote and hold office only in the Service to which he has been assigned by the Medical Executive Committee. However, any member of the Medical Staff is privileged to attend the meetings of any Service in which he may have an interest.

C. The Medical Executive Committee may, at its discretion, assign a Staff member who has overlapping training in more than one area, to a Service other than that of his primary training, if such assignment is requested by the Provider. Such individual may vote in only the one (1) assigned Service.

ARTICLE XII: COMMITTEES

Section 1. General

A. All committee members from the Medical Staff and committee chairs shall be appointed by the Chief of Staff, after consultation with the President. The President shall appoint the other committee members, except as otherwise provided in these Bylaws. The term of appointment will be specified by committee, shall begin on January 1, and members may serve consecutive terms unless otherwise provided in the Bylaws. The Chief of Staff shall submit his appointments to the President for publication by December 1st of each year, whenever possible.

B. The Chief of Staff and the President (or the CMO as his designee) shall serve as ex-officio members of all committees, nonvoting unless otherwise provided in these Bylaws, and may attend all committees' meetings including meetings in executive session. Non- voting, ex-

officio members of committee may not be counted in establishing a quorum.

C. All committees shall maintain minutes and report to the Medical Executive Committee.

D. Standing committees may utilize sub-committees and ad hoc committees as needed to accomplish their duties. A sub-committee or ad hoc committee must have at least one (1) voting member of the originating standing committee. An ad hoc committee shall terminate automatically on completion of the function for which it was established.

Section 2. Medical Executive Committee (MEC)

A. Composition: The Medical Executive Committee shall consist of:

- the officers of the Medical Staff,
- the immediate past Chief of Staff,
- the Chairman of the Credentials Committee,
- the Chairman of the Quality Monitoring Committee (QMC),
- the Chief of Service and Chief of Service-Elect of each Service, and
- the Director of the Hospitalist Program or a full-time hospitalist designated by the Director.

The President (or the CMO as his designee) and the CNO attend all Medical Executive Committee meetings as ex-officio members. The Chief of Staff shall serve as chair and the Assistant Chief of Staff shall serve as acting chair in his absence. A majority of the voting members of the Medical Executive Committee must be physicians.

B. Duties: By these Bylaws, the Medical Staff delegates to the Medical Executive Committee the authority to carry out Medical Staff responsibilities and to act on behalf of the Medical Staff between meetings, unless otherwise provided in these Bylaws. The duties of the Medical Executive Committee shall be to:

1. represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;
2. coordinate the activities and general policies of the various Services;
3. receive and act upon all department and committee reports at their monthly meetings;
4. approve and implement policies of the Medical Staff not otherwise the responsibility of the Services;
5. provide a liaison between the Medical Staff and the President (or the CMO as his designee) and the Board of Directors;
6. recommend action to the President (or the CMO as his designee) on matters of a medical nature;
7. make recommendations on Medical Center management matters to the Board of Directors through the President;
8. fulfill the Medical Staff's accountability to the Board of Directors for the medical care rendered to patients in the Medical Center and for oversight of the Continuous Quality Improvement plan and activities;
9. ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Medical Center;

10. help to prioritize hospital-sponsored educational activities based on services offered by the hospital and findings of performance improvement activities; either directly or through delegation to an education committee;
11. review the recommendations of the Services and make recommendations to the Board of Directors for Staff membership, assignments to Services and delineation of clinical privileges, including criteria for clinical privileges;
12. review periodically information available regarding the performance and clinical competence of Staff members and other Providers with clinical privileges, including through focused and ongoing professional practice evaluations, and as a result of such reviews to make recommendations to the Board of Directors for reappointments and renewal or changes in clinical privileges;
13. take all reasonable steps to ensure professional and ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in corrective or review measures when warranted;
14. report at Medical Staff meetings as needed;
15. review and evaluate monthly the Continuous Quality Improvement activities;
16. review, either directly or through delegation to an ad hoc bylaws committee. the Bylaws and Rules and Regulations of the Medical Staff as needed and at least every three (3) years; and
17. delegate biomedical ethics issues that arise to the Ethics Committee.

C. Meetings: The Medical Executive Committee shall meet at least ten (10) times per year on a monthly basis, and when called by the Chief of Staff. The Medical Executive Committee shall report to the Medical Staff at its meetings, except on matters of individual Provider medical peer review.

D. Conflict Resolution: In the event of disagreement between the voting members of the Medical Staff and the Medical Executive Committee on an issue delegated to the Medical Executive Committee, the Medical Staff may request implementation of these conflict resolution procedures as follows. These procedures may not be used on issues of individual Provider medical peer review or on issues upon which the Board of Directors has already made a final decision.

1. A petition for reconsideration of an issue signed by at least ten percent (10%) of the Medical Staff must be filed in the Medical Staff Office within ten (10) days of recommendation or action on the issue by the Medical Executive Committee.
2. The Medical Executive Committee will call a special meeting of the Medical Staff in accordance with the procedures in these Bylaws to discuss the issue. The Medical Executive Committee may, with the approval of the President, use the services of a facilitator or mediator at that meeting.
3. Within five (5) days of the meeting, the Medical Executive Committee will reconsider the issue, take a new vote on the issue, and communicate the results of the new vote to the voting members of the Medical Staff.
4. If, within ten (10) days of communication of the results to the Medical Staff under subsection 3., at least twenty-five percent (25%) of the Medical Staff sign a petition for removal of the Medical Executive Committee's delegated authority on the issue, a special meeting of the Medical Staff shall be called and a vote conducted. A quorum

shall require the presence of at least twenty percent (20%) voting members of the Medical Staff and removal of the delegated authority on the issue shall require the majority vote of the voting members present and voting.

E. Removal of Delegated Authority: Removal of authority that has been delegated to the Medical Executive Committee in any manner other than as provided in subsection D. above shall require amendment of these Bylaws.

Section 3. Credentials Committee

A. Composition: The Credentials Committee shall consist of at least five (5) members from the Medical Staff, the Chief Medical Officer, the President, and the Chief Nursing Officer as ex-officio members. One of the five (5) members shall be the Assistant Chief of Staff. There shall be at least two (2) representatives from each Service, who may not be the Chief of Service. All appointments, shall be for two (2) year terms.

B. Duties: The duties of the Credentials Committee shall be to:

1. Review credentials for all applicants to the Staff with a complete application, and make recommendations to the Medical Executive Committee as to appointment and clinical privileges in accordance with Articles V and VI;
2. Review the delineation of privileges and any criteria as designated by the Services and make recommendations to the Medical Executive Committee for delineations; and
3. Review credentials and delineation of privileges as designated by the appropriate Services on a periodic basis for all current Staff members and all requests for new privileges.

C. Meetings: The Credentials Committee shall meet at least ten (10) times per year, on a monthly basis, and otherwise as needed on call of the chair.

Section 4. Quality Monitoring Committee

A. Composition: The Quality Monitoring Committee (QMC) shall consist of at least ten (10) members of the Medical Staff and the Chief Medical Officer. There shall be at least five (5) representatives from each Service. The chair will be appointed from the members by the Chief of Staff. Initially, five (5) members shall be appointed for one (1) year terms to allow for staggered terms. All other and future appointments shall be for two (2) year terms.

B. Duties: The duties of the Quality Monitoring Committee shall be to:

1. review the quality and safety of patient care rendered by individual Providers;
2. verify that services are reasonable, medically necessary and provided in the appropriate setting;
3. evaluate the quality of documentation in the medical record;
4. review the operations and policies of specialty units;
5. review the usage of pharmaceuticals, blood, and blood products by the Medical Center; and
6. review infection control/employee health surveillance activities.

C. Meetings: This committee shall meet at least ten (10) times per year, on a monthly basis, and otherwise as needed on call of the chair.

D. Subcommittees of the Quality Monitoring Committee: Medical and surgical subspecialties with a minimum of three (3) members on active staff may elect to form a specialty specific subcommittee of the QMC. This subcommittee may perform their own peer review of cases specific to the subspecialty. The subcommittee will report actions to the QMC as a summary report. Any actions arising from the subcommittee that recommends an adverse action will be separately adjudicated by the QMC. The QMC maintains final authority on peer review despite the recommendations of the subcommittee.

Section 5. Physician Wellness Committee

A. Composition: The Physician Wellness Committee shall consist of three (3) members of the Medical Staff, one of whom shall be appointed as chair.

B. Duties: The duties of the Physician Wellness Committee shall be to:
1. facilitate confidential diagnosis, treatment, and rehabilitation of Providers who suffer from a potentially impairing condition; and
2. aid an impaired Provider in retaining or regaining optimal professional functioning, without the use of discipline, if possible, while serving the best interests of quality patient care.

C. Meetings: The Physician Wellness Committee shall meet as needed on call of the chair.

Section 6. Joint Conference Committee

A. Composition: The Joint Conference Committee shall consist of the Chief of Staff, the Assistant Chief of Staff, and the immediate past Chief of Staff or another designee of the Medical Executive Committee, three (3) members of the Board of Directors to include the Chairman, and the President. All members shall have voting rights except for the President who shall vote only in the event of a tie.

B. Duties: The Joint Conference Committee shall be established jointly by the Medical Staff and the Board of Directors for purposes of resolving conflicts, whether actual or potential, between the Medical Executive Committee and/or the Medical Staff and the Board of Directors. The Joint Conference Committee shall review and make recommendations as set forth in these Bylaws and on referral from the Board of Directors. The committee may be assigned other tasks with the approval of the Chairman and the Chief of Staff.

C. Composition: The Joint Conference Committee shall meet as needed on call of the President, the Chairman of the Board of Directors, or the Chief of Staff.

Section 7. Cardiac Cath/Interventional Radiology Lab Committee

Composition: The Cardiac Cath/Interventional Radiology Lab Committee shall consist of those members from the Medical Staff who use the lab and at least one additional member of the Medical Staff, appointed by administration. The medical director of Cardiology and the medical director of Radiology will be Co-Chairs.

A. Duties: The duties of the Cardiac Cath/Interventional Radiology Lab Committee shall be:
   1) To review the operations and policies of the Lab.
   2) To recommend criteria for privileging in the Lab.
   3) To review the quality of patient care rendered in the Lab.

B. Meetings: The Cardiac Cath/Interventional Radiology Lab Committee shall meet quarterly, as needed. A permanent record of its proceedings shall be maintained.

ARTICLE XIII. MEDICAL STAFF MEETINGS

Section 1. Regular Meetings

Regular meetings of the Medical Staff shall be held quarterly. The fourth quarter meeting will include the election of Staff officers for the upcoming year. The meeting schedule will be published on the annual calendar. The voting members of the Staff will be notified either electronically, by telephone, or by mail of any changes to the published calendar.

Section 2. Special Meetings

Special meetings of the Medical Staff may be called one of two ways, unless otherwise provided in these Bylaws:

A. The Chief of Staff or the Medical Executive Committee may call a special meeting of the Medical Staff at any time; or

B. The Chief of Staff shall call a special meeting within ten (10) days after receipt of a written request stating the purpose for such meeting, which is signed by not less than twenty-five percent (25%) of the voting members of the Medical Staff.

The Chief of Staff shall designate the time and place of any special meeting. The voting members of the Staff shall be notified of the date, time, place, and agenda of the special meeting either electronically, by telephone, or by mail.

Section 3. Voting

A. Voting by the Medical Staff may be at Staff meetings or conducted by mail (or email) ballot as set forth below.

B. At a Staff meeting, a quorum consists of those present, and a simple majority is considered a passing vote. Voting by proxy is not permitted.

C. Voting by mail (or email) may be used for removal of Staff Officers or for amendment, repeal, or adoption of Medical Staff Bylaws or Rules and Regulations or Medical Staff Policies. Action taken without a meeting requires mail (or email or other electronic survey technology) ballots to be submitted from at least two-thirds (2/3rds) of the Medical Staff and a simple majority of the submitted ballots is considered a passing vote.

Section 4. Minutes

Minutes of each regular and special meeting of the Medical Staff shall be prepared and shall include a record of the attendance of members, the business transacted and state their conclusions, recommendations and actions. The minutes shall be signed by the Chief of Staff.

ARTICLE XIV. COMMITTEE AND SERVICE MEETINGS

Section 1. Regular Meetings

Committees shall meet monthly unless otherwise provided in the Bylaws. Services shall meet at least quarterly. The meeting schedule will be published on the annual calendar. All voting members of the medical staff will be notified of any changes to the published calendar electronically, by telephone, or by mail (or email).

Section 2. Special Meetings

A special meeting of any committee or Service may be called by or at the request of: the committee chair or Chief of Service, respectively; the Chief of Staff; or by fifty percent (50%) vote or written request of the group's voting members. All voting members of the respective committee or Service will be notified of the date, time, place, and agenda of a special meeting electronically, by telephone, or by mail (or email).

Section 3. Voting

A. Voting may be at Committee or Service meetings or conducted by mail (or email) ballot as set forth below.

B. At a Committee meeting, a quorum consists of fifty percent (50%) of the voting members. A simple majority is considered a passing vote. Voting by proxy is not permitted.

C. At a Service meeting, a quorum consists of those present. A simple majority is considered a passing vote. Voting by proxy is not permitted.

D. Voting by mail (or email) may be used for both Committee and Service meetings. Action taken without a meeting requires mail (or email or other electronic survey technology) ballots to be submitted from at least two-thirds (2/3rds) of the voting members. A simple majority of the submitted ballots is considered a passing vote.

Section 4. 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, the business transacted and state their conclusions, recommendations and actions. The minutes shall be signed by the committee chair or the Chief of Service.

Section 5. Special Appearance

At the discretion of the chair or presiding officer, when a Member’s practice or conduct is scheduled for discussion at a meeting, the Member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least seven (7)

days prior to the meeting and shall include the date, time and place of the meeting and a general indication of the issue involved. Failure of the member to appear at any meeting, with respect to which he was given such notice, unless excused by the Medical Executive Committee upon showing of good because, may be a basis for Corrective Action.

ARTICLE XV. MEDICAL PEER REVIEW

Section 1. Medical Peer Review

A. Each committee (whether Medical Staff, Service, standing, sub-committee, ad hoc, or joint) and each Service, as well as the Medical Staff when meeting as a whole, shall be constituted and operate as a "medical peer review committee," "medical committee," and "professional review body," as such terms are defined by state and federal law, and is authorized by the Board of Directors through these Bylaws to perform "medical peer review" and "professional review activity" (collectively "medical peer review").

B. Medical peer review shall be as defined in the Texas Medical Practice Act and the federal Health Care Quality Improvement Act and include, without limitation, the evaluation of the quality of medical and health care services; evaluation of the qualifications and professional conduct of Providers, Advanced Practice Providers, and other health care professionals and the health care services they provide; evaluation of the merits of complaints relating to Providers, Advanced Practice Providers or other health care professionals; and reports made to a governmental agency or another entity that performs medical peer review. Medical peer review shall also include the performance and results of focused professional practice evaluation and ongoing professional practice evaluation.

C. Members of a committee, Service, or the Medical Staff shall act as members of and on behalf of the medical peer review committee, medical committee, or professional review body when performing a function or responsibility of the committee, Service, or Medical Staff.

D. The Chief of Staff may appoint other individuals to serve as agents of a committee and assist in carrying out the functions and responsibilities of the committee, as may the Chief of Service and the chair of a committee. The President, legal counsel to the Medical Center, and the Medical Staff Office and Quality Department shall be considered agents of all Medical Staff committees, Services, and the Medical Staff as applicable when performing their respective functions and responsibilities. An action by an agent or member of a committee**,** Service, or the Medical Staff when performing such functions and responsibilities shall be considered an action taken on behalf of the appropriate committee, Service, or the Medical Staff as applicable, not an action taken in the agent's or member's individual capacity.

Section 2. Confidentiality

A. All records and proceedings of the Medical Staff, the Services, Service Sub- committees, Medical Staff committees (whether standing, sub-committees, ad hoc committees, or joint committees), and the Board of Directors, including without limitation any minutes of meetings, disclosures, discussion, statements, actions, or recommendations in the course

of medical peer review, as defined above, shall be privileged and confidential, subject to disclosure only in accordance with Medical Staff and Medical Center policies and requirements, unless otherwise required by state and/or federal law, and shall be privileged to the fullest extent permitted by state and federal law.

B. All members of the Medical Staff, other Providers holding clinical privileges, and Advanced Practice Providers, as well as those applying for such status, and all other individuals participating in, providing information to, or attending meetings of the Medical Staff, Services, Service Sub-committees, Medical Staff committees, or the Board of Directors, or serving as agents or members thereof, are required to maintain the records and proceedings related to any medical peer review activities as confidential, subject to disclosure only in accordance with Medical Staff and Medical Center policies and requirements, unless otherwise required by state or federal law. These confidential documents may be accessed and utilized only in performance of authorized Medical Staff or Medical Center functions.

C. A permanent file of the minutes of each meeting of the Medical Staff, a Service, and a Medical Staff or Service committee shall be maintained by the Medical Center. If the minutes are electronically recorded, such recordings shall be erased immediately after permanent transcription.

D. Waiver of the privilege of confidentiality as to the records and proceedings of the Medical Staff or any Medical Staff committee, Service, or Service Sub-committee shall require the written consent of the presiding officer of the entity as well as the Chief of Staff and the President. The Medical Center shall be responsible for maintenance and custody of the records and proceedings of all Medical Staff committees, Services, Service Sub-committees, and the Medical Staff.

Section 3. Immunity

A. Express conditions to any Provider's and/or Advanced Practice Provider's application for Medical Staff appointment, reappointment, and/or clinical privileges, and to the exercise of Medical Staff membership and/or clinical privileges at this Medical Center, shall be the following:

1. Any act, communication, report, recommendation, or disclosure with respect to any applicant or member performed or made in good faith without malice and at the request of an authorized representative of the Medical Center or any other health care facility shall be privileged to the fullest extent permitted by law.
2. Such privilege shall extend to all members of the Medical Staff, the President, the Board of Directors, and all Medical Center employees and representatives, and to third parties who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article, the term "third parties" means both individuals and organizations from which information has been requested by an authorized representative of the Board of Directors, the Medical Staff, or the Medical Center.
3. There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or other disclosure,

even where the information involved would otherwise be deemed privileged. Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care entity's medical peer review activities related, but not limited to:

a) Applications for appointment or reappointment, or for clinical privileges;
b) Corrective action, including summary action;
c) Hearings and appellate reviews;
d) Continuous Quality Improvement plan implementation and other medical care evaluations, including focused and ongoing professional practice evaluations;
e) Utilization review; and
f) Other Medical Center, Medical Staff, Service, or committee activities related to medical peer review.

4. The acts, communications, reports, recommendations, and disclosures referred to in this Article may relate to a Provider's or Advanced Practice Provider's professional competence or conduct or any other matter that might directly or indirectly have an effect on the delivery of health care services or operations of the Medical Center or the Medical Staff.
5. Each Provider and Advanced Practice Provider shall upon request of the Medical Center execute releases in accordance with the provisions of this Article in favor of the individuals and organizations specified; provided that, the effectiveness of the privileges afforded by this Article and elsewhere in these Bylaws is not contingent on execution of such releases.
6. The consents, authorizations, releases, rights, privileges, and immunities provided by other Articles of these Bylaws for the protection of the Medical Staff, the Medical Center, its Board of Directors, employees, and representatives, and third parties, or in the applications for appointment, reappointment, and/or clinical privileges, shall also be fully applicable to the activities and procedures covered by this Article.

B. Any immunity afforded by these Bylaws shall be in addition to, not in limitation of, any immunity afforded by state and federal law.

Section 4. Mandatory Reporting

A. The President, in consultation with the Chief of Staff, shall be responsible to comply with any mandatory reporting requirements of the Medical Center under state and/or federal law pertaining to Medical Staff membership and/or clinical privileges. Nothing in this section or the other provisions of the Bylaws shall prevent an individual member of the Medical Staff or the Board of Directors from making any other report to state or federal agencies as permitted or required by law.

B. For purposes of mandatory reporting as required by the federal Health Care Quality Improvement Act and/or state law, an "investigation" is only:

1. an investigation initiated by the Medical Executive Committee following receipt of a request for possible corrective action as set forth in Article VIII, based on professional competence or conduct; or

2. that period of time following issuance of an Adverse Recommendation or Action, as defined in Article VIII, by the Medical Executive Committee or Board of Directors based on professional competence or conduct.

Any other use of the term "investigation" in these Bylaws or in policies does not constitute an investigation for purposes of mandatory reporting.

C. A Summary Corrective action pursuant to Article VIII, Section 4 that is an Adverse Recommendation or Action is considered a "professional review action" for purposes of mandatory reporting pursuant to the Health Care Quality Improvement Act when affirmed by the Medical Executive Committee or when the Provider waives such review.

Section 5. Conflict of Interest

A. Whenever a Provider is participating in medical peer review and/or performing a function for a committee, Service, the Medical Staff, the Board of Directors, or the Medical Center, and the Provider's personal or professional interests could be reasonably interpreted as being in conflict with the interests of the committee, Service, Medical Staff, Board of Directors, Medical Center, or an individual under review by such entity, the Provider shall disclose those interests and the potential for conflict to the appropriate decision makers prior to such participation. The presiding officer of the entity, with the approval of the President, may require the Provider to refrain from any participation in decisions that may be affected by or affect the Provider's interests.

B. A Provider shall not be eligible to perform medical peer review, including participating in any deliberation or voting by a committee or Service of which he is a member, regarding his own delivery of patient care, the granting of clinical privileges and/or Medical Staff membership to him, or any other medical peer review activity involving the Provider, except to the extent specifically provided for when subject to an Investigation for purposes of possible corrective action as provided in Article VII.

C. Any family members of a Provider shall not be eligible to perform medical peer review, including deliberation or voting by any committee or Service of which the family member is a member, regarding the Provider's delivery of patient care, the granting of clinical privileges and/or Medical Staff membership, or any other medical peer review activity involving the Provider. "Family member" shall mean a Provider's (i) parents or stepparents, including spouses of the same, (ii) ancestors, (iii) spouse, (iv) child or stepchild, grandchild, or great grandchildren, (v) siblings, whether related by whole or half blood, or (vi) the spouse of an individual described in clause (iv) or clause (v), and shall include adoptive relationships of the above.

ARTICLE XVI: RULES AND REGULATIONS AND POLICIES

Section 1. General

The Medical Executive Committee shall adopt such Rules and Regulations and Medical Staff policies as may be necessary to implement more specifically the general principles found within these Bylaws. These shall relate to the proper conduct of the Medical Staff organizational activities as well as embody the level of practice that is to be required of each Provider in the Medical

Center. Such Rules and Regulations and Medical Staff policies shall be a part of these Bylaws.

Section 2. Amendment by Medical Executive Committee

The Rules and Regulations and any Medical Staff policies may be amended or repealed at any meeting of the Medical Executive Committee at which a quorum is present, by a two-thirds (2/3) vote of those present. Except as provided below, prior to amendment of the Rules and Regulations by the Medical Executive Committee, the members of the Medical Staff shall be notified of the proposed amendment, which notice shall include procedures for submitting comments on the proposed amendment to the Medical Executive Committee prior to voting. In the event of a need for urgent amendment of the Rules and Regulations in order to comply with law or regulations, the Medical Executive Committee may provisionally adopt an amendment and submit it to the Board of Directors for approval without first notifying the members of the Medical Staff. In such case, the members of the Medical Staff shall be notified within five (5) days following adoption of the amendment and provided with a procedure for retrospective review of and submission of comments to the Medical Executive Committee. If there is no conflict between the majority of the comments submitted and the amendment approved by the Medical Executive Committee, the provisionally approved amendment will become final. If there is conflict between the majority of the comments submitted and the provisionally approved amendment, the Medical Staff may invoke the conflict resolution procedures in Article XII.2.D. above. Any required notice shall be as set out in Section 3 below.

Section 3. Amendment by Medical Staff

The voting members of the Medical Staff may also adopt or amend Rules and Regulations and Medical Staff policies, subject to approval of the Board of Directors. Prior to such action, the proposal, which must be the subject of a petition signed by at least twenty-five percent (25%) of the Medical Staff members, must first be presented to the Medical Executive Committee for review and comment. The Medical Executive Committee's comments must be included in the presentation of the proposal to the Medical Staff for a vote which shall be accomplished by mail ballot. Any notice required by this Article XVI and the mail ballot shall be deemed delivered: (i) when deposited in the U. S. mail with postage prepaid (or when deposited with an authorized mail delivery service); (ii) when deposited in the Medical Center's internal mail distribution if the member is on the distribution list; (iii) when sent by electronic mail which shall be deemed delivered upon read-receipt from an internet server, addressed to the member at the member's address as it appears of record in the Medical Staff Office; or (iv) when hand delivered to the member or the member's office. Passage of an amendment shall require an affirmative vote of fifty-one percent (51%) of the ballots returned within twenty-one (21) days of the date of mailing or electronic delivery or hand delivery.

Section 4. Approval by Board of Directors and Notice

Any adoption or amendment as provided above shall not become effective unless and until approved by the Board of Directors. All members of the Medical Staff and others with delineated clinical privileges shall be notified when amendments are approved by the Board of Directors.

ARTICLE XVII. AMENDMENTS, REPEAL, AND ADOPTION OF NEW BYLAWS

Section 1. Procedures

The Bylaws may be amended, repealed, or new bylaws adopted by mail or email ballot to all Medical Staff members describing the proposal or at a Staff meeting by the voting members of the Medical Staff. Amendments, repeal, or new bylaws may be proposed for vote by either the Medical Executive Committee, at least twenty-five percent (25%) members of the Medical Staff in writing to the Medical Executive Committee, or the Board of Directors. Any proposal must be forwarded to the Medical Executive Committee for review and recommendation prior to submission for vote.

The Medical Executive Committee shall select the method of voting. If submitted for vote at a Staff meeting, the procedures for the meeting in Article XIII shall be followed. Any notice required by this Article XVII and the mail, or email, ballot shall be deemed delivered: (i) when deposited in the U. S. mail with postage prepaid (or when deposited with an authorized mail delivery service); (ii) when deposited in the Medical Center's internal mail distribution if the member is on the distribution list; (iii) when sent by electronic mail which shall be deemed delivered upon read-receipt from an internet server, addressed to the member at the member's address as it appears of record in the Medical Staff Office; or (iv) when hand delivered to the member or the member's office. Passage of an amendment, repeal, or new bylaws shall require an affirmative vote of fifty-one percent (51%) of the ballots returned within twenty-one (21) days of the date of mailing or electronic delivery or hand delivery.

Section 2. Approval by Board of Directors and Notice

Amendments, repeals, or adoption of new bylaws so made shall be forwarded to the Board of Directors for review and approval, who shall act within thirty (30) days of the submission. The amendment, repeal, or new bylaws shall not be effective unless and until approved by the Board of Directors and only on notice to the members of the Medical Staff, but in no event later than thirty (30) days from the Board of Directors' approval.

Section 3. Prohibition on Unilateral Amendment

Neither the Medical Executive Committee, the Medical Staff nor the Board of Directors may unilaterally amend the Bylaws, the Rules and Regulations or a Medical Staff policy.

Section 4. Prohibition on Conflict

The Bylaws, and any Rules and Regulations and Medical Staff policies, may not conflict with the bylaws of the Board of Directors.