MIDLAND MEMORIAL HOSPITAL
Midland, Texas

MEDICAL STAFF BYLAWS

Date: October 2004

Revised 9/24/2014
Revised 7/30/2014
Revised 12/18/2013
Revised 06/27/12
Revised 05/30/12
Revised 02/24/10
Revised 01/27/10
Revised 12/16/09
Revised 05/27/09
Revised 12/17/08
Revised 04/30/08
Revised0 4/25/07
Revised 01/31/07

MIDLAND MEMORIAL HOSPITAL
REVISED AND RESTATED MEDICAL STAFF BYLAWS
TABLE OF CONTENTS

DEFINITIONS

1. **ADMINISTRATOR** means the person appointed by the Board to act on its behalf in the overall management of the Hospital. The Administrator holds the title of chief executive officer of the Hospital. In the event of his or her absence, the Administrator may select a designee to temporarily serve in the role of Administrator.

2. **BOARD** means Board of Trustees of the Midland Memorial Foundation, the governing body of the Hospital.

3. **BYLAWS** means these Medical Staff Bylaws, created and adopted by the Medical Staff of Midland Memorial Hospital, as approved by the Board, to establish a framework for self-governance, evaluation of care and services, and accountability to the Board. These Bylaws do not create an employer-employee relationship or a contractual relationship between members of the Medical Staff and the Hospital.

4. **CHIEF OF STAFF** means the president of the Medical Staff elected by its members.

5. **CLINICAL PRIVILEGES** or **PRIVILEGES** means the permission granted to render specific patient services. *Revised 9/24/2014*

6. **DENTIST** means an individual who holds a current and valid license to practice dentistry issued by the Texas State Board of Dental Examiners.

7. **HEALTH CARE QUALITY IMPROVEMENT ACT ("HCQIA")** means the Health Care Quality Improvement Act of 1986, codified at 42 U.S.C. § 11101 *et. seq.*

8. **HOSPITAL** means Midland Memorial Hospital**,** including all hospital campuses.

9. **HOUSE STAFF** means individuals who are graduates of medical, dental, osteopathic, or podiatric schools, who are assigned to the Hospital by their professional graduate training program, and who participate in patient care under the direction of licensed independent practitioners of the pertinent clinical discipline who have clinical privileges in the Hospital and are members of the Medical Staff.

10. **HOSPITAL ACCREDITING BODY** means the accrediting body for the hospitals whose standards are referred to in these Bylaws. *Revised 1/13/2010*

11. **LIMITED LICENSE PRACTITIONER** means a dentist or podiatrist.

12. **LOCUM TENENS** means a practitioner who serves as an appointee of the Medical Staff that is ill, out of town, or unavailable due to other emergency situations, filling in for a permanent vacancy, or when there are no other Medical Staff members available who can provide such coverage to attend in-hospital patients. Revised 9/24/2014

13. **MEDICAL EXECUTIVE COMMITTEE ("MEC")** means the Executive Committee of the Medical Staff.

14. **MEDICAL STAFF OR STAFF** means those practitioners who have been appointed as members of the Medical Staff pursuant to the terms of these Bylaws

15. **MEDICAL STAFF YEAR** means the calendar year.

16. **MEMBER** means, unless otherwise expre**ss**ly limited, a physician, dentist, or podiatrist holding a current Texas license to practice within the scope of his or her license who has been admitted to membership on the Medical Staff.

17. **NATIONAL PRACTITIONER DATA BANK ("NPDB")** means the national clearinghouse established pursuant to the Health Care Quality Improvement Act, for obtaining and reporting information with respect to adverse actions or malpractice claims against physicians or other practitioners.

18. **ORAL SURGEON** means an individual who has successfully completed an accredited post-graduate program in oral and maxillofacial surgery and has been granted clinical privileges pursuant to these Bylaws permitting such member to conduct a complete history and physical examination in order to assess the medical, surgical and anesthetic risks of the proposed operative and other procedure(s).

19. **PHYSICIAN** means an individual who holds a current and valid license to practice medicine issued by the Texas Medical Board ("TMB").

20. **PODIATRIST** means an individual who holds a current and valid license to practice podiatry issued by the Texas State Board of Podiatry Examiners.

21. **PRACTITIONER** means a licensed physician, dentist, oral surgeon, or podiatrist who is authorized by law and who also is permitted by the Hospital to provide patient care services without direction or supervision, within the scope of his or her license and in accordance with individually granted clinical privileges.

22. **TELEMEDICINE** means the use of medical information from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment, and services.

23. **TEXAS MEDICAL BOARD ("TMB")** means the state licensing agency for physicians and physician assistants.

ABBREVIATIONS

1. **ABMS** means the American Board of Medical Specialties.
2. **ACC** means Allison Cancer Center.
3. **ACGME** means the American Council of Graduate Medical Education.
4. **ADA** means the American Dental Association.
5. **AHP** means Allied Health Professional.
6. **AOA** means the American Osteopathic Association.
7. **APMA** means the American Podiatric Medical Association.
8. **CRNA** means Certified Registered Nurse Anesthetist.
9. **ECFMG** means Examination Certificate for Foreign Medical Graduates.
10. **TMA** means the Texas Medical Association.
11. **TTUHSC** means the Texas Tech University Health Science Center.

MIDLAND MEMORIAL HOSPITAL
MEDICAL STAFF BYLAWS

Midland Memorial Hospital, owned by Midland County Hospital District, a governmental entity organized pursuant to Texas Health and Safety Code, Chapter 281, is a Texas licensed hospital managed by the Midland Memorial Foundation, and organized to serve as a general hospital providing patient care, medical education, and research. These Bylaws (1) provide for the organization of the Medical Staff, (2) provide a framework for Medical Staff self-governance to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and (3) govern the orderly resolution of those purposes, subject to the authority of the Board of Trustees. These Bylaws are adopted by the Medical Staff and approved by the Board to accomplish the Hospital's and the Medical Staff's purposes set forth herein.

ARTICLE I
NAME

The name of this organization is the Medical Staff of Midland Memorial Hospital

ARTICLE II
PURPOSE

The Medical Staff is committed to providing quality, respectful, and efficient care to the people of Midland and surrounding counties, in accord with the ethical professional principles of its members and with applicable laws and regulations. These Bylaws:

(a) provide a system of Medical Staff governance and patient care that provides Hospital patients with medical care consistent with the generally recognized standards of the profession and the community;

(b) provide quality medical care through an ongoing review and evaluation of the overall care, treatment, and services provided in the Hospital, and each member's performance in the delivery of that care;

(c) provide a mechanism for reviewing the qualifications of applicants and members of the Medical Staff and to make recommendations to the Board with respect to the admission and termination of members;

(d) provide a mechanism for monitoring the performance of members and recommending corrective action when a member's performance falls below the standards established by the Medical Staff and the community;

(e) provide for consultation to the Board with respect to contractual agreements with Hospital-based physicians;

(f) provide for an appropriate educational setting that will maintain scientific standards and promote continuous advancement in professional knowledge and skill;

(g) provide a mechanism for the initiation and maintenance of Rules and Regulations for the self-governance of the Medical Staff; and

(h) provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by representatives of the Medical Staff, Board, and the Administrator.

ARTICLE III
MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

Membership on the Medical Staff of the Hospital is a privilege that shall be extended only to licensed, professionally competent practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. No practitioner, including those in a medical administrative position by virtue of a contract with the Hospital, shall admit or provide medical or health-related services to patients in the Hospital unless he or she is a member of the Medical Staff, or has been granted clinical privileges in accordance with the procedures set forth in these Bylaws. Appointment to the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these Bylaws.

3.2 QUALIFICATIONS FOR MEMBERSHIP

3.2.1 GENERAL QUALIFICATIONS

Only practitioners who satisfy the following requirements shall be deemed to possess basic qualifications for Medical Staff membership:

(a) satisfactorily document their (1) current licensure and Drug Enforcement Agency ("DEA") and Department of Public Safety ("DPS") numbers, if applicable, (2) adequate experience, education, and training, (3) current professional competence and good judgment, (4) appropriate personal and professional qualifications, as determined by the MEC and the Board, and (5) adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff and the Board that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care, (5) TB Screening on initial appointment and then on a biennial reappointment basis; *Revised 12/17/08*

(b) agree to (1) adhere to the ethics of their respective professions, (2) adhere to the laws and regulations governing their practice, be these laws and regulations Federal, State, or local; (3) work cooperatively with others so as not to adversely affect patient care and the efficient administration of the Hospital, and (4) participate in and properly discharge those responsibilities determined by the Medical Staff;

(c) have appropriate skills and training as determined by the department chair in the department to which an applicant has applied according to policies adopted by the department;

(d) have skills and training to fulfill patient care needs for which the Hospital needs additional Staff members and has adequate facilities and support services for the applicant and his or her patients;

(e) are not currently excluded, suspended, debarred, or ineligible to participate in any Federal or State health care program, or have not been convicted of a criminal offense related to the provision of health care items or services and not been reinstated in a Federal or State health care program after a period of exclusion suspension, or ineligibility; and

(f) maintain in force professional liability insurance in not less than the minimum amounts, if any, as from time to time may be determined by the Board after consultation with the MEC. The Board, upon written request, for good cause shown, may waive this requirement with regard to a member as long as such waiver is not granted or withheld on an arbitrary, discriminatory, or capricious basis. This requirement shall not apply to a member in the Honorary Staff category, unless the member has admitting privileges.

3.2.2 ADDITIONAL QUALIFICATIONS

(a) The Hospital may refuse to process an application for appointment or reappointment based upon the existence of an exclusive contract if such application for appointment or reappointment requests privileges to provide the same or similar services as those provided under the exclusive contract. In such circumstances, the Administrator shall promptly notify the applicant in writing that the application cannot be processed because of the existence of such an exclusive contract. An applicant or member whose application for appointment or reappointment is denied on such basis shall not be entitled to the procedural rights afforded by Article IX.

(b) Subsequent to the date of adoption of these Bylaws, new applicants to the Medical Staff shall be required to have or achieve board certification in their specialty within the allowed period of eligibility as defined by the specialty board or within five (5) years of the date the applicant received approval by the Board of Trustees, whichever happens first. If a board specialty has a re-certification program, members admitted to the Medical Staff after the adoption of these Bylaws are required to follow the applicable board's guidelines regarding periodic re-certification.

Either failure to achieve board certification within this time period or failure to maintain certification may cause revocation of clinical privileges granted specific to that specialty board. Acceptable board certifications include only those recognized by the American Board of Medical Specialties, their Royal College counterparts and those recognized by the respective colleges of the Limited License Practitioners. Requests for approval of board certifications other than those listed shall be forwarded to the Medical Executive Committee.

Members of the Staff prior to the adoption of these Bylaws are encouraged but not required to achieve board certification. Revised 10/2007

(c) Medical Staff members are required to participate in the Hospital's mandated training and continuing education, and orientation for initial

appointment and for reappointment, as formulated by the MEC, to assure knowledge of appropriate Hospital policies and procedures regulating such areas as compliance, conflicts of interest, confidentiality, harassment, safety and risk management, etc. Initial appointment and reappointment are contingent upon satisfactory documentation of this training.

3.2.3 PARTICULAR QUALIFICATIONS

The organization shall have an organized medical staff that is composed of fully licensed doctors of medicine or osteopathy. In accordance with State law, the medical staff include practitioners as defined in Section 1861 (r) of the Social Security Act of a physician. Revised 5/24/2012

(a) *Physicians, Podiatrists and Oral Surgeons*.

(1) Physicians. An applicant for physician membership in the Medical Staff, except for the Honorary Staff, must hold an M.D. or D.O. degree, or equivalent foreign degree issued by a medical or osteopathic school approved at the time of issuance of such degree by the TSBME, and must also hold a valid and unsuspended license to practice medicine issued by the TSBME, or

(2) Oral Surgeons. An applicant for membership in the Medical Staff as an oral surgeon must hold a D.D.S. or equivalent degree issued by a dental school approved at the time of issuance of such degree by the Texas State Board of Dental Examiners and must also hold a valid and current certificate to practice dentistry issued by the Texas State Board of Dental Examiners.

(3) Podiatrists. An applicant for podiatric membership on the Medical Staff must hold a D.P.M. degree conferred by a school approved at the time of issuance of such degree by the Texas State Board of Podiatry Examiners and must hold a valid and current license to practice podiatry issued by the Texas State Board of Podiatry Examiners. Effective 12/16/09

(b) *Limited License Practitioners*.

(1) Dentists. An applicant for dental membership in the Medical Staff must hold a D.D.S. or equivalent degree issued by a dental school approved at the time of the issuance of such degree by the Texas State Board of Dental Examiners and must also hold a valid and current certificate to practice dentistry issued by the Texas State Board of Dental Examiners.

3.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership on the Medical Staff solely because he or she holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any specialty clinical board, or because such person had, or presently has, staff membership or privileges at another health care facility.

3.4 NONDISCRIMINATION

No aspect of Medical Staff membership or particular clinical privileges shall be granted or denied on the basis of sex, race, age, creed, color, or national origin.

3.5 WAIVER OF QUALIFICATIONS

A qualification for membership required in these Bylaws that is not required by State or Federal law or regulation or accreditation standard may be waived in the discretion of the MEC, subject to the approval of the Board, upon determination that such waiver will serve the best interests of the patients and the Hospital.

3.6 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for the Honorary Staff, the ongoing responsibilities of each member of the Medical Staff include: *Revised 4/25/07*

(a) providing patients with the quality of care that meets the professional standards of the Medical Staff of the Hospital, the community and the United States;

(b) abiding by the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Hospital policies and procedures;

(c) discharging in a responsible and cooperative manner responsibilities and assignments imposed upon the member by virtue of Medical Staff membership, including committee assignments;

(d) preparing and completing in timely fashion medical records for all the patients to whom the member provides care in the Hospital, such records stating clearly and completely the diagnoses and treatments pertinent to the hospital stay;

(e) aiding in Medical Staff approved educational programs for medical students, interns, resident physicians, resident dentists, Staff physicians and dentists, nurses, and other Hospital personnel;

(f) working cooperatively with Members, nurses, Hospital administration, and others so as not to adversely affect patient care;

(g) making appropriate arrangements for coverage for his or her patients as determined by the MEC;

(h) refusing to engage in improper inducements for patient referral;

(i) participating in continuing education programs as required by the MEC;

(j) participating in emergency service coverage or consultation panels as may be determined by the MEC and the Board;

(k) complying with the Hospital's policies and procedures regarding the confidentiality of health care information and abiding by the Hospital's Notice of Privacy Practices with regard to Hospital patients; and

(l) discharging other Staff obligations as may be lawfully established from time to time by the Medical Staff or MEC.

(m) Appendix A at the end of these Bylaws.

ARTICLE IV CATEGORIES OF MEMBERSHIP

4.1 CATEGORIES

The categories of the Medical Staff shall include the following: Active, Consulting, Provisional, and Honorary. At each time of reappointment, the member's Staff category shall be determined.

4.2 ACTIVE STAFF

4.2.1 QUALIFICATIONS

The Active Staff shall consist of members who:

(a) meet the general qualifications for membership set forth in Section 3.2;

(b) have at least 25 patient contacts (including outpatient lab/radiology/ therapy orders) in the Hospital per year, and are regularly involved in Medical Staff functions, as determined by the MEC, or possess skills not generally provided by other members of the Active Staff, or make outstanding service contributions to the Medical Staff such that Active Staff membership is recommended by the MEC, subject to the approval of the Board;

(c) have offices or residences that, in the opinion of the MEC and the Board, are located closely enough to the Hospital to provide continuity of patient care; and

(d) have satisfactorily completed their designated term in the Provisional Staff category.

4.2.2 PREROGATIVES

Except as otherwise provided, the prerogatives of a member of the Active Staff shall be to:

(a) subject to bed availability, admit patients and exercise such clinical privileges as are granted pursuant to Article VII;

(b) attend and vote on matters presented at general and special meetings of the Medical Staff and of the department, section, and committees of which he or she is a member;

(c) hold Staff, section, or department office and serve as a voting member of committees to which he or she is duly appointed or elected by the Medical Staff, subject to approval by the Board or its duly authorized representative; and

(d) receive such other prerogatives as may be designated by the Board after consultation with the MEC.

4.2.3 DUTIES

Each member of the Active Staff shall discharge the basic responsibilities of Staff members as required in Section 3.6 of these Bylaws; provide continuous care and supervision of his or her patients in the Hospital; perform a physical examination and medical on each of his or her patients as prescribed in the Medical Staff Rules and Regulations; and perform such further duties as may be required under these Bylaws or the Rules and Regulations. Revised 4/30/2008

4.2.4 TRANSFER OF ACTIVE STAFF MEMBER

After two (2) consecutive years in which a member of the Active Staff fails to regularly care for patients in the Hospital, or be regularly involved in Medical Staff functions, as described in Section 4.2.1, that member shall be automatically transferred to the appropriate category, if any, for which the member is qualified.

4.3 CONSULTING STAFF

4.3.1 QUALIFICATIONS

The consulting Medical Staff shall consist of members who:

(a) meet the general qualifications for membership set forth in Section 3.2;

(b) have fewer than 25 patient contacts at the Hospital per year, and are not regularly involved in the Medical Staff functions on a continuing basis, as determined by the Medical Staff; provided, however, that such members must have at least two patient contacts to maintain membership;

(c) are members in good standing of the Active Medical Staff of another hospital licensed in Texas and accredited by hospital accrediting body;

provided, however, that exceptions to this requirement may be made by the MEC, subject to approval by the Board, for good cause shown;

(d) expect to practice at the Hospital primarily on an on-call basis as a member of a medical group that has representation on the Active Staff, *or* have specialty training not currently represented on the Active Staff, *or* provide consultative services to a Hospital or Emergency Department patient on an individual basis or as part of a call list if one exists for the specialty in question; and

(e) have satisfactorily completed appointment on the Provisional Staff category.

4.3.2 PREROGATIVES

Except as otherwise provided, the Consulting Staff member shall be entitled to:

(a) subject to bed availability, admit patients to the Hospital within the limitations of Section 4.3.1(b) and exercise such clinical privileges as are granted pursuant to Article VII; and

(b) attend in a nonvoting capacity meetings of the Medical Staff and the department or section of which he or she is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment. The Consulting Staff member shall not be required to attend meetings, but shall be responsible for acquiring the information discussed at meetings that he or she does not attend.

Consulting staff members are subject to the same quality assurance requirements as all other members of the Medical Staff. Consulting staff members shall not be eligible to hold office on the Medical Staff.

4.3.3 DUTIES

Each member of the Consulting Staff shall discharge the basic responsibilities of Staff members as required in Section 3.6 of these Bylaws; provide continuous care and supervision of his or her patients in the Hospital; perform a physical examination and medical history on each of his or her patients as prescribed in the Medical Staff Rules and Regulations; and perform such further duties as may be required under these Bylaws or the Rules and Regulations. Revised 4/30/2008

4.3.4 LIMITATION

Consulting staff members who routinely have more than 25 patient contacts annually or regularly care for patients at the Hospital shall, upon review of the MEC, be obligated to seek appointment to the Active Staff category.

4.4 PROVISIONAL STAFF

Members appointed to the Provisional Staff shall be designated as Provisional/Active or Provisional/Consulting, as appropriate.

4.4.1 QUALIFICATIONS

The Provisional Staff shall consist of members who:

(a) meet the general Medical Staff membership qualifications set forth in Section 3.2, and 4.2.1 or 4.3.1, as applicable; and

(b) immediately prior to their application and appointment were not members in good standing of the Medical Staff.

4.4.2 PREROGATIVES

The Provisional Staff member shall be entitled to:

(a) exercise such clinical privileges as are granted pursuant to Article VII, including the right to admit patients, subject to bed availability, if such privileges are granted; and

(b) attend meetings of the Medical Staff and the department or section of which he or she is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

Provisional staff members shall not be eligible to hold office in the Medical Staff organization, but shall serve upon committees if appointed.

4.4.3 DUTIES

Each member of the Provisional Staff shall discharge the responsibilities of Staff members as required in Section 3.6 of these Bylaws; provide continuous care and supervision of his or her patients in the Hospital; perform a physical examination and medical history on each of his or her patients as prescribed in the Medical Staff Rules and Regulations; and perform such further duties as may be required under these Bylaws or the Rules and Regulations. Revised 4/30/2008

4.4.4 OBSERVATION OF PROVISIONAL STAFF MEMBER

Provisional staff members may be required to undergo a period of observation. The observation shall be to evaluate the member's (a) proficiency in the exercise of clinical privileges initially granted, and (b) overall eligibility for continued Staff membership and advancement within Staff categories. Observation of Provisional Staff members shall follow whatever frequency and format each department deems appropriate.

4.4.5 TERM OF PROVISIONAL STAFF STATUS

A member shall remain on the Provisional Staff for a period of two (2) years unless that status is extended by the MEC for an additional period of up to two (2) years upon a

determination of good cause, which determination shall not be subject to review pursuant to Article IX.

4.4.6 ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS

(a) If the Provisional Staff member has satisfactorily demonstrated his or her ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued Medical Staff membership, the member shall be eligible for placement in the Active or Consulting Staff, as appropriate, upon recommendation of the MEC.

(b) In all other cases, the appropriate department shall advise the Credentials Committee, which shall make its report to the MEC, which, in turn, shall make its recommendation to the Board regarding a modification or termination of membership or clinical privileges, or an extension of Provisional Staff status.

4.5 HONORARY STAFF

4.5.1 QUALIFICATIONS

The Honorary Staff shall consist of past Medical Staff members (Active or Consulting) who no longer practice at the Hospital, but are interested in attending and participating in the discussions and the meetings of the organized Medical Staff. Honorary Staff members shall be nominated by a member of the Active Staff to the Credentials Committee. If the Credentials Committee concurs by majority vote, it forwards the recommendation to the Medical Executive Committee. A favorable majority vote endorses the nomination, which then is forwarded to the Board for final action. Honorary status is restricted to those individuals whom the medical staff wishes to honor.

4.5.2 PREROGATIVES

Honorary staff members may not admit patients to the Hospital, exercise clinical privileges in the Hospital, vote or hold office in this Medical Staff organization, or serve upon committees. They may, however, at the discretion of the Chief of Staff, attend Staff, department, and section meetings, including open committee meetings and educational programs. Honorary Staff members shall not be subject to reappointment, and termination of Honorary staff membership shall not constitute grounds for a hearing under Article IX of these Bylaws.

4.5.3 DUTIES

Each member of the Honorary staff shall abide by these Bylaws, Medical Staff Rules and Regulations, and the ethical principles applicable to his or her profession.

4.6 HOUSE STAFF

4.6.1 QUALIFICATIONS

House Staff shall not be considered members of the Medical Staff, and shall not be entitled to any of the rights, privileges, or hearing or appeal rights under these Bylaws. House staff shall be credentialed by the sponsoring medical school or training program in accordance

with provisions of the written affiliation agreement between the Hospital and the school or program; credentialing information shall be made available to the Hospital upon request and as needed by the Medical Staff in making any training assignments and in the performance of their supervisory function. It shall not be necessary for the Hospital to submit a query to the National Practitioner Data Bank prior to permitting a House Staff member to provide services at the Hospital.

4.6.2 LIMITATIONS

(a) House Staff may render patient care services at the Hospital pursuant to and limited by the following:

(1) applicable provisions of State professional licensure requirements;

(2) the written affiliation agreement between the Hospital and the medical school or training program; and

(3) the protocols established by the MEC, in conjunction with the sponsoring medical school or training program, which shall address: the scope of House Staff roles, responsibilities and patient care activities; mechanisms for the direction and supervision of House Staff, including individual House Staff members' progressive involvement and independence in patient care activities; the degree to which House Staff members may write patient care orders, the circumstances under which they may do so, and what entries, if any, must be countersigned by a member of the Medical Staff; and any other conditions imposed upon House Staff by the Hospital or the Medical Staff.

(b) While functioning in the Hospital, House Staff shall abide by all provisions of these Medical Staff Bylaws, Medical Staff Rules and Regulations, and Hospital and Medical Staff policies and procedures, and shall be subject to limitation or termination of their ability to function at the Hospital at any time in the discretion of the Administrator or the Chief of Staff.

(c) House Staff may perform only those services set forth in the training protocols developed by the applicable training program, in concert with the MEC, to the extent that such services do not exceed or conflict with the Rules and Regulations of the Medical Staff or Hospital policies, and to the extent approved by the Board.

(d) A House Staff member shall be responsible and accountable at all times to a member of the Medical Staff with clinical privileges appropriate to supervise the House Staff member.

(e) House Staff may be invited or required to attend meetings of the Medical Staff, departments, sections, or committees, but shall have no voting rights.

4.7 AFFILIATE STAFF *Additional staff status added 9/24/2014*

4.7.1 QUALIFICATIONS

The Affiliate Staff shall not be considered members of the Medical Staff, but may have the same rights, privileges, or hearing or appeal rights as medical staff and meet the general qualifications for privileges set forth in Section 7.1. Affiliate staff practitioners shall function as Locum Tenens at MMH, subject to the approval of the Board and have satisfactorily completed their designated term as a Locum Tenens under section 7.5.2.

4.7.2 PREROGATIVES

Except as otherwise provided, the Affiliate Staff practitioner shall be entitled to:

(a) attend in a nonvoting capacity meetings of the Medical Staff and the department or section of which he or she is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is granted by the committee chair.. The Affiliate Staff practitioner shall be required to be knowledgeable of information discussed of the medical staff and the department or section of which he or she is a member.

(b) Affiliate staff practitioners are subject to the same quality improvement requirements as all other members of the Medical Staff. Affiliate staff practitioners shall not be eligible to hold office on the Medical Staff.

(c) Affiliate staff practitioners, initial appointment shall be for a period of one (1) year. Subsequent reappointments shall be for periods of up to two (2) years.

4.7.3 DUTIES

(a) Each practitioner of the Affiliate Staff shall discharge the basic responsibilities of Staff members as required in Section 3.6 of these Bylaws; provide continuous care and supervision of his or her patients in the Hospital; perform a physical examination and medical history on each of his or her patients as prescribed in the Medical Staff Rules and Regulations; and perform such further duties as may be required under these Bylaws or the Rules and Regulations including call coverage

4.8 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these Bylaws, and by the Medical Staff Rules and Regulations.

4.9 MODIFICATION OF MEMBERSHIP CATEGORY

On its own, upon recommendation of the Credentials Committee, or pursuant to a request by a member, the MEC, subject to the approval of the Board, may recommend a change in the Medical Staff category of a member consistent with the requirements of these Bylaws.

ARTICLE V APPOINTMENT AND REAPPOINTMENT

5.1 GENERAL

Except as otherwise specified herein, no person (including persons engaged by the Hospital in administrative positions) shall exercise clinical privileges in the Hospital unless and until he or she applies for and receives appointment to the Medical Staff or is granted clinical privileges as set forth in these Bylaws. By applying to the Medical Staff for appointment, or by accepting an appointment to the Medical Staff, the applicant acknowledges responsibility to first review these Bylaws and agrees that throughout any period of membership he or she will comply with the responsibilities of Medical Staff membership and with the Bylaws and Rules and Regulations of the Medical Staff as they exist, and as they may be modified from time to time. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these Bylaws.

5.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement, or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and Staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. This burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate by the MEC, which may select the examining physician. The applicant or member has a duty to advise the Medical Staff of any change with respect to information previously submitted by him or her related to his or her credentials. Any change in information, including but not limited to any adverse action by a licensure board, Federal or State health care program, or another healthcare facility shall be reported to the Hospital within five (5) days of the action. For purposes of this section, adverse action shall mean any action based on professional competence or conduct that affects the licensure, membership, or clinical privileges of a practitioner. The applicant's failure to sustain these duties shall be grounds for denial of the application or reapplication.

5.3 DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these Bylaws, initial appointments to the Medical Staff shall be provisional and for a period of two (2) years. Reappointments shall be for a period of up to two (2) years.

5.4 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

5.4.1 APPLICATION FORM

An application form shall be developed by the MEC, or if a specific application form is required by law, the MEC shall determine what additional information shall be required to be included with the application, subject to the approval of the Board. The entire application process is a record of the MEC and the Credentials Committee and all communications regarding

a physician's credentials file and the application process are generated by these Committees. The form shall require detailed information, which shall include, but not be limited to:

(a) the applicant's qualifications, including, but not limited to, relevant training and experience, current licensure, current competence, current DEA and DPS registration **(if required),** and continuing medical education information related to the clinical privileges to be exercised by the applicant,

(b) internship, residency, fellowships, and/or other medical training;

(c) references of peers familiar with the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism. Two peer recommendations are required for appointment. At least one must be obtained from a practitioner in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice. Only one peer reference shall be allowed from his or her group practice. Revised 4/30/2008; 5/24/2012; 9/24/2014

(d) specific requests for membership categories, departments, and clinical privileges, and a statement that no health problems exist that could affect the applicant's ability to perform the privileges requested;

(e) past or pending professional disciplinary actions, past or pending licensure limitations (voluntary or involuntary), past or pending malpractice actions, voluntary or involuntary termination of Medical Staff membership, or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital, and any professional review actions that may adversely affect the applicant's participation in the Medicare or Medicaid program;

(f) physical and mental health status;

(g) membership in professional societies;

(h) evidence of specialty board certification or qualification for such certification;

(i) previous practice experience, including the names and addresses of all hospitals or other health care facilities where the applicant has practiced;

(j) research and publications; and

(k) professional liability insurance in amounts required by the Board for the applicant's specialty.

Each application for initial appointment to the Medical Staff shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the applicant. When an applicant requests an application form, he or she shall be given a copy of these Bylaws, the Medical Staff

Rules and Regulations, the Hospital Bylaws, and summaries of other applicable policies relating to clinical practice in the Hospital, if any.

5.4.2 EFFECT OF APPLICATION

In addition to the matters set forth in Section 5.1, by applying for appointment to the Medical Staff each applicant:

(a) signifies his or her willingness to appear for interviews in regard to the application and present a state or federal photo ID prior to activation of privileges; *Revised 12/17/08*

(b) authorizes consultation with members of staff of other hospitals and others who have been associated with him or her and who may have information bearing on his or her competence, qualifications, performance, and ethical qualifications, and authorizes such individuals and organizations to candidly provide all such information;

(c) consents to inspection of all records and documents that may be material to an evaluation of his or her qualifications and ability to carry out clinical privileges requested, as well as his or her moral and ethical qualifications for membership, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

(d) releases from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the applicant;

(e) releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information in good faith regarding the applicant's competence, ethics, character, and other qualifications, including otherwise confidential information;

(f) consents to the disclosure to other hospitals, medical associations, licensing boards, the National Practitioner Data Bank, and any other entity to which disclosure is required by law, any information regarding his or her professional or ethical standing that the Hospital or Medical Staff may have, and releases the Medical Staff and Hospital from liability for so doing to the fullest extent permitted by law;

(g) if a requirement then exists for Medical Staff dues, acknowledges responsibility for timely payment;

(h) pledges to provide for continuous quality care for his or her patients; and

(i) pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, seeking consultation whenever necessary, refraining from providing "ghost" surgical or medical services, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners.

5.4.3 VERIFICATION OF INFORMATION

(a) The applicant shall deliver an application to the Administrator and an advance payment of Medical Staff dues or application fees, if any is required.

(b) The application and all supporting materials then available shall be transmitted to the person designated by the Credentials Committee. The Credentials Committee, or its designee at the request of the Credentials Committee, shall within ninety (90) days after receiving all requested information from the applicant, verify, through primary sources:

(1) Current Licensure. The Medical Staff shall verify and document current licensure for all applicants with the primary source at the time of appointment to the Medical Staff and granting of clinical privileges, reappointment, renewal of clinical privileges, revision of privileges, and at the time of license expiration. Such verification shall be by letter or secure electronic communication obtained from the appropriate state licensing board. Verification of current licensure through the primary source via a secure electronic communication or by telephone is acceptable if such verification is documented. *Revised 12/17/08*

(2) Relevant Training or Experience. At the time of appointment to membership and granting of clinical privileges, the Hospital shall obtain verification of relevant training or experience from the primary source whenever feasible. The primary source is the original source of the specific credential that can be used to verify the accuracy of a credential reported by an applicant. Primary sources include the specialty certifying board, and letters from professional schools or residency or postdoctoral programs. Verification of relevant training may be obtained by contacting the primary source via secure electronic communication or telephone, if this verification is documented.

(3) Current Competence. Current competence, at the time of appointment to membership and initial granting of clinical privileges is verified in writing by peers practicing in the same professional discipline as the applicant, and knowledgeable about the applicant's professional performance. The Hospital shall obtain directly from primary sources, in the form of written documentation from authoritative sources, which contain informed opinions on an applicant's scope and level of performance. Such primary source verification may be obtained through a secure electronic communication or by phone contact with the primary source. Written documentation that describes the applicant's actual clinical performance in general terms, the satisfactory

discharge of his or her professional obligations as a Medical Staff member, and his or her ethical performance are acceptable.

(4) If practicable, the documentation shall also address at least the following specific aspects of current competence:

i. for applicants in fields performing operative and other procedure(s): the types of operative procedures performed as the surgeon of record; the handling of complicated deliveries; or the skill demonstrated in performing invasive procedures, including information on appropriateness and outcomes;

ii. for applicants in non-surgical fields, the types and outcomes of medical conditions managed by the applicant as the responsible physician; and

iii. the applicant's clinical judgment and technical skills.

(c) *National Practitioner Data Bank*. The Administrator or his or her designee, on behalf of the MEC, shall also verify the information with respect to each application with (a) the National Practitioner Data Bank; (b) the OIG List of Excluded Individuals/Entities; (c) AMA Master Profile; (d) Verification of ECFMG (as applicable); (e) the TSBME pursuant to the Texas Medical Practice Act, located at Texas Occupations Code chap. 151 *et seq*.,; and any other Federal and State laws and regulations, or hospital accrediting body standards. Revised 5/24/2012

(d) *Completed Applications*. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain the required information. When collection and verification is complete, as determined by the Credentials Committee, all such information shall be transmitted to the Credentials Committee and the appropriate department. Upon completion of all collection and verification processes, the application shall be considered a "Completed Application."

5.4.4 PROCESSING OF COMPLETED APPLICATION

Completed Applications for initial staff appointments, reappointments, and requests for clinical privileges shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and except for good cause shall be processed within the time periods specified in this Section 5.4.4. The department chair, the Credentials Committee and the MEC shall act on a Completed Application within ninety (90) days after receiving the Completed Application from the Administrator or his or her designee. The Board shall then take action on the Completed Application at its next regular meeting, but not later than sixty (60) days after the date on which the recommendation of the MEC is received, and shall notify the applicant within twenty (20) days of its final action.

5.4.5 DEPARTMENT ACTION

After receipt of the Completed Application, the chair or appropriate committee of each department to which the application is submitted shall review the Completed Application and supporting documentation, and may conduct a personal interview with the applicant at the discretion of the chair or committee. The chair or appropriate committee shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges granted, and shall transmit to the Credentials Committee a written report and recommendation as to appointment and, if appointment is recommended, as to membership category, department affiliation, section, if any, clinical privileges to be granted, and any special conditions to be attached to the appointment. The chair may also request that the Credentials Committee defer action on the application pending the receipt of additional information. In the discretion of the department, after obtaining the approval of the Administrator, the department may request an independent peer review organization to review some or all of the information provided by the applicant and to make recommendations based on such information. The reason for each recommendation shall be stated and supported by references to the Completed Application and all other documentation or information considered, all of which shall be transmitted with the report.

5.4.6 CREDENTIALS COMMITTEE ACTION

The Credentials Committee shall review the Completed Application, evaluate and verify the supporting documentation, the department chair's report and recommendations, and other relevant information. The Credentials Committee may elect to interview the applicant and seek additional information. In the discretion of the Credentials Committee, after obtaining the approval of the Administrator, the Credentials Committee may request an independent peer review organization to review some or all of the information provided by the applicant and to make recommendations based on such information. As soon as practicable, the Credentials Committee shall transmit to the MEC a written report and its recommendations as to appointment and, if appointment is recommended, as to membership category, department affiliation, section, if any, clinical privileges to be granted, and any special conditions to be attached to the appointment. The Credentials Committee may also recommend that the MEC defer action on the application. The reason for each recommendation shall be stated and supported by references to the completed application and all other documentation considered, all of which shall be transmitted with the report.

5.4.7 MEDICAL EXECUTIVE COMMITTEE ACTION

At its next regular meeting after receipt of the Credentials Committee report and recommendations, or as soon thereafter as is practicable, the MEC shall consider the report and any other relevant information. The MEC may request additional information, return the matter to the Credentials Committee or the department for further investigation, and/or elect to interview the applicant. The MEC shall forward to the Administrator for prompt transmittal to the Board, a written report and recommendation as to Medical Staff appointment and, if appointment is recommended, as to membership category, department affiliation, section, if any, clinical privileges to be granted, and any special conditions to be attached to the appointment. The MEC may also defer action on the application pending the receipt of further information. The reasons for each recommendation shall be stated and supported by references to the completed application and all other documentation considered, all of which shall be transmitted with the report.

5.4.8 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

(a) *Favorable Recommendation*. When the recommendation of the MEC is favorable to the applicant, it shall be promptly forwarded, together with supporting documentation, to the Board.

(b) *Adverse Recommendation*. When a final recommendation of the MEC is adverse to the applicant, the applicant and the Board shall be informed promptly by written notice and the applicant shall be entitled to invoke the procedural rights provided in Article IX. Such adverse recommendation shall not be acted upon by the Board until after the applicant has exercised, or has waived, his or her right to a hearing pursuant to Article IX of these Bylaws.

5.4.9 BOARD ACTION ON THE APPLICATION

The Board may accept, modify, or reject the recommendation of the MEC, or may refer the matter back to the MEC for further consideration, stating the purpose for such referral. The following procedures shall apply with respect to action on the application:

(a) *Favorable Recommendation of the MEC and Unfavorable Decision by the Board*. If the MEC issues a favorable recommendation and the Board's decision is unfavorable, a hearing shall be held before the Board, or a duly authorized committee or other designee which the Board may appoint, unless the applicant has already received a hearing before the hearing committee of the Medical Staff pursuant to Article IX. If a hearing before the Board is held, insofar as practicable the procedures described in Article IX shall apply, except as they may be expressly modified by rules, policies, or procedures established by the Board.

(1) Waiver of Hearing by Applicant. If no hearing is requested by the applicant, the decision of the Board shall constitute final action.

(2) Joint Conference Committee Action. If, following such hearing, the proposed recommendation of the Board is still unfavorable to the applicant, the matter shall be referred to the Joint Conference Committee for consideration, and an appeal from the hearing, if any, shall be to the Joint Conference Committee which shall have access to all records from the hearing. The Joint Conference Committee shall issue a decision, in writing, within thirty (30) days of receipt of the matter unless such time period is extended by the committee for good cause. The decision shall specify the reasons for the action taken.

(3) Final Action by the Board. The decision of the Joint Conference Committee shall be forwarded to the Board, which, at its next

regularly scheduled meeting, shall render a final decision with respect to the application.

(b) *Adverse Recommendation of the MEC*. In the event that the recommendation of the MEC, either with respect to appointment or privileges, is unfavorable to the applicant, the procedural rights set forth in Article IX shall apply.

(1) Waiver of Hearing by Applicant. If no hearing is requested by the applicant, the MEC shall make its recommendation to the Board, which shall take final action with respect to the appointment.

(2) Concurrence of Recommendations of the MEC and the Board. If a hearing is requested, and after consideration of the decision of the hearing committee, the MEC and the Board concur in an unfavorable recommendation following an appeal, if any, pursuant to Article IX, the decision of the Board shall be final.

(3) Conflict between Recommendations of the MEC and the Board. If a hearing is requested, and after consideration of the decision of the hearing committee, if the action of the Board is favorable to the applicant and the recommendation of the MEC is unfavorable, the matter shall be referred to the Joint Conference Committee for consideration within fifteen (15) days of such referral.

i. *Joint Conference Committee Action*. The Joint Conference Committee shall have access to all records from the hearing and appeal. The written decision of the Joint Conference Committee shall, within thirty (30) days of receipt of the matter, unless such time period is extended by that Committee for good cause shown, be forwarded to the Board. The decision shall specify the reasons for the action taken.

ii. *Final Action by the Board*. The Board, at its next regularly scheduled meeting, shall consider the recommendation of the Joint Conference Committee and render a final decision with respect to the application.

5.4.10 NOTICE OF FINAL DECISION

Notice of the final decision shall be given to the Chief of Staff, the MEC, the Credentials Committee, the chair of each department concerned, the applicant, and the Administrator. A decision and notice to appoint or reappoint shall include, if applicable: (a) the staff category to which the applicant is appointed; (b) the department to which he or she is assigned; (c) the clinical privileges granted; and (d) any special conditions attached to the appointment.

5.4.11 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of one (1) year. Any such reapplication shall be processed as an initial application, except that the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse decision no longer exists.

5.5 REAPPOINTMENTS AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

5.5.1 APPLICATION

(a) At least four (4) months prior to the expiration date of each member's appointment (except for temporary appointments), a reapplication form developed by the MEC and approved by the Board shall be mailed or delivered to the member. If an application for reappointment is not received from the member at least ninety (90) days prior to such expiration date, written notice shall be promptly sent to the applicant advising him or her that the application has not been received. At least forty-five (45) days prior to the expiration date of each member's appointment, each Medical Staff member shall submit to the Medical Staff Office the completed application form for renewal of appointment to the Staff for the next two-year appointment period, and for renewal or modification of clinical privileges.

(b) The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in this Article V, as well as other relevant matters. Upon receipt of the application, the information shall be processed as set forth commencing at Section 5.4.3. The Credentials Committee also shall review (1) focused performance improvement activities related to the applicant regarding the quality of health care, treatment, and services provided by the member at the Hospital; (2) the member's satisfactory attendance of meetings of the Medical Staff, departments and/or section, and assigned committees, if applicable; (3) the member's compliance with organized Medical Staff Bylaws, Rules and Regulations; and (4) the number of patients admitted per year to determine whether a change in Staff status is appropriate.

(c) A Medical Staff member who seeks a change in Medical Staff status or modification of clinical privileges may submit such a request at any time upon a form developed by the MEC, except that such application may not be filed within six (6) months of the time a similar request has been denied.

5.5.2 EFFECT OF APPLICATION

The effect of an application for reappointment or modification of Staff status or privileges is the same as an application for appointment, as set forth in Section 5.4.2.

5.5.3 STANDARDS AND PROCEDURE FOR REVIEW

When a Staff member submits an application for reappointment, or when the member submits an application for modification of Staff status or clinical privileges, the member shall be subject to an in-depth review generally following the procedures set forth in Section 5.4 above. The Administrator, on behalf of the MEC, shall also verify the information with respect to each application and reapplication with (a) the National Practitioner Data Bank; (b) the OIG List of Excluded Individuals/Entities; and (c) AMA Master Profile; (d) the TSBME pursuant to the Texas Medical Practice Act, located at Texas Occupations Code chap.151 *et seq.*,; and any other Federal and State laws and regulations, or hospital accrediting body standards. Revised 5/24/2012

5.5.4 EXTENSION OF APPOINTMENT

If an application for reappointment has not been fully processed by the expiration date of the member's appointment, the Staff member's appointment may be temporarily extended in accordance with the provisions of Section 7.5.2 related to the granting of temporary privileges in order to meet an important patient care need. Any temporary extension of an appointment pursuant to this Section 5.5.4 does not create a right on behalf of the member for continued appointment through the entire next term.

5.5.5 FAILURE TO FILE REAPPOINTMENT APPLICATION

Failure without good cause to timely file a completed application for reappointment shall result in the automatic termination of the member's admitting privileges and expiration of other practice privileges and prerogatives at the end of the current Staff appointment, unless such privileges are extended by the MEC with the approval of the Board. If the member fails to submit a completed application for reappointment within forty-five (45) days past the date such application was due, the member shall be deemed to have resigned from membership in the Medical Staff effective as of the end of the current Staff appointment. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article IX shall not apply.

5.6 LEAVE OF ABSENCE

5.6.1 LEAVE STATUS

At the discretion of the MEC, subject to the approval of the Board, a Medical Staff member may obtain a voluntary leave of absence from the Staff upon submitting a written request to the MEC stating the approximate period of leave desired, which may not exceed one (1) year. During the period of leave, the member shall not exercise clinical privileges at the Hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the Medical Staff.

5.6.2 TERMINATION OF LEAVE

At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff member may request reinstatement of privileges by submitting a written notice to that effect to the MEC. The Staff member shall submit a summary of relevant activities during the leave, if the MEC so requests. The MEC shall make a recommendation to the Board concerning the reinstatement of the member's privileges and prerogatives, and the procedure provided in Sections 5.4.8 – 5.4.9 shall be followed.

5.6.3 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article IX shall not apply. A request for Medical Staff membership, subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

ARTICLE VI PERFORMANCE MEASUREMENT

6.1 DETERMINATION OF GENERAL COMPETENCIES Applicants and members of the medical staff must satisfactorily exhibit the general competencies outlined at the time of appointment and reappointment respectively. The general competencies of the practitioner can be ascertained in several ways.

1. Two peer references that affirmatively attest to the general competencies of the practitioner along with a positive recommendation for appointment or reappointment to the medical staff. At least one peer recommendation must be obtained from a practitioner in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice. Revised 9/24/2014 Recommendations from peers will be obtained and evaluated for all new applicants for privileges. A minimum of two (2) peer recommendations will be required for renewal of privileges. Revised 5/24/2012

2. The decision of the Department, Credentials Committee, and the Medical Executive Committee (MEC) that the practitioner exhibits the general competencies based on the practitioner's relevant education, training, experience, and known information about the practitioner's performance.

3. Specific information that may arise out of ongoing and/or focused evaluation of a practitioner that affirmatively or adversely speaks to that practitioner's general competencies.

A practitioner that is unable to satisfactorily exhibit the general competencies outlined may be subject to the focused evaluation of his or her professional practice.

6.2 FOCUSED PROFESSIONAL PRACTICE EVALUATION

6.2.1 INITIALLY REQUESTED PRIVILEGES

When a practitioner is granted privileges for the first time, he or she must undergo an initial period of focused professional practice evaluation.

6.2.2 QUALITY OF CARE CONCERN

A focused review of a practitioner's performance will occur when issues are identified that may affect the provision of safe, high-quality medical care. The following criteria will trigger the need for a focused evaluation and the process will be conducted through Article VIII (Corrective Action) in the bylaws:

1. There are aggregate, valid, practitioner-specific data that demonstrate a significant untoward variation from internal or external performance benchmarks.

2. There is a problematic pattern or trend identified as a result of the ongoing professional practice evaluation of the practitioner.

3. There is a complaint or quality of care concern raised against the practitioner that is of a serious nature.

4. There is evidence of behavior, health, and/or performance issues that carries an immediate threat to the health and safety of the patient, public, or other members of the health care team.

6.2.3 CIRCUMSTANCES REQUIRING EVALUATION FROM AN EXTERNAL SOURCE

At times, there may be need for an outside evaluation to occur. The following guidelines address the use of outside review. Outside evaluation should be conducted under the following circumstances:

1. There is no peer on the Medical Staff

2. There are no peers on the Medical Staff who are not involved in the issues surrounding the evaluation.

3. The Department or the MEC determines that an outside evaluation will assist in making a determination on the competency of the practitioner.

4. The practitioner being evaluated requests an outside review, and, in the opinion of the Department Chair or the MEC, there is merit to the request.

6.2.4 USE OF EVALUATION FINDINGS IN APPOINTMENT /REAPPOINTMENT

A summary of the evaluation findings will be made available to the Department Chair at the time of the practitioner's reappointment and/or request for additional privileges. This information shall be considered in making the recommendation for reappointment and/or privileging.

6.3 ONGOING PROFESSIONAL PRACTICE EVALUATION

Ongoing professional practice evaluation allows Midland Memorial Hospital to identify professional practice trends that may impact on the quality of care and patient safety. Early identification of problematic performance allows for timely intervention.

Practitioner specific performance data is required to be evaluated, analyzed and appropriate action taken as necessary when variation is present and/or standard of care has not

been met as determined by the medical staff. Performance data will be collected periodically within the reappointment period or as required as a part of the peer review process. This may include comparative and/or national data if available. Areas required to be measured (as applicable) will include. Revised 5/24/2012

6.3.1 INDICATORS USED IN ONGOING PROFESSIONAL PRACTICE EVALUATION

Each department of the medical staff shall determine the quality and patient safety indicators that shall comprise the ongoing professional practice evaluation of its members. These indicators may be occurrence-based (i.e. identified each time they occur), or rate-based (i.e. monitored as a percentage of occurrence against a defined population). The indicators chosen by departments may include, but are not necessarily limited to, the following areas:

1. Performance of operative and/or invasive procedures and their outcomes.
2. Patterns of blood and/or pharmaceutical usage.
3. Requests for tests and procedures.
4. Length of stay patterns.
5. Morbidity and mortality data.
6. Practitioner use of consultants.
7. Complaints received from patients, families, or staff and/or unusual occurrences.
8. Other relevant indicators as determined by the medical staff.

6.3.2 COLLECTING INFORMATION

Once the departments have determined the indicators to be measured, the organization will employ those processes necessary to assure that information on practitioners can be collected, aggregated, analyzed, and acted upon. Collection of this information may take the form of any of the following:

1. Periodic chart review.
2. Direct observation.
3. Monitoring of diagnostic and treatment techniques.
4. Use of valid data from health information systems.
5. Discussions with other individuals involved in the care of each patient, including consulting physicians, assistants (at surgery for example), nurses, and administrative personnel.

6.3.3 REPORTING OF INFORMATION

Information on the professional practice of practitioners will be presented to the practitioner's department and/or other appropriate medical staff committee. Information should be presented at intervals frequent enough to assure timely identification of issues, patterns, or trends. The following guidelines should be used in determining when information is reviewed by the department.

1. Occurrence-based indicators should be submitted within 60 days of occurrence. This does not apply to occurrences which may pose an immediate threat to the health and safety of patients, the public, or other members of the healthcare team. These occurrences must be reviewed immediately.

2. Rate-based indicators should be reported on a quarterly basis or more frequently if indicated.

6.3.4 EVALUATION OF INFORMATION

The information presented will be evaluated by the appropriate control committee to determine if a potential quality of care or safety issue exists. The evaluation by the appropriate control committee should be completed within 30 days of submission for review.

6.3.5 USE OF INFORMATION

As result of the evaluation, the MEC may take the following actions:

1. No action, as the review demonstrates satisfactory performance by the practitioner.

2. Education and/or training to improve the practitioner's performance in the indicator(s) measured.

3. Focused evaluation of the practitioner to better understand practice issues relative to the indicator(s) measured and/or to determine competency.

4. Suspension, termination, limitation, and/or revocation of the privilege(s) in question according to mechanisms outlined in Article IX of the Medical Staff Bylaws.

A summary of the ongoing professional practice evaluation will be made available to the Department Chair at the time of the practitioner's reappointment and/or request for change of privileges. This information shall be considered in making the recommendation for reappointment and/or privileging. Added 4/30/2008

ARTICLE VII
CLINICAL
PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws, a member providing clinical services at the Hospital shall be entitled to exercise only those clinical privileges specifically granted to such member pursuant to this Article VII. Such privileges and services must be Hospital-specific, within the scope of any license, certificate, or other legal credential authorizing practice in this State and consistent with any restrictions thereon, and shall be subject to the Rules and

Regulations of the clinical department and the authority of the department chair and the Medical Staff. Clinical privileges shall be for a period of up to two (2) years and concurrent with the member's appointment to the Medical Staff.

There shall be a provision to authorize LIPs to order outpatient services that are within their scope of service to order. Revised 5/24/2012

7.2 DELINEATION OF PRIVILEGES IN GENERAL

7.2.1 REQUESTS

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. A request by a member for a modification of clinical privileges may be made at any time, subject to the limitation in Section 5.5.1(c), but such requests must be supported by documentation of training and/or experience supportive of the request. All requests for clinical privileges must be accompanied by a statement from the applicant/member that no health problems exist that could affect the applicant/member's ability to perform the privileges requested.

7.2.2 BASES FOR INITIAL CLINICAL PRIVILEGES DETERMINATION

(a) Requests for initial clinical privileges shall be evaluated on the basis of the member's ability to provide patient care, treatment, and services within the scope of the privileges requested. Specifically, consideration shall be given to peer recommendations from peers practicing in the same professional discipline as the applicant who have personal knowledge of the applicant. Such peer recommendations shall address the applicant's relevant training and experience, current competence, and any effects of health status on the privileges being requested.

(b) Additionally, prior to granting privileges, consideration shall be given to: challenges to any licensure or registration; voluntary and involuntary relinquishment of any license or registration, voluntary and involuntary termination of Medical Staff membership; voluntary and involuntary limitation, reduction, or loss of clinical privileges; any evidence of an unusual pattern or an excessive number of professional liability actions resulting in final judgment against the applicant; documentation as to the applicant's health status; relevant practitioner-specific data as compared to aggregate data, when available; morbidity and mortality data, when available.

(c) Querying of the National Practitioner Data Bank and verification of the member's current licensure, specific relevant training, and current competence shall be conducted in accordance with Section 5.4.3.

(d) The chair of the department to which the applicant is seeking clinical privileges belongs shall review the applicant's application for clinical privileges, and recommend to the Credentials Committee whether the

requested privileges should be granted as requested, granted with restrictions, or denied.

7.2.3 BASES FOR RENEWAL OF CLINICAL PRIVILEGES

(a) Renewal of clinical privileges shall be evaluated on the basis of the member's current competence and ability to perform the privileges requested, as evidenced by the member's professional performance, including clinical and technical skills and information from the Hospital's performance improvement activities. If insufficient peer review information regarding a member is available, peer review recommendations from peers practicing in the same professional discipline as the member, and who have personal knowledge of the member, shall be obtained. Such peer recommendations shall address the member's relevant training and experience, current competence, and any effects of health status on the privileges being requested.

(b) Additionally, prior to renewing clinical privileges, consideration shall be given to: challenges to any licensure or registration; voluntary and involuntary relinquishment of any license or registration, voluntary and involuntary termination of Medical Staff membership; voluntary and involuntary limitation, reduction, or loss of clinical privileges; involvement in a professional liability actions resulting in final judgment against the member; documentation as to the member's health status; relevant practitioner-specific data as compared to aggregate data, when available; morbidity and mortality data, when available.

(c) Querying of the National Practitioner Data Bank and verification of the member's current licensure, specific relevant training, and current competence shall be conducted in accordance with Section 5.5.3.

(d) The chair of the department to which the member seeking renewal of clinical privileges belongs, shall review the member's application for reappointment, and recommend to the Credentials Committee whether the member's requested privileges should be renewed as requested, renewed with modifications, or denied.

7.3 PROCTORING

Initial appointees to the Medical Staff and all members granted new clinical privileges are required to have a period of focused professional practice evaluation (proctoring). A specific proctoring plan, appropriate to the individual practitioner and his/her privileges, shall be developed for each new appointee. Each appointee or recipient of new clinical privileges who is subject to proctoring shall be assigned to a department where performance on an appropriate number of cases, as established by the department, shall be observed and/or reviewed by the chair of the department, or the chair's designee. The exercise of clinical privileges in any other department shall also be subject to similar proctoring by that department's chair or his or her designee. The member shall remain subject to such proctoring until the MEC has been furnished with: Revised 4/30/2008

(a) a report signed by the chair of the department(s) to which the member is assigned evaluating the applicant's performance, and a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that department, has discharged all of the responsibilities of Staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made; and

(b) a report signed by the chairs of the other department(s) in which the appointee may exercise clinical privileges, evaluating the applicant's performance, and a statement that the member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments.

7.4 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

7.4.1 ADMISSIONS

Limited License Practitioners may only admit patients if a physician member of the Medical Staff conducts or directly supervises the admitting history and physical examination (except the portion related to services to be provided by the Limited License Practitioner), and assumes responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization and are outside of the Limited License Practitioner's lawful scope of practice.

7.4.2 SURGERY

Surgical procedures performed by Limited License Practitioners shall be under the overall supervision of the chair of the Department of Surgery or his or her designee.

7.4.3 MEDICAL APPRAISAL

All patients admitted for care in the Hospital by a Limited License Practitioner shall receive the same basic medical appraisal as patients admitted by other services, and a physician member shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. If a dispute exists regarding proposed treatment between a physician member and a Limited License Practitioner based upon medical or surgical factors outside the scope of the licensure of the Limited License Practitioner, the proposed treatment may be suspended in the sole discretion of the physician member.

7.5 TEMPORARY CLINICAL PRIVILEGES

When dictated by an urgent patient care need or when an application is complete without any negative or adverse information and before any action is taken by the medical staff or governing body, the chief executive officer or designee, may grant temporary clinical privileges.

7.5.1 TO MEET AN IMPORTANT PATIENT CARE NEED AND MEDICAL STAFF APPLICANTS

Temporary privileges may be granted for a period of time not to exceed one hundred twenty (120) days. The Administrator or designee, may grant temporary privileges upon recommendation of a member of the medical executive committee, president of the medical staff, or medical director or designee provided there is verification (which may be by telephone or secure electronic transmission) of: Revised 5/24/2012

(a) current licensure; relevant training or experience; education; ability to perform the privileges requested; professional references (*including current competence)*; and any other criteria required to be verified by section 5.4.3 of these Bylaws.

(b) the results of the National Practitioner Data Bank (NPDB) query, American Medical Association (AMA), American Osteopathic Association (AOA), Office of Inspector General (OIG) Medicare/Medicaid Exclusions have been obtained and evaluated; and Effective 12/16/09

(c) the applicant has:

(1) a completed application;

(2) no current or previously successful challenge to licensure or registration;

(3) not been subject to involuntary termination of medical staff membership at another organization; and

(4) not been subject to involuntary limitation, reduction, denial or loss of clinical privileges at another health care facility.

7.5.2 LOCUM TENENS

The administrator or designee may grant locum tenens privileges upon recommendation of a member of the medical executive committee, president of the medical staff, or medical director or designee, provided there is verification of information as outlines in Section 5.4.3 of the Medical Staff Bylaws. Locum tenens temporary privileges may be granted for a period of time not to exceed six (6) months The practitioner acting as locum tenens must then complete a full application for Affiliate Staff Status if his/her duration of practice is expected to exceed 6 months. *Revised 9/24/2014*

In no circumstance shall the period of locum tenens exceed required coverage or for the duration of 6 months Revised 12/18/2013

7.5.4 DISASTER RESPONSE AND RECOVERY

During disasters in which the Hospital's Emergency Operations Plan (CODE 1000) plan has been activated, and the Hospital is unable to handle the immediate patient needs, granting of disaster privileges must be authorized by the Chief of Staff or the Disaster Medical Director, or authorized designee. Disaster privileges will be granted on a case-by-case basis. An individual who presents as a volunteer Licensed Independent Practitioner (LIP) should be

directed to the medical staff pool or other area as designated by the Emergency Management Command Center.

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

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

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

Before a volunteer practitioner is considered eligible to function as a volunteer LIP, Midland Memorial Hospital will obtain his or her valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following:

- A current picture identification card from a health care organization that clearly identifies professional designations..
- A current license to practice.
- Primary source verification of licensure.
- Identification indicating that the individual is a member of a Disaster medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health professionals (ESAR-VHP), or other recognized state or federal response hospital or group.
- Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances.
- Confirmation by a LIP currently privileged by the hospital or a staff member with personal knowledge of the volunteer practitioner's ability to act as a LIP during a disaster. *Revised 12/17/08*

Primary source verification of licensure of individuals that receive emergency privileges must begin as soon as the immediate situation is under control and be completed within 72 hours from the time the volunteer practitioner presents to the organization.

In the extraordinary circumstance that primary source verification cannot be completed within 72 hours (e.g. no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be a documentation of the following: why primary source verification could not be performed in the

required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to recertify the situation as soon as possible.

Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges. Revised 4/30/2008

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

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

- Implementation of the emergency management plan ceases.
- The capability of the organization's staff becomes adequate to meet patient care needs.
- A decision is made that the professional practice of the volunteer LIP does not meet professional standards. *Revised 12/17/08*

7.5.5 GENERAL CONDITIONS OF TEMPORARY PRIVILEGES

(a) Unless otherwise specified by this Section 7.5, a practitioner granted temporary privileges shall act under the supervision of the department chair, or his or her designee, to which the practitioner has been assigned, and shall ensure that the chair, or the chair's designee, is kept closely informed as to his or her activities within the Hospital. *Revised 4/25/07*

(b) Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated by the Chief of Staff upon recommendation of the department chair or Credentials Committee.

(c) Requirements for proctoring and monitoring, including but not limited to those in Section 7.3, may be imposed on such terms as may be appropriate under the circumstances upon any practitioner granted temporary privileges by the Chief of Staff after consultation with the department chair or his or her designee.

(d) At any time, temporary privileges may be terminated by the Chief of Staff with the concurrence of the department chair or his or her designee. In such cases, the appropriate department chair shall assign a member of the Medical Staff to assume responsibility for the care of such practitioner's patient(s). The wishes of the patient shall be considered in the choice of a replacement Medical Staff member.

(e) A practitioner shall not be entitled to the procedural rights afforded by Article IX because a request for temporary privileges is refused or because all or any portion of temporary privileges are terminated or suspended.

(f) All practitioners requesting or receiving temporary privileges shall be bound by the Bylaws and Rules and Regulations of the Medical Staff.

7.6 EMERGENCY PRIVILEGES

In the case of an emergency, any member of the Medical Staff, to the degree permitted by his or her license and regardless of department, Staff status, or clinical privileges, shall be permitted to provide any type of patient care, treatment, and services necessary as a life-saving measure or to prevent serious harm. The member shall make every reasonable effort to communicate promptly with the department chair concerning the need for emergency care and assistance by members of the Medical Staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the department chair with respect to further care of the patient at the Hospital. For purposes of organ, cornea, or tissue procurement, members of a Medicare-certified organ, corneal, or tissue procurement organization shall be extended emergency privileges in order to retrieve donated organs, tissues, or corneas.

7.7 MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

On its own, or upon recommendation of the Credentials Committee, the MEC may recommend a change in the clinical privileges or department assignment(s), of a member. The MEC may also recommend that the granting of additional privileges to a current Medical Staff member be made subject to monitoring in accordance with procedures outlined in Section 7.3. If a Medical Staff member requesting a modification of clinical privileges or department assignments fails to furnish the information necessary to evaluate the request within forty-five (45) days of submission of the request, the application shall automatically lapse, and the applicant shall not be entitled to a hearing as set forth in Article IX.

7.8 TELEMEDICINE PRIVILEGES

(a) Practitioners who wish to provide telemedicine services, as defined in these Bylaws, in prescribing, rendering a diagnosis, or otherwise providing clinical treatment to a Hospital patient, without clinical supervision or direction from a Medical Staff member, shall be required to apply for and be granted clinical privileges for such services.

(b) Credentialing of practitioners for privileges to perform telemedicine services to patients at the Hospital may be accomplished by:

(1) fully credentialing the practitioner providing telemedicine services according to the procedures set forth in Articles V and VII of these Bylaws;

(2) credentialing the practitioner providing telemedicine services in accordance with the procedures set forth in this Article VII, using credentialing information provided by the site where the practitioner is providing the professional service (the "Distant Site"); or

(3) credentialing the practitioner based solely upon the credentialing information and decisions of the Distant Site if:

i. a written agreement with the distant-site;

ii. the Distant Site meets all Medicare Conditions of Participation;

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

iv. The individual distant-site physician or practitioner is privileged at the distant-site telemedicine entity providing the telemedicine services, and provides the hospital with a current list of the distant-site physician's or practitioner's privileges at the distant-site telemedicine entity; and

v. The hospital conducts an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site telemedicine entity such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the hospital's patients, and all complaints the hospital has received about the distant-site physician or practitioner.

ARTICLE VIII CORRECTIVE ACTION

8.1 CORRECTIVE ACTION

8.1.1 CRITERIA FOR INITIATION

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members. When information indicates that a member may have exhibited acts, demeanor, or conduct reasonably likely to be (a) detrimental to patient safety or to the delivery of quality patient care within the Hospital, (b) unethical, (c) contrary to the Hospital's policies and procedures applicable to patient care, or the Medical Staff Bylaws or Rules and Regulations, (d) disruptive to the business operation of the Hospital, including financial and regulatory compliance aspects (e) unprofessional, or (f) below applicable professional standards, a request for an investigation or action against such member may be initiated by the Administrator, one or more members of the Board, the Chief of Staff, a department chair, the chair of any appropriate standing committee of the Medical Staff, or one or more members of the MEC.

8.1.2 INITIATION

A request for an investigation must be in writing, submitted to the MEC, and supported by reference to the specific activities or conduct alleged. If the MEC initiates the request, it shall document the reasons. The MEC shall promptly notify the Administrator in writing of all requests for corrective action received by the MEC and shall continue to keep the Administrator fully informed of all action taken with respect to the investigation.

8.1.3 INVESTIGATION

The MEC may determine not to proceed with an investigation and, if such determination is made, the request to investigate will be deemed denied. Alternatively, the MEC may determine to proceed with an investigation and, if so, it shall direct an investigation to be undertaken. The MEC may conduct the investigation itself, or may assign the task to a Medical Staff officer, department, or standing or ad hoc committee of the Medical Staff. If the investigation is delegated to an officer or committee other than the MEC, such officer or committee shall proceed with the investigation in a prompt manner. The member shall be notified that an investigation is being conducted and, if requested, shall provide information to the investigating body in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, review medical files or other documents and conduct interviews with witnesses; however, such investigation shall not constitute a "hearing" as that term is used in Article VIII, nor shall the procedural rules with respect to hearings or appeals apply. If additional matters requiring investigation are discovered during the investigation, the investigation may be expanded, with appropriate notice to the affected member. The investigating body may, in its sole discretion, grant the member under investigation an interview, at which the member being investigated may discuss the matters under investigation. A record of such interview shall be made by the investigating body and forwarded to the MEC with its report. Within seven (7) days after the conclusion of the investigation, the investigating body shall forward a written report of the investigation to the MEC. The report may include recommendations for appropriate corrective action. Despite the status of any investigation, at all times the MEC shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

8.1.4 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as practicable after the conclusion of the investigation, the MEC shall take action upon the request, which may include, without limitation:

(a) determining that no corrective action be taken and, if the MEC determines there was not credible evidence for the complaint in the first instance, removing any adverse information from the member's file;

(b) deferring action for a reasonable time where circumstances warrant;

(c) issuing letters of admonition, reprimand, or warning, provided that nothing herein shall be deemed to preclude a department or section chair 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; letters of admonition, reprimand, or warning shall not entitle the practitioner to the hearing and appellate review procedures of Article IX of these Bylaws;

(d) 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 monitoring;

(e) recommending reduction, modification, suspension, or revocation of clinical privileges;

(f) recommending reductions of membership status or limitation of any prerogatives related to the member's delivery of patient care;

(g) recommending suspension, revocation, or probation of Medical Staff membership; or

(h) taking other actions deemed appropriate under the circumstances.

8.1.5 SUBSEQUENT ACTION

(a) If corrective action that is grounds for a hearing as set forth in Section 9.2 of these Bylaws is recommended by the MEC, that recommendation shall be transmitted to the Board and to the member under investigation. If applicable, the member shall be given notice that the recommendation entitles him to invoke the hearing and appellate review procedures in Article IX.

(b) The recommendation of the MEC, if approved by the Board, shall become final action unless within thirty (30) days of receiving notice of the MEC's recommendation to take corrective action, the member requests a hearing, in which case the final decision shall be determined as set forth in Article IX.

8.2 MEDICARE FRAUD AND ABUSE

If a member is convicted of a crime pursuant to the Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. 100-93 (the "Anti-Kickback Statute," codified at 42 U.S.C. § 1320a–7b), or is suspended from Medicare or Medicaid participation for program abuse, the member's Medical Staff status and clinical privileges may be subject to suspension by the MEC, as of the date such action with respect to the Medicare or Medicaid program becomes effective. If a member is suspended pursuant to this Section 8.2, he shall not be entitled to a hearing and appellate review pursuant to Article IX of these Bylaws.

8.3 SUMMARY SUSPENSION OR RESTRICTION

8.3.1 CRITERIA FOR INITIATION

Whenever a member's conduct appears to require that immediate action be taken to protect the life or well-being of patients or to prevent a substantial and imminent likelihood of significant impairment of the life, health, and safety of any patient, or other person, the Administrator after consultation with the Chief of Staff, the Chief of Staff or his or her designee, the MEC, the chair of the department or his or her designee in which the member holds privileges, or the Board, may summarily restrict or suspend the Medical Staff membership or

clinical privileges of such member. The alleged activities or conduct of the member that forms the basis of the summary restriction or suspension (a) may have occurred prior to the initiation of an investigation under Article VIII of these Bylaws, (b) may have been discovered during the course of such an investigation, or during a routine audit or investigation of any Medical Staff or Hospital committee, or (c) may be known to any individual at the Hospital. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice of the suspension or restriction to the member, the Board, the MEC, and the Administrator. The summary restriction or suspension shall be limited in duration and shall remain in effect for the period stated or, if not so limited, shall remain in effect until resolved by the procedures specified in this Section 8.3. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be assigned promptly to another member of the Medical Staff by the appropriate department chair or by the Chief of Staff, considering, when feasible, the wishes of the patient in the choice of a replacement Medical Staff member. A suspension that lasts fewer than thirty (30) days is not reportable to the National Practitioner Data Bank, and is not grounds for a hearing under Article IX.

8.3.2 MEDICAL EXECUTIVE COMMITTEE ACTION

Within five (5) working days of such suspension, a meeting of the MEC shall be convened to review and consider the action. Upon request of the MEC, the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the member, constitute a "hearing" within the meaning of Article IX nor shall any procedural rules apply except those adopted by the MEC. The member's failure without good cause to attend any MEC meeting upon request shall constitute a waiver of his or her rights under Article IX. The MEC may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the member with notice of its decision.

8.3.3 PROCEDURAL RIGHTS

Unless the MEC terminates the summary restriction or suspension within thirty (30) days of such restriction or suspension, the member shall be entitled to the procedural rights afforded by Article IX of these Bylaws.

8.4 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the member's privileges or membership may be suspended or limited as described by the Administrator with the concurrence of the Chief of Staff. Such automatic suspension or limitation shall not result in the right to a hearing under Article IX of these Bylaws.

8.4.1 LICENSURE

(a) *Revocation and Suspension.* Whenever a member's license or other legal credential authorizing practice in this State is revoked or suspended, Medical Staff membership and clinical privileges shall be automatically revoked or suspended as of the date such action becomes effective.

(b) *Restriction.* Whenever a member's license or other legal credential authorizing practice in this State is limited or restricted by the applicable

licensing or certifying authority, any clinical privileges that the member has been granted at the Hospital that are within the scope of such limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such licensing or certifying authority's action becomes effective and throughout its duration.

(c) *Probation*. If a member is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its duration.

8.4.2 CONTROLLED SUBSTANCES

(a) *Revocation and Suspension.* If a member's DEA or DPS certificate is revoked, limited, or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

(b) *Probation*. If a member's DEA or DPS certificate is subject to probation, the member's right to prescribe such medications automatically shall become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term, pending investigation by the MEC.

8.4.3 PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance in amounts and of a type required by the Board shall be a basis for automatic suspension of a member's clinical privileges, and if within thirty (30) days after written warnings of the delinquency the member does not provide evidence of required professional liability insurance, the member's membership shall be automatically terminated.

8.4.4 MEDICAL RECORDS

Members of the Medical Staff are required to complete medical records according to the time periods set forth in the Rules and Regulations. A temporary suspension in the form of withdrawal of admitting and other related privileges until medical records are completed shall be imposed by the Chief of Staff, or his or her designee, after notice of delinquency for failure to complete medical records within such period.

For the purpose of this Section 8.4.4, "related privileges" includes voluntary on-call service for the emergency room, scheduling surgery, assisting in surgery, consulting on Hospital cases, and providing professional services within the Hospital for future patients. Bona fide vacation or illness may constitute an excuse subject to approval by the MEC. Members whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations. All admissions by a suspended member shall be reviewed automatically; corrective action may be implemented if a suspended member admits patients who are not in life-threatening situations. The suspension shall continue until lifted by the Administrator, or the Chief of Staff, or his or her designee.

8.4.5 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

A member who fails without good cause to appear at a meeting scheduled for the purpose of discussing the member's practice or conduct at which the member is requested to attend automatically shall be suspended from exercising all or such portion of clinical privileges as may be specified in the meeting. Failure of a member to appear at any meeting, with respect to which he or she was given notice to attend, unless excused by the MEC upon a showing of good cause, shall be a basis for corrective action.

8.4.6 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as practicable after action is taken as described in Section 8.4, the MEC shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate.

8.5 TERMINATION OF MEDICAL-ADMINISTRATIVE/CONTRACT PHYSICIANS

Termination of a member pursuant to a contract to deliver medical services to patients in the Hospital shall not be considered corrective action unless the member is terminated for reasons relating to professional character, competence, ethics, or performance and the action is reportable to the National Practitioner Data Bank.

8.6 PRACTITIONER HEALTH AND CONDUCT

Concerns about unprofessional conduct by a practitioner, or concerns about a practitioner's health status or physical or mental impairment should be referred to the Physician/Practitioner Health and Rehabilitation Committee. Actions based on health concerns shall not be treated as corrective action except as set forth in Section 13.14 herein or in the Physician/Practitioner Health and Rehabilitation Policy.

ARTICLE IX HEARING AND APPELLATE REVIEW

9.1 GENERAL PROVISIONS

9.1.1 EXHAUSTION OF REMEDIES

If an adverse action described in Section 8.1.4 is taken or recommended, the applicant or member must exhaust the remedies afforded by these Bylaws before resorting to legal action. For purposes of this Article IX, the term "member" may include "applicant," as applicable under the circumstances.

9.1.2 RIGHT TO HEARING AND APPELLATE REVIEW

(a) When any member receives notice of a recommendation of the MEC that, if ratified by decision of the Board, will adversely affect his or her

appointment to or status as a member of the Medical Staff or his or her exercise of clinical privileges, he or she shall be entitled to a hearing before a hearing committee appointed by the MEC. If the recommendation of the MEC following such hearing is still adverse to the affected member, he or she shall then be entitled to an appellate review by the Board, or a committee appointed by the Board, before the Board makes a final decision on the matter.

(b) When any member receives notice of a decision by the Board that will adversely affect his or her appointment to, or status as, a member of the Medical Staff, or his or her exercise of clinical privileges, and this decision is not based on a prior adverse recommendation by the MEC with respect to which he or she was entitled to a hearing and appellate review, he or she shall be entitled to a hearing by a committee appointed by the Board, and if this hearing does not result in a favorable recommendation, to an appellate review by the Board, before the Board makes a final decision on the matter.

(c) The purpose of the hearing is to determine whether the member meets the Hospital's criteria for continued exercise of the member's Medical Staff membership and clinical privileges. The scope of the hearing shall be restricted to the issues cited by the MEC or the Board in its recommendation or decision. All evidence relevant to the member's qualifications for continued exercise of the member's Medical Staff membership and clinical privileges shall be admissible whether or not such evidence was considered by the Board or the MEC at an earlier time.

(d) All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article IX to assure that the affected member is accorded all rights to which he or she is entitled.

9.2 GROUNDS FOR HEARING

Except as otherwise specified in these Bylaws, the following actions or recommended actions shall be deemed adverse actions and constitute grounds for a hearing:

(a) denial of Medical Staff membership;

(b) denial of Medical Staff reappointment;

(c) denial of requested clinical privileges (excluding temporary privileges) based on professional competence or conduct;

(d) involuntary reduction of current clinical privileges (excluding temporary privileges) based on professional competence or conduct;

(e) suspension of medical staff membership or clinical privileges (excluding temporary privileges) based on professional competence or conduct and reportable to the National Practitioner Data Bank; or

(f) termination of medical staff membership or clinical privileges (excluding temporary privileges) based on professional competence or conduct and reportable to the National Practitioner Data Bank.

9.3 REQUESTS FOR HEARING

9.3.1 NOTICE OF ACTION OR PROPOSED ACTION AND RIGHT TO REQUEST A HEARING

A practitioner shall promptly be given written notice of a proposed adverse recommendation or action. The notice of adverse recommendation or action shall state (a) that an adverse recommendation or action has been taken or is proposed to be taken; (b) the reasons for the action or recommendation; (c) that the practitioner has a right to request a hearing on the action or recommendation in accordance with the Medical Staff Bylaws at any time within thirty (30) days after receipt of the notice; (d) that failure to request a hearing within thirty (30) days shall constitute a waiver of a right to a hearing and to a appellate review; (e) that if a hearing is

requested on a timely basis, he/she will be given further notice stating the time, place, and date of the hearing, and a list of witnesses, if any, expected to testify at the hearing on behalf of the Board or the MEC; and (f) that if the practitioner so requests in writing, he or she shall be given reasonable access to relevant records, reports and other materials related to the adverse recommendation on which the MEC or the Board, as the case may be, intends to rely and that are not otherwise privileged under law. Also, the notice of adverse action or recommendation shall state that in the hearing, the practitioner has the right to representation by an attorney or other person of his choice; the right to have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of one-half of any reasonable charges associated with the preparation thereof; the right to call, examine and cross-examine witnesses; the right to present evidence determined to be relevant by the hearing officer or panel, regardless of its admissibility in a court of law; to submit a written statement at the close of the hearing; and upon completion of the hearing, the right to receive the written recommendation of the hearing officer or panel, including a statement of the basis for the recommendations. Such notice shall be sent by certified mail, return receipt requested.

9.3.2 REQUEST FOR HEARING

The member shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Administrator, who shall transmit a copy to the MEC and the Board. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

9.3.3 WAIVER OF HEARING

When the waived hearing or appellate review relates to an adverse recommendation of the MEC, or of a hearing committee appointed by the Board, the recommendation shall then become and remain effective against the member pending the Board's final decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the Board, the same shall then become and remain effective against the member in the same manner as a final decision of the Board provided for in Section 9.5.9. In either of such events, the Administrator shall promptly notify the affected member of this status by certified mail, return receipt requested.

9.3.4 NOTICE OF TIME, PLACE, AND PROCEDURES FOR HEARING

Upon receipt of a request for hearing, the MEC or the Board, whichever recommended the adverse action, shall promptly schedule a hearing and give notice to the member of the time, place, and date of the hearing and a list of the witnesses (if any) expected to testify at the hearing on behalf of the person, committee, or other entity making the adverse recommendation or taking adverse action. Unless extended by the hearing committee, the date of the commencement of the hearing shall be not less than thirty (30) days, nor more than ninety (90) days from the date of receipt of the request by the Administrator for a hearing; provided, however, that when a request concerns a member who is under a summary suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed ten (10) working days from the date of the notice unless the parties agree otherwise.

9.3.5 FAILURE TO SET HEARING DATE

Notwithstanding a practitioner's request for a hearing under the Bylaws, if a practitioner does not in good faith cooperate with the Hospital to schedule a hearing date, and as a result, a hearing has not been scheduled after a period of ninety (90) days from the date of the Hospital's proposal for a hearing date, the practitioner shall be deemed to have waived his or her right to a hearing, and to have accepted the adverse action or recommendation, unless both parties agree to a delayed hearing date. In the case of waiver based upon a failure to proceed with a hearing in a timely manner with regard to an adverse action by the Board, the action shall become effective as the Board's final decision. In the case of waiver of an adverse recommendation by the MEC, the recommendation shall become effective pending final decision by the Board. The Board shall consider the MEC's recommendation at its next regular meeting, and if the Board is in accord with the recommendation, its decision shall be final. If the Board's action has the effect of changing the MEC's recommendation, the matter shall be submitted to a Joint Conference Committee as provided in the case of appellate review in Sections 9.5.7 through 9.5.8. The Board's action on the matter following receipt of the Joint Conference Committee's recommendation shall constitute its final decision. The Administrator shall promptly notify the practitioner of the Board's final decision.

9.3.6 COMPOSITION OF HEARING COMMITTEE

(a) When a hearing is requested pursuant to an adverse recommendation of the MEC, the MEC may, in its sole discretion, direct that the hearing be held: (1) before an arbitrator mutually acceptable to the member and the Hospital, (2) before a hearing officer who is appointed by the MEC and who is not in direct economic competition with the member involved, (3) before a panel of individuals from the Medical Staff who are appointed by the MEC and are not in direct economic competition with the member involved, or (4) by an independent peer review panel from outside the Hospital who are not in direct economic competition with the member involved. If the hearing is held before a panel composed of Medical Staff members, such panel shall have no fewer than five (5) members of the Medical Staff, appointed by the Chief of Staff, who have not actively participated in the consideration of the matter leading up to the adverse recommendation or action and who are not in direct economic competition with the member who is the subject of the adverse action. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the hearing committee. Such appointment shall include designation of the chair. 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.

(b) When a hearing is requested based on an adverse decision of the Board that is contrary to the recommendation of the MEC, the Board shall appoint a hearing committee to conduct a hearing and shall designate one of the members of this committee as chair. At least one representative from the Medical Staff shall be included on this committee.

9.3.7 FAILURE TO ATTEND AND PROCEED

Failure without good cause of the member to personally attend and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

9.3.8 POSTPONEMENTS AND EXTENSIONS

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted by the hearing committee, or its chair acting upon its behalf, within the discretion of the committee or its chair, only on a showing of good cause.

9.4 HEARING PROCEDURE

9.4.1 REPRESENTATION

The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency, or

character. If requested by either the member, the MEC or the Board, as applicable, both sides may be represented by legal counsel.

In the absence of a request for legal counsel, the member shall be entitled to be accompanied by and represented at the hearing only by a member licensed to practice in the State of Texas who is not also an attorney, and the MEC or the Board, as applicable, may appoint a representative who is not an attorney to present its action or recommendation, the materials that support its recommendation, examine witnesses, and respond to appropriate questions. If attorneys are not present at the hearing, nothing herein is intended to deprive the affected member, hearing committee, MEC, or Board of the right to legal counsel in preparation for the hearing or appeal. The MEC shall have sole discretion to determine the role of attorneys, if any, present at the hearing, including, but not limited to, determinations whether the attorneys shall be allowed to speak on behalf of the person or entity he or she represents, or whether the attorney shall be limited to advising the person or entity he or she represents.

9.4.2 THE HEARING OFFICER

The MEC shall appoint a hearing officer to preside at the hearing. The hearing officer may be the chair of the hearing committee. In the sole discretion of the MEC or the Board, as applicable, the hearing officer may be an attorney qualified to preside over a quasi-judicial hearing. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure, or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances. If requested by the hearing committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

9.4.3 RECORD OF THE HEARING

A reporter shall be present to make a record of the hearing proceedings. The cost of attendance of the reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the party requesting it.

9.4.4 RIGHTS OF THE PARTIES

Within reasonable limitations, the members of the hearing committee and the affected member at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence. The member may be called by the hearing committee appointed by the MEC, or the Board, as appropriate, and be examined as if under cross-examination.

The MEC, when its action has prompted the hearing, shall appoint one of its members or another member of the Medical Staff to represent it at the hearing, to present the facts in support of its adverse recommendation, and to examine witnesses. The Board, when its action has prompted the hearing, shall appoint one of its members to represent it at the hearing,

to present the facts in support of its adverse decision, and to examine the witnesses. It shall be the obligation of the representative of the MEC or the Board, as applicable, to present appropriate evidence in support of the adverse recommendation or decision, but the affected practitioner shall then be responsible for supporting his or her challenge to the adverse recommendation or decision by providing appropriate evidence showing that the charges or grounds involved lack any factual basis or that such basis or any action based upon them is either arbitrary, unreasonable, or capricious.

The parties shall have the right to submit a written statement within ten (10) days from the close of the hearing.

9.4.5 MISCELLANEOUS

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article IX. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The hearing committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

9.4.6 RECESS AND CONCLUSION

After consultation with the chair of the hearing committee, the hearing officer may recess the hearing and reconvene the same without special notice at such times and intervals as may be reasonable, with due consideration for reaching an expeditious conclusion to the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if requested, the hearing shall be closed.

9.4.7 DECISION OF THE HEARING COMMITTEE

Within fifteen (15) days after final adjournment of the hearing, the hearing committee shall render a decision, which shall be accompanied by a report in writing and shall be delivered to the MEC, or to the Board, whichever appointed it. If the member is currently under suspension, the hearing committee shall render a decision and report to the MEC, or to the Board, whichever appointed it, within seven (7) days. A copy of the decision shall also be forwarded to the Administrator, the MEC, the Board, and the member. The report shall contain a concise statement of the reasons in support of the decision.

9.4.8 DECISION OF THE MEC OR THE BOARD

The MEC, or the Board, as applicable, shall review the report and decision of the hearing Committee at its next regularly scheduled meeting and shall, within thirty (30) days of such meeting, give notice of its decision to the Administrator, the MEC or Board, as appropriate, and the member. The MEC may affirm, modify, or reverse the decision of the hearing committee. If a member is under summary suspension, the MEC, or the Board, as appropriate, shall review the report and decision of the hearing committee within ten (10) working days and shall give notice of its decision to the MEC, or the Board, as appropriate, the Administrator, and the member. If the decision is made by the MEC, the Board, at its next regularly scheduled meeting, shall review the hearing record and the decision of the MEC and render a decision, which may affirm, modify, or reverse the recommendation of the MEC. This decision of the Board shall be final subject only to the right of appeal or review described in Section 9.5 . If the

decision is rendered by the Board after reviewing the report of the hearing committee, such decision shall be final subject only to such rights of appeal or review described in Section 9.5.

9.5 APPEAL

9.5.1 TIME FOR APPEAL

Within ten (10) days after receipt of the decision of the Board, the member may request an appellate review. The decision shall be deemed to have been received (a) three (3) days after sent by prepaid, regular mail, (b) on the date a certified letter, return receipt requested was received, or (c) the date the decision was communicated orally to the affected physician by the Chief of Staff or Administrator. A written request for such review shall be delivered to the Chief of Staff, the Administrator, and any other party to the hearing. Failure to timely request appellate review shall constitute waiver of the right to review and an acceptance of the recommendation of the MEC, if the MEC's recommendation is approved by the Board.

9.5.2 GROUNDS FOR APPEAL

A written request for an appeal shall include an identification of the grounds for appeal, and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be: (a) substantial noncompliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice; or (b) the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 9.5.6.

9.5.3 WRITTEN STATEMENT BY MEMBER

The affected member shall have access to the report and record (and transcript, if any) of the hearing committee and other non-privileged documents that were considered in making the adverse recommendation or decision against him or her. He or she shall have the right to submit a written statement in his or her own behalf, in which those factual and procedural matters with which he or she disagrees, and his or her reasons for such disagreement, shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Board through the Administrator by certified mail, return receipt requested, at least seven (7) days prior to the scheduled date for the appellate review. A similar statement may be submitted by the MEC of the Medical Staff or by the chair of the hearing committee appointed by the Board, and if submitted, the Administrator shall provide a copy thereof to the affected member at least seven (7) days prior to the date of such appellate review by certified mail, return receipt requested.

9.5.4 TIME, PLACE, AND NOTICE

If an appellate review is to be conducted, the appeal board shall, within seven (7) days after receipt of notice of appeal, schedule a review date and cause each side to be given notice of the time, place, and date of the appellate review, including a time and place for oral argument, if such has been requested and permitted pursuant to Section 9.5.6. The date of appellate review shall not be less than thirty (30) nor more than forty-five (45) days from the date of such notice; provided, however, that when a request for appellate review concerns a member who is under summary suspension which is then in effect, the appellate review shall be

held as soon as the arrangements may reasonably be made. The time for appellate review may be extended by the appeal board for good cause.

9.5.5 APPEAL BOARD

The Board may sit as the appeal board, or it may appoint an appeal board, which shall be composed of not less than three (3) members of the Board. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. The appeal board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal.

9.5.6 APPEAL PROCEDURE

The proceeding by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the hearing committee, provided, however, that the appeal board may, in its sole discretion, accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the hearing committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the previous hearing; or the appeal board may remand the matter to the hearing committee for the taking of further evidence and for decision. If a hearing to consider initial evidence is provided by the appeal board, the procedures set forth herein for hearings before the hearing committee shall generally apply to hearings before the Board, except as reasonably modified by the Board. Each party shall have the right to be represented by legal counsel in connection with the appeal, to present a written statement in support of his or her position on appeal and, in its sole discretion, the appeal board may in its sole discretion allow each party or representative to personally appear and make oral argument. The appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The appeal board shall present to the Board its written recommendations whether the Board should affirm, modify, or reverse the decision of the MEC or the Board, or remand the matter to the hearing committee for further review and decision.

9.5.7 DECISION BY THE BOARD

(a) Except as otherwise provided herein, within thirty (30) days after the conclusion of the appellate review proceeding, the Board shall render a decision in writing and shall forward copies thereof to each party involved in the hearing.

(b) The Board may affirm, modify, or reverse the decision of the MEC or the Board's prior decision, or remand the matter to the hearing committee or the MEC for reconsideration. If the matter is remanded to the hearing committee for further review and recommendation, such committee shall conduct its review within ten (10) working days and make its recommendations to the Board. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree, or for good cause, as jointly determined by the chair of the Board and the hearing committee or MEC.

(c) If the Board's decision differs substantially from the MEC's recommendation, the Board shall refer the matter to a Joint Conference Committee as provided in Section 9.5.8.

9.5.8 JOINT CONFERENCE REVIEW

Within fourteen (14) days of its receipt of a matter referred to it by the Board, the Joint Conference Committee composed of equal numbers of Medical Staff members and Board members shall convene to consider the matter. The Joint Conference Committee shall have access to the records from the hearing and appeal. The decision of the Joint Conference Committee shall be given in writing to the Board within ten (10) working days of receipt of the matter unless extended for good cause. The decision of the Joint Conference Committee shall specify the reasons for its recommendation.

9.5.9 FINAL ACTION BY THE BOARD

At its next regularly scheduled meeting, the Board shall consider the recommendation of the Joint Conference Committee and render a final decision. Such action of the Board shall constitute final action.

9.5.10 RIGHT TO ONE HEARING

No member shall be entitled to more than one (1) evidentiary hearing and one (1) appellate review on any matter which shall have been the subject of adverse action or recommendation.

9.6 EXCEPTIONS TO HEARING RIGHTS

9.6.1 MEDICAL-ADMINISTRATIVE/CONTRACT PHYSICIANS

Members who are subject to a contract with the Hospital in a medical-administrative capacity or pursuant to a contract to deliver medical services to patients of the Hospital are not entitled to the procedural rights specified in this Article IX if their Medical Staff membership, status, or privileges are restricted, terminated, or modified pursuant to the terms of a contract with the Hospital. If, however, a contract physician's Medical Staff status, membership, or privileges are modified, restricted, or terminated because of issues relating to professional character, competence, or ethics, and the action is reportable to the National Practitioner Data Bank, the contract member shall be entitled to the procedural rights of this Article IX.

ARTICLE X DEPARTMENTS AND SECTIONS

10.1 ORGANIZATION OF DEPARTMENTS AND SECTIONS

The Medical Staff shall be divided into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a chair selected and entrusted with the authority, duties, and responsibilities specified in Section 10.6.5. A department may be further divided, as appropriate, into sections that shall be directly responsible to the department within which they function, and which shall have a section chief selected and

entrusted with the authority, duties, and responsibilities specified in Section 10.9.5. When appropriate, the MEC or the Board may recommend to the Medical Staff the creation, elimination, modification, or combination of departments or sections.

10.2 CURRENT DEPARTMENTS AND SECTIONS

10.2.1 CURRENT DEPARTMENTS

The current departments are:

(a) Medical Services;

(b) Surgical Services; and

(c) Hospital-Based Services.

10.2.2 SECTIONS

The current sections of Hospital departments are:

(a) Within the Medical Services Department:

(1) Medical Control Committee composed of Section chiefs or their designated representative Revised 7/30/14

i. Family Practice Section;

ii. Medicine Section (including: Allergy/Immunology; Cardiology; Endocrinology; Gastroenterology; Internal Medicine; Medical Oncology; Nephrology; Physiatry; Pulmonary Medicine; and Rheumatology);

iii. Neurology/Psychiatry Section; and

iv. Pediatrics Section;

(b) Within the Surgical Services Department:

(1) Surgical Control Committee composed of Section chiefs or their designated representative Revised 7/30/2014

i. Anesthesia/Pain Management Section;

ii. Obstetrics Section; and

iii. Surgery Section (including: Cardiovascular, Vascular and Thoracic Surgery; General Surgery; Gynecology; Neurosurgery; Ophthalmology; Oral Surgery/Dentistry; Orthopedics; Otolaryngology; Plastic/Reconstructive Surgery; Podiatry; and Urology);

(c) Within the Hospital-Based Services Department:

(1) Hospital-Based Services Control Committee composed of Section chiefs or their designated representative Revised 7/30/2014

i. Emergency Services and Ambulatory Care Section;

ii. Pathology Section; and

iii. Radiology Section.

10.3 ASSIGNMENT TO DEPARTMENTS AND SECTIONS

Each member shall be assigned membership in at least one department, and to a section, if any, within such department, but may also be granted membership and/or clinical privileges in other departments or sections consistent with practice privileges granted.

10.4 FUNCTIONS OF DEPARTMENTS

The general functions of each department shall include:

(a) conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. The number of such reviews to be conducted during the year shall be as determined by the MEC in consultation with other appropriate committees. The department shall routinely collect information about important aspects of patient care provided in the department, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work subject to such review is a member of that department;

(b) recommending to the MEC guidelines for the granting of clinical privileges and the performance of specified services within the department;

(c) evaluating and making appropriate recommendations regarding the qualification of applicants seeking appointment or reappointment and clinical privileges within that department;

(d) developing criteria for the minimal content of medical histories and physical examinations within the department (for inpatient and non-inpatient services), which may vary by setting or level of care, and monitoring the quality of medical histories and physical examinations;

(e) reviewing and evaluating departmental adherence to Medical Staff policies and procedures and sound principles of clinical practice;

(f) coordinating patient care provided by the department's members with nursing and ancillary patient care services;

(g) submitting written reports to the MEC concerning the department's review and evaluation activities, actions taken thereon, and the results of such actions, and recommendations for maintaining and improving the quality of care provided in the department and the Hospital;

(h) having at least quarterly meetings for the purpose of considering patient care review findings and the results of the department's other review and evaluation activities, as well as reports on other department and Staff functions;

(i) establishing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocols;

(j) developing and implementing, subject to MEC input, continuing education activities and programs for the department that relate, at least in part, to the type and nature of care, treatment, and services offered by department, and are based upon the findings of the department's performance improvement activities, and documenting individual practitioner participation in such continuing education;

(k) taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified;

(l) accounting to the MEC for all professional and Medical Staff administrative activities within the department; and

(m) formulating recommendations for departmental Rules and Regulations reasonably necessary for the proper discharge of its responsibilities subject to approval by the MEC, the Board, and the Medical Staff.

10.5 FUNCTIONS OF SECTIONS

Subject to approval of the MEC, each section shall perform the functions assigned to it by the department chair. Such functions may include, without limitation, retrospective patient care reviews, evaluation of patient care practices, credentials review and privileges delineation, and continuing education programs. The section shall transmit regular reports to the department chair on the conduct of its assigned functions.

10.6 DEPARTMENT CHAIRMEN

10.6.1 QUALIFICATIONS

Each department shall have a chair who shall be a member of the department which he or she is to head and the active Medical Staff and shall be certified by an appropriate specialty board, or affirmatively establish comparable competence through the credentialing process. Department chairs shall have been a member of the Active Staff in their respective department/section for at least one year. Department chairs may not simultaneously hold leadership positions on another hospital medical staff.

10.6.2 SELECTION

Department chairs shall be elected by a simple majority vote of the Active Staff members of the department in even numbered years at the last meeting of the department prior to the annual Staff meeting. The selection of the department chair is subject to ratification by the MEC. Vacancy in the office of department chair due to any reason shall be filled for the unexpired term through special election by the respective department with such mechanisms as that department may adopt.

10.6.3 TERM OF OFFICE

Each department chair shall serve a two-year (2-year) term, which coincides with the Medical Staff year, or until his or her successor is appointed, unless they shall sooner resign, be removed from office, or lose their Medical Staff membership or clinical privileges in that department. Department officers shall serve no more than two terms consecutively.

10.6.4 REMOVAL

After election and ratification, removal of a department chair from office may occur for cause by a two-thirds vote of the Board, the MEC, or the department members eligible to vote in the department. Just cause may include, but not be limited to, failure to carry out the usual and expected duties of the office, failure to be a member in good standing of the Medical Staff, failure to comply with applicable laws, regulations, and hospital accrediting body or Medicare Conditions of Participation, failure to comply with professional ethics, or failure to observe Medical Staff or Hospital Bylaws, policies or procedures.

10.6.5 DUTIES

Each chair shall have the following roles and responsibilities, including:

(a) continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;

(b) recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department;

(c) recommending clinical privileges for each member of the department;

(d) assessing and recommending to the relevant Hospital authority off-site resources for needed patient care, treatment, and services not provided by the department or the organization;

(e) the integration of the department into the primary functions of the Hospital;

(f) the coordination and integration of interdepartmental and intradepartmental services;

(g) the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;

(h) the recommendation of a sufficient number of qualified and competent persons to provide care, treatment, and service;

(i) the determination of the qualifications and competence of department personnel who are not members of the Medical Staff and who provide patient care, treatment, and services;

(j) the continuous assessment and improvement of the quality of care, treatment, and services;

(k) the maintenance of quality control programs, as appropriate;

(l) the orientation and continuing education of all persons in the department or service; and

(m) recommendations for space and other resources needed by the department or service.

10.7 ADDITIONAL DEPARTMENTS

In addition to the departments and sections specified, new departments and sections may be formed by application of interested members to the MEC. Upon recommendation by the MEC and approval by the Board, the new department or section may be established. Chairmen for newly formed departments and sections will be appointed as described in this Article X.

10.8 THE COMMITTEES OF THE DEPARTMENT

The affairs of each department may be delegated to a designee or to a committee of department members appointed by the chair of the department.

10.9 SECTION CHIEFS

10.9.1 QUALIFICATIONS

Each section shall have a chief who shall be a member of the active Medical Staff and a member of the section which he or she is to head, and shall be certified by an appropriate specialty board, or affirmatively establish comparable competence through the credentialing process. Section chiefs shall have been a member of the Active Staff in their respective department/section for at least one year. Section chiefs may not simultaneously hold leadership positions on another hospital medical staff.

10.9.2 SELECTION

Subject to the approval of the MEC, the section chief shall be elected annually the month before the annual meeting by the members of the section. Vacancies due to any reason shall be filled for the unexpired term by the department chair.

10.9.3 TERM OF OFFICE

Each section chief shall serve a one (1) or two (2) year term, which coincides with the Medical Staff year or until his or her successor is chosen, unless he or she shall sooner resign

or be removed from office or lose Medical Staff membership or clinical privileges in that section. section chiefs may serve no more than two terms consecutively.

10.9.4 REMOVAL

After election and ratification, removal of a section chief from office may occur for cause by a two-thirds vote of the Board, the MEC, or the department members eligible to vote in the department. Just cause may include, but not be limited to, failure to carry out the usual and expected duties of the office, failure to be a member in good standing of the Medical Staff, failure to comply with applicable laws, regulations, and hospital accrediting body or Medicare Conditions of Participation, failure to comply with professional ethics, or failure to observe Medical Staff or Hospital Bylaws, policies or procedures.

10.9.5 DUTIES

Each section chief shall:

(a) act as presiding officer at section meetings;

(b) assist in the development and implementation, in cooperation with the department chair, of programs to carry out the quality review, and evaluation and monitoring functions of the section;

(c) provide oversight of care, treatment, and services rendered by practitioners who are members of the section;

(d) evaluate the clinical work performed in the section;

(e) conduct investigations and submit reports and recommendations to the department chair regarding the clinical privileges to be exercised within his or her section by members of, or applicants to, the Medical Staff;

(f) submit a monthly report of the activities of his or her section to the department chair; and

(g) perform such other duties commensurate with the office as may from time to time be reasonably requested by the department chair, the Chief of Staff, or the MEC.

ARTICLE XI
OFFICERS

11.1 OFFICERS OF THE MEDICAL STAFF

11.1.1 IDENTIFICATION

The officers of the Medical Staff shall be the Chief of Staff, Chief of Staff-elect, Immediate Past-Chief of Staff, and two Medical Staff representatives to the Board.

11.1.2 QUALIFICATIONS

Officers must be members of the Active Staff at the time of their nominations and election, and must remain members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved. All officers must have been a member of the Hospital's Active Staff for at least five (5) years. Department chairs and section chiefs shall have been a member of the Active Staff in their respective department/section for at least one year. Officers may not simultaneously hold leadership positions on another hospital medical staff.

11.1.3 NOMINATIONS

The Medical Staff elections shall be held at the annual Medical Staff meeting each Medical Staff year. The Chief of the medical staff shall convene a Nominating Committee (90) days prior to the annual medical meeting. The Nominating Committee shall prepare a slate of officers which shall consist of one or more nominees for each office and for the representative position on the Board of Trustees, when appropriate.

The slate of candidates will be provided to the medical staff sixty (60) days prior to the annual meeting of the medical staff for their review by email or mail. Each medical staff member will have two (2) weeks to review the candidates. Additional write in candidates may be submitted by the medical staff during this time. Write in candidates will be submitted to the chair of the nominating committee. A write-in-candidate must be endorsed by 10% of the voting medical staff. The write in candidate must provide written consent.

The nominating committee's recommendations along with additional write-in candidates will be sent to the medical staff on a ballot one month prior to the annual meeting of the medical staff. Medical staff members have two (2) weeks to submit their ballot to the Medical Staff Administrator by faxing the prepared document or emailing to the Medical Staff Administrator (MSA). The MSA fax number and email address will be on the ballot. . The members of the nominating committee will count the ballots and present the newly elected officers at the annual medical staff meeting. Revised 6/27/2012

11.1.4 ELECTIONS

The Chief of Staff-elect shall be elected in even numbered years at each annual meeting of the Medical Staff. Because the two Medical Staff representatives to the Board serve staggered terms, the number of such representatives elected at the annual meeting may be none, one, or two. A nominee shall be elected upon receiving a majority of the valid votes cast, subject to the approval of the Board. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the MEC shall decide the election by secret written ballot at its next meeting or a special meeting called for that purpose. Proxy votes will not be allowed.

11.1.5 TERM OF ELECTED OFFICE

Each officer, other than the Medical Staff representatives to the Board, shall serve a two (2) year term, commencing on the first day of the Medical Staff year following his or her election. Each officer shall serve in such office until the end of his or her term, or until a successor is elected, unless he or she shall sooner resign or be removed from office. At the end

of his or her term, the Chief of Staff-elect shall automatically assume the office of Chief of Staff. The Medical Staff representatives to the Board shall serve a term of office for the term normally served by a member of the Board, and shall serve staggered terms in order to provide continuity. Officers may not serve consecutive terms in the same office.

11.1.6 RECALL OF OFFICERS

Except as otherwise provided in these Bylaws, recall of a Medical Staff officer may be initiated by the MEC, the Board, or shall be initiated by a petition signed by at least one-quarter of the members of the Medical Staff eligible to vote for officers. Recall shall be considered at a special meeting of the Medical Staff or Board called for that purpose. Recall shall require a two-thirds vote of the Medical Staff members or Board who actually cast votes at the special meeting in person or by mail ballot. Just cause may include, but not be limited to, failure to carry out the usual and expected duties of the office, failure to be a member in good standing of the Medical Staff, failure to comply with applicable laws, regulations, and hospital accrediting body Standards or Medicare Conditions of Participation, failure to comply with professional ethics, or failure to observe Medical Staff or Hospital Bylaws, policies or procedures.

11.1.7 VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership on the Medical Staff. If there is a vacancy in the office of Chief of Staff, the Chief of Staff-elect shall serve out that remaining term and shall immediately direct the Nominating Committee to decide promptly upon nominees for the office of Chief of Staff-elect. Such nominees shall be reported to the MEC and to the Medical Staff. A special election to fill the position shall occur at the next regular Staff meeting. If there is a vacancy in the office of Chief of Staff-elect, the MEC shall appoint an interim officer to fill this office until the next regular election, at which time the election shall also include the office of Chief of Staff. In the event of any other vacancy, such vacancy shall be filled for the remaining term of office by appointment of the MEC.

11.2 DUTIES OF OFFICERS

11.2.1 CHIEF OF STAFF

The Chief of Staff shall serve as the chief officer of the Medical Staff. The duties of the Chief of Staff shall include, but not be limited to:

(a) enforcing the Medical Staff Bylaws and Rules and Regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards when corrective action has been requested or initiated;

(b) calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;

(c) serving as chair of the MEC;

(d) serving as an ex officio member of all other Staff committees, without vote, unless his or her membership in a particular committee is required by these Bylaws;

(e) interacting with the Administrator and Board in all matters of mutual concern within the Hospital;

(f) appointing, in consultation with the MEC, committee members for all standing and special Medical Staff committees, liaison, or multi-disciplinary committees, except where otherwise provided by these Bylaws and, except where otherwise indicated, designating the chair of these committees;

(g) representing the views and policies of the Medical Staff to the Board and to the Administrator;

(h) being a spokesman for the Medical Staff in external professional and public relations;

(i) serving on liaison committees with the Board and administration, including the Joint Conference Committee, as well as outside licensing or accreditation agencies; and

(j) performing such other functions as may be assigned to him or her by these Bylaws, the Medical Staff, or by the MEC.

11.2.2 CHIEF OF STAFF-ELECT

The Chief of Staff-elect shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Chief of Staff-elect shall be a member of the MEC, the Medical Staff Quality Council, and the Joint Conference Committee, and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws, or by the MEC.

11.2.3 IMMEDIATE PAST CHIEF OF STAFF

The immediate past Chief of Staff shall be a member of the MEC, the Medical Staff Quality Council, an ex officio member of the Joint Conference Committee, and shall perform such other duties as may be assigned by the Chief of Staff or delegated by these Bylaws, or by the MEC.

11.2.4 MEDICAL STAFF REPRESENTATIVES TO THE BOARD OF TRUSTEES

Medical Staff representatives to the Board shall previously have served in the capacity of Chief of Staff. The Medical Staff representatives to the Board shall present to the Board the opinions, policies, concerns, needs, and grievances of the Medical Staff, and shall perform such additional duties as may be appropriately assigned to them by the Chief of Staff, MEC or Board. They shall attend MEC meetings as ex officio members.

12.1 MEETINGS

12.1.1 ANNUAL MEETING

There shall be an annual meeting of the Medical Staff. The Chief of Staff, or such other officers, department or section chiefs, or committee chairs as the Chief of Staff or MEC may designate, shall present reports on actions taken during the preceding year and on other matters of interest and importance to the members. Notice of this meeting shall be given to the members not less than three (3) nor more than fifteen (15) days prior to the meeting.

12.1.2 REGULAR MEETINGS

Regular meetings of the members shall be held each quarter, except that the annual meeting shall constitute the regular meeting during the quarter in which it occurs. The date, place, and time of the regular meetings shall be determined by the MEC, and adequate notice shall be given to the members.

12.1.3 AGENDA

The order of business at a meeting of the Medical Staff shall be determined by the Chief of Staff and MEC. The agenda shall include, insofar as feasible:

(a) reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;

(b) administrative reports from the Chief of Staff, departments, committees, and the Administrator;

(c) election of officers and Medical Staff representatives to the Board when required by these Bylaws or otherwise appropriate;

(d) reports by responsible officers, committees, and departments on the overall results of patient care audits and other quality review, evaluation, and monitoring activities of the Staff and on the fulfillment of other required Staff functions;

(e) recommendations for improving patient care within the Hospital;

(f) old business; and

(g) new business.

12.1.4 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Board, the Administrator, the Chief of Staff, or the MEC, or upon the written request of one-fourth of the

members of the Active Staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the MEC within thirty (30) days after receipt of a valid request. No later than ten (10) days prior to the meeting, notice shall be mailed or delivered to the members of the Staff, which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

12.2 COMMITTEE AND DEPARTMENT MEETINGS

12.2.1 REGULAR MEETINGS

Except as otherwise specified in these Bylaws, the chairs of committees, departments, and sections may establish the times for the holding of regular meetings. The chairs shall make every reasonable effort to ensure the meeting dates are disseminated to the members with adequate notice.

12.2.2 SPECIAL MEETINGS

A special meeting of any Medical Staff committee, department, or section may be called by the chair thereof, the MEC, the Administrator, or the Chief of Staff, and shall be called by written request of one-third of the current members eligible to vote, but not less than three (3) members.

12.3 QUORUM

12.3.1 STAFF MEETINGS

Those voting members present at any regular or special meeting in person or through written ballot shall constitute a quorum for the purpose of amending these Bylaws. Those voting members present shall constitute a quorum for all other actions.

12.3.2 DEPARTMENT AND COMMITTEE MEETINGS

A quorum of 50 percent of the voting members of the MEC shall be required for meetings of such committee. For department, section meetings and other committees, a quorum shall consist of those voting members present.

12.4 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these Bylaws. Committee action may be conducted by telephone conference, which shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Valid action may

be taken without a meeting by a committee if it is acknowledged by a writing setting forth the action so taken, which is signed by at least two-thirds of the members entitled to vote.

12.5 MINUTES

Except as otherwise specified herein, minutes of meetings shall be prepared and retained for the time period required by law or Hospital policy. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters. A copy of the minutes shall be signed by the presiding officer of the meeting and forwarded to the MEC and the Administrator.

12.6 ATTENDANCE REQUIREMENTS

12.6.1 REGULAR ATTENDANCE

Except as stated below, each member of the Active and Active/Provisional Staff during the term of appointment who are entitled to attend meetings under Article IV shall be required to attend at least 50 percent of Medical Executive, Credentials and Medical Staff Quality Committee meetings. Failure to meet the attendance requirement for Medical Staff meetings may be grounds for removal from such committee or for corrective action pursuant to Article VIII. Ex-officio members of committees are not required to attend 50 percent of the meetings of such committees.

12.6.2 SPECIAL ATTENDANCE

At the discretion of the Chief of Staff or other presiding officer, when a member's practice or conduct is scheduled for discussion at a regular department, section, or committee 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 (unless such time period is waived by the practitioner affected) and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a member to appear at any meeting with respect to which he or she was given such notice, unless excused by the MEC upon a showing of good cause, shall be a basis for corrective action.

12.7 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order. Actions taken shall not be subject to later challenge on the basis of parliamentary or other decisions from the chair, except where the actions were in direct conflict with these Bylaws or related points of order were raised at the meeting in which the action was taken.

ARTICLE XIII
COMMITTEES

13.1 DESIGNATION

The committees described in this Article XIII shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the MEC to perform specified tasks. Unless otherwise specified, the Medical Staff members of all committees shall be appointed by and may be removed by the Chief of Staff, subject to consultation with and approval by the MEC. The Administrator shall appoint all non-medical staff members of committees after consultation with the Chief of Staff. Each committee chair shall be appointed by the Chief of Staff. Every chair must be a physician member of the Medical Staff. Medical Staff committees shall be responsible to the MEC.

13.2 GENERAL PROVISIONS

13.2.1 TERMS OF COMMITTEE MEMBERS

Unless otherwise specified, committee members shall be appointed for a term of **[one (1) year]**, and shall serve until the earlier to occur of (a) the end of such period and until the member's successor is appointed, or (b) the resignation or removal of such committee member.

13.2.2 REMOVAL

If a member of a committee ceases to be a member in good standing of the Medical Staff, loses employment or a contract relationship with the Hospital, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, such member may be removed from the committee by the MEC or the Board.

13.2.3 VACANCIES

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee was made; provided, however, that if an individual who obtains membership on a committee by virtue of these Bylaws is removed from such committee for cause, a successor may be selected by the MEC.

13.2.4 EX-OFFICIO COMMITTEE MEMBERS

Except where named as a regular member or a voting member, the Chief of Staff, Administrator, or their respective designees shall be ex officio nonvoting members of all committees.

13.2.5 CHANGES IN STANDING COMMITTEES

Standing committees may be established or consolidated by the MEC with the approval of the Board.

13.3 MEDICAL EXECUTIVE COMMITTEE

13.3.1 COMPOSITION

The MEC shall consist of the following voting members: the Chief of Staff, who shall act as chair, the Chief of Staff-elect, the immediate past Chief of Staff, the chair of each department of the Medical Staff, and the section chief of the following sections: Medicine, Neurology/Psychiatry, Pediatrics, Anesthesia, Surgery, Family Practice, Obstetrics, Radiology, Pathology, Emergency Services/Ambulatory Care. The Chief Executive Officer (CEO) and the Chief Nursing Officer (CNO) or their designees, the chairs of the Credentials Committee, Utilization Management Committee, Allied Health Professional Committee, and Pharmacy and Therapeutics/Institutional Review Committee, and the Medical Staff's representatives to the Board shall serve as ex officio members of the MEC without vote. Revised 12/16/09

13.3.2 DUTIES

The Medical Staff delegates authority to the MEC to carry out Medical Staff responsibilities. Specifically, the duties of the MEC shall include, but not be limited to:

(a) representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws and the Hospital's Bylaws;

(b) instituting and recommending corrective action in accordance with Article VIII, including termination of Medical Staff membership, where appropriate;

(c) requesting evaluations of practitioners privileged through the Medical Staff process in instances where there is doubt about an applicant's ability to perform the privileges requested;

(d) receiving and acting upon reports and recommendations from Medical Staff departments, sections, committees, officials of the Staff, and Hospital and individual practitioners;

(e) making recommendations directly to the Board regarding:

(1) the Medical Staff's structure;

(2) the process used to review credentials and delineate privileges;

(3) the delineation of privileges for each practitioner privileged through the Medical Staff process; and

(4) Medical Staff membership.

(f) coordinating and implementing the professional and organizational activities and policies of the Medical Staff;

(g) recommending action to the Board on matters of a medical-administrative nature;

(h) establishing the organization of quality improvement activities and mechanisms of the Medical Staff;

(i) evaluating the medical care rendered to patients in the Hospital, including care provided by Allied Health Professionals;

(j) participating in the development of Medical Staff and Hospital policies, practice, and planning;

(k) taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members, including the initiation of, and participation in, Medical Staff corrective action or review measures when warranted;

(l) designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees;

(m) reporting to the Medical Staff at each regular Staff meeting;

(n) assisting in the obtaining and maintaining of hospital accreditation;

(o) reviewing the findings of performance improvement activities and developing priorities for continuing education activities that focus on the type and nature of care, treatment, and services offered by the Hospital;

(p) developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster;

(q) reviewing the quality and appropriateness of services provided by contract physicians;

(r) requesting any practitioner to appear before the MEC whenever the committee considers it necessary in order to carry out its duties and responsibilities;

(s) identifying community health needs and setting goals to meet those needs;

(t) communicating with the committees responsible for professional graduate medical education regarding the safety and quality of patient care, treatment and services provided by House Staff, as well as the educational and supervisory needs of House Staff;

(u) reporting to the Board regarding the discharge by the Medical Staff of its individual and organizational responsibilities for quality improvement; and

(v) taking such other actions as it deems necessary to accomplish the functions of the Medical Staff and that may be assigned to it by the Administrator or the Board.

13.3.3 MEETINGS

The MEC shall meet as often as necessary at the call of its chair, but at least monthly, and shall maintain a written record of its proceedings and actions and shall report, through the Administrator, to the Board.

13.4 CREDENTIALS COMMITTEE

13.4.1 COMPOSITION

The Credentials Committee shall consist of at least four members of the Active Staff, one from each department and one at-large member.

13.4.2 DUTIES

The duties of the Credentials Committee shall include, but not be limited to:

(a) reviewing and evaluating the qualifications of each practitioner applying for initial appointment, reappointment, or modification of or for clinical privileges, and, in connection with these duties, obtaining and considering the recommendations of the appropriate departments;

(b) submitting to the MEC required reports and information on the qualifications of each practitioner applying for membership or particular clinical privileges, including recommendations with respect to appointment, membership category, department affiliation, clinical privileges, and special conditions;

(c) investigating, reviewing, and reporting on matters referred by the Chief of Staff or the MEC regarding the qualifications, conduct, professional character, or competence of any applicant or Medical Staff member;

(d) submitting periodic reports to the MEC on its activities and the status of pending applications;

(e) making recommendations to the MEC regarding the qualifications of each practitioner applying for initial appointment, reappointment, or modification of and for clinical privileges;

(f) treating in a confidential manner all matters brought before it insofar as possible without interfering with the duty of the committee to report its recommendations through official channels; and

(g) performing other related functions delegated to it by the MEC.

13.4.3 MEETINGS

The Credentials Committee shall meet as often as necessary at the call of its chair, but at least monthly. Attendance at the meetings shall be limited to members of the committee and persons invited by the committee to assist in its deliberations. The Committee shall maintain a written record of its proceedings and actions and shall report its activities and recommendations on a monthly basis to the MEC.

13.5 JOINT CONFERENCE COMMITTEE

13.5.1 COMPOSITION

The Joint Conference Committee shall be composed of at least six (6) persons, and shall include three representatives from the Board, and three members of the MEC (including the Chief of Staff). The Administrator and the chair of the Board shall serve as ex officio nonvoting members. The chairmanship of the Joint Conference Committee shall alternate annually between the chair of the Board and the Chief of Staff of the Hospital.

13.5.2 DUTIES

The Joint Conference Committee shall constitute a forum for the discussion of matters of Hospital and Medical Staff policy, practice, and planning on which the MEC and the Board do not agree, and such other matters as may be referred by the MEC or the Board. The Joint Conference Committee shall exercise other responsibilities set forth in these Bylaws.

13.5.3 MEETINGS

The Joint Conference Committee shall meet as often as necessary at the call of its chair, and it shall submit written reports of its activities to the MEC and to the Board. The chair of the Board, the Chief of Staff, the Administrator, or a majority of the voting members of the committee then in office may call meetings of this Committee.

13.6 BYLAWS COMMITTEE

13.6.1 COMPOSITION

The Bylaws Committee shall consist of at least five (5) members of the Medical Staff appointed by the MEC. The Administrator or his or her designee shall be an ex officio member. The members shall serve for a term of up to five (5) years in staggered terms such that one (1) new member shall be elected annually. During the first year, the MEC shall designate which members shall serve terms shorter than five (5) years.

13.6.2 DUTIES

The duties of the Bylaws Committee shall include, but not be limited to:

(a) conducting an annual review of the Medical Staff Bylaws, as well as the Rules and Regulations;

(b) submitting recommendations to the MEC for changes in these documents as necessary to reflect current Medical Staff practices; and

(c) receiving and evaluating for recommendation to the MEC suggestions from the Board, the committees of the Hospital, the committees of the Medical Staff, the Chief of Staff, and the Administrator for modification of the items specified in Section 13.6.2(a).

13.6.3 MEETINGS

The Bylaws Committee shall meet as often as necessary at the call of its chair, but at least annually. It shall maintain a written record of its proceedings and actions and shall report its activities and recommendations to the MEC.

13.7 NOMINATING COMMITTEE

13.7.1 COMPOSITION

The Nominating Committee shall consist of no fewer than three (3) members of the Active medical staff. The chair shall be appointed by the Chief of Staff.

13.7.2 DUTIES

The duties of the Nominating Committee shall include, but not be limited to:

(a) nominating one (1) or more qualified nominees for each office as well as for Medical Staff's representatives to the Board; and

(b) reporting the nominations to the MEC at its September meeting and mailing the nominations to the voting members of the Medical Staff at least thirty (30) days prior to the election.

13.7.3 MEETINGS

The Nominating Committee shall meet as often as necessary at the call of its chair, but at least annually. The Nominating Committee shall be accountable to the Staff via the Chief of Staff and to the Board via the Administrator.

13.8 CONTINUING MEDICAL EDUCATION COMMITTEE

13.8.1 COMPOSITION

The CME Committee shall consist of at least five (5) members of the Active Staff, including, but not limited to representatives of the Pathology, Radiology, Internal Medicine, and Surgery Sections. The Administrator or his or her designee shall serve as an ex officio member without vote. The chair shall be elected by the members.

13.8.2 DUTIES

The duties of the CME Committee shall include, but not be limited to:

(a) coordinating and implementing the determinations of the MEC with respect to continuing education programs for practitioners, through departmental and general Staff activities;

(b) documenting individual Medical Staff members' participation in continuing education activities;

(c) evaluating the effectiveness of current continuing education programs and making recommendations to the MEC as to how these programs might be improved or what new programs might be developed;

(d) reviewing and making recommendations to the MEC concerning proposed and implemented research and teaching programs;

(e) conducting a periodic review of texts and journals available for Staff use and recommending deletions or additions;

(f) reviewing, evaluating, and recommending worthwhile innovations in patient services; and

(g) performing other related functions delegated to it by the MEC.

13.8.3 MEETINGS

The Continuing Medical Education Committee shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a written record of its proceedings and actions and report its activities and recommendations to the MEC.

13.9 INFECTION PREVENTION and CONTROLCOMMITTEE

13.9.1 COMPOSITION

The Infection Prevention and Control Committee shall consist of at least three (3) members of the Active Staff, including, but not limited to representatives of the Surgery and Medicine departments, and Pathology Section. Nonvoting participants include the Administrator or his or her designee, and representatives from Nursing, Pharmacy, Laboratory, Housekeeping, and Engineering. The Chief of Staff shall appoint, with the approval of the MEC, such other members of the Medical Staff in a voting or nonvoting capacity as he or she deems appropriate, or as may be required by hospital accrediting body. Non-physician personnel shall be appointed by the Administrator.

13.9.2 DUTIES

The duties of the Infection Control Committee shall include, but not be limited to:

(a) developing and monitoring a Hospital-wide infection control program and maintaining surveillance over the program;

(b) developing a system for reporting, identifying, and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, and follow-up activities;

(c) developing and implementing a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing, and evaluating aseptic, isolation, and sanitation techniques;

(d) developing written policies defining special indications for isolation requirements;

(e) acting upon recommendations related to infection control received from the Chief of Staff, the MEC, departments, and other committees;

(f) reviewing sensitivities of organisms specific to the facility;

(g) recommending corrective action based on records and reports of infections and infection potential among patients and Hospital personnel;

(h) verifying required reporting to State and local health departments;

(i) reviewing and approving or denying all special infection control studies to be conducted throughout the Hospital;

(j) instituting, through its chair, or his or her designee, any appropriate control measures or studies when there is reason to believe there may be a danger to any patient or personnel; and

(k) performing other related functions delegated to it by the MEC.

13.9.3 MEETINGS

The Infection Control Committee shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a written record of its proceedings and actions and shall submit reports of its activities and recommendations to the MEC, the Administrator, and the Director of the Nursing department or service.

13.10 PHARMACY & THERAPEUTICS/INSTITUTIONAL REVIEW BOARD COMMITTEE

13.10.1 COMPOSITION

The Pharmacy and Therapeutics/Institutional Review Board Committee shall consist of at least three (3) members of the Active Staff, including one (1) member from each department and the Director of Pharmacy or his/her designee. The Administrator, or his or her designee, and the Director of Nurses, or his or her designee, shall serve as nonvoting ex officio members of the committee.

13.10.2 DUTIES

The duties of the Pharmacy and Therapeutics Committee/IRB shall include, but not be limited to:

(a) developing and maintaining professional policies and procedures regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and automatic stop orders relating to drugs in the Hospital, including antibiotic use;

(b) advising the Medical Staff and the pharmaceutical service of changes in the availability of drugs and of changes in laws and regulations concerning the use and handling of drugs;

(c) evaluating clinical data concerning new drugs or preparations for use in the Hospital;

(d) developing and reviewing, on a regular basis, a formulary or drug list for use in the Hospital;

(e) advising the pharmacist in the selection and stocking of drugs, and the nursing staff in the stocking, safekeeping, and administration of drugs;

(f) developing policies and procedures for screening, distributing, handling, and administering parenteral fluids and medical devices;

(g) establishing and maintaining a mechanism for defining, reviewing, and reporting adverse reactions to drugs, including antibiotics;

(h) coordinating action on findings from the Medical Staff's review of the clinical use of antibiotics;

(i) performing clinical antibiotic usage assessment, as well as any statistical prevalence study of antibiotic usage, which includes review of the prophylactic and therapeutic use of antibiotics for inpatients, ambulatory care patients, and emergency care patients;

(j) assisting other Hospital and Medical Staff committees in the evaluation of drug utilization, drug therapy, adverse drug reactions, and intravenous therapy through a review of medical records; and

(k) evaluating requests for therapeutic trials and experimental treatment protocols with respect to appropriateness, patient safety, and informed consent.

13.10.3 MEETINGS

The Pharmacy and Therapeutics Committee/IRB shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a record of its proceedings and shall report to the MEC its activities and recommendations on not less than a quarterly basis.

13.11 MEDICAL STAFF QUALITY COUNCIL

13.11.1 COMPOSITION

The Medical Staff Quality Council shall consist of the Chief of Staff, Chief of Staff-elect, three (3) department chairs, and other members selected from among the chairs of the Credentials Committee, Utilization Management Committee, Pharmacy and Therapeutics/ Institutional Review Board Committee, Allied Health Professional Committee, and Physician/Practitioner Health and Rehabilitation Committee. Nonvoting members shall include the hospital President or his or her designee, the director of Health Information Management, and of Quality Resource Management. It is recommended that each Medical Staff member of the Medical Staff Quality Council also represent his or her department as a peer reviewer. The chair shall have served at least one (1) year on the Medical Staff Quality Council within the last three

(3) years and shall be elected by the majority of voting members present at the first meeting of the Medical Staff year.

13.11.2 DUTIES

The Medical Staff Quality Council shall provide leadership in measuring, assessing, and improving processes that primarily depend on the activities of one or more practitioners and other individuals credentialed and privileged through the Medical Staff process. The duties of the Medical Staff Quality Council shall include, but not be limited to:

(a) overseeing the Hospital-wide quality improvement plan, which incorporates sentinel event and patient safety data, for measuring, assessing, and improving:

(1) medical assessment and treatment of patients;

(2) appropriateness of clinical practice patterns;

(3) significant departures from established patterns of clinical practice;

(4) use of medications;

(5) use of blood and blood components;

(6) operative and other procedure(s);

(7) the use of developed criteria for autopsies;

(b) monitoring the quality assurance, patient safety, and patient satisfaction activities of the Hospital's departments, sections, and committees;

(c) developing a process for the focused review of a practitioner's performance and evaluation of practitioner's performance by peers for purposes of improving the practitioner's performance, including the development of:

(1) a definition of the special circumstances requiring a focused review;

(2) a method for selecting focused review panels for specific circumstances;

(3) timeframes in which focused review activities are to be conducted;

(4) circumstances under which external peer review is required;

(5) a mechanism for reevaluating the clinical privileges of a practitioner whose performance is questioned as a result of such focused review activities;

(6) a mechanism for communicating the findings, conclusions, recommendations, and actions taken to the appropriate parties; and

(7) a process for implementing changes to improve practitioner performance;

(d) receiving and acting on reports from the Hospital's clinical departments and sections, Utilization Management Committee, Credentials Committee, Pharmacy and Therapeutics/Institutional Review Board Committee and Physician/Practitioner Health and Rehabilitation Committee;

(e) monitoring and instituting measures to assuring the accurate, timely, and legible completion of patients' medical records;

(f) submitting regular confidential reports to the MEC on the quality review activities conducted; and

(g) performing other related functions delegated to it by the MEC.

13.11.3 MEETINGS

The Medical Staff Quality Council shall meet as often as necessary to perform its functions at the call of its chair, but at least monthly. It shall maintain a written record of its proceedings and actions and report its activities and recommendations to the MEC and Board, except that routine reports to the Board shall not include peer evaluations related to individual members.

13.12 UTILIZATION MANAGEMENT COMMITTEE

13.12.1 COMPOSITION

The Utilization Management Committee shall consist of at least four (4) members of the Active Staff, including the Utilization Review Physician. Ex-officio members shall include the Administrator or his or her designee, the director of Medical Records, and other designated members of Hospital administration. Subcommittees may be appointed by the committee for departments or sections as the committee may deem appropriate. The chair shall have served at least one (1) year on the Utilization Management Committee within the last three (3) years and shall be appointed by the Chief of Staff.

13.12.2 DUTIES

The duties of the Utilization Management Committee shall include, but not be limited to:

(a) conducting utilization review studies designed to evaluate the appropriateness of admissions to the Hospital, lengths of stay, discharge practices, use of medical and Hospital services, and related factors that may contribute to the effective utilization of services. The Committee shall communicate the results of its studies and other pertinent data to the MEC and shall make recommendations for the utilization of resources and facilities commensurate with quality patient care and safety;

(b) establishing a utilization review plan, which shall be approved by the MEC, and which shall comply with the standards of hospital accrediting

body and which meets the requirements of Titles XVIII and XIX of the Social Security Act, and assisting the Medical Staff and Hospital personnel in implementing such plan. Such plan shall be reviewed and evaluated at least annually, and revised as appropriate;

(c) obtaining, reviewing, and evaluating information and raw statistical data obtained or generated by the Hospital's case management system or as requested by the MEC;

(d) identifying utilization problems by examining the findings of related quality assurance activities and other relevant documentation; these may include profile analyses, the results of patient care evaluation studies, the results of surgical case review, drug usage evaluation, blood utilization review, infection control activities, and reimbursement agency utilization reports that are Hospital specific;

(e) assisting Hospital personnel in monitoring the prospective payment system in interpretation and dissemination of:

(1) Federal regulations and legislation;

(2) DRG activities and guidelines;

(3) Hospital policies and procedures that have an impact on the Medical Staff;

(f) identifying and monitoring cost and day outliers;

(g) serving as advisors to the Hospital utilization review staff;

(h) evaluating Medicare Peer Review Organization activities, including recommendations and denials and other third party review results;

(i) reviewing those diagnoses, procedures, or practitioners with identified or suspected utilization-related problems;

(j) reviewing Medicare and Medicaid admissions with all other categories of patients reviewed, at least, on a sample basis. In conjunction with preadmission, admission, and extended stay reviews, the committee will analyze its findings, and where factors are identified that contribute to the ineffective use of inpatient services, recommendations of more effective procedures will be made. The Committee will maintain liaisons with and seek the assistance of other committees as necessary;

(k) reviewing at intervals the Hospital's discharge planning program; and

(l) performing such related functions as may be delegated to it by the MEC.

13.12.3 MEETINGS

The Utilization Management Committee shall meet as often as necessary at the call of its chair, but at least monthly. It shall maintain a written record of its proceedings and actions, and shall submit a monthly report of its activities and recommendations to the MEC via its chair.

13.13 CANCER AND RADIATION SAFETY COMMITTEE

13.13.1 COMPOSITION

The Cancer Committee shall consist of at least five (5) members of the Active Staff, including representatives from Surgery, Medical Oncology, Radiation Oncology, Diagnostic Radiology, and Pathology. The Chairman shall be the cancer liaison physician, appointed by the Chief of Staff. Ex-officio members of the committee shall include the Administrator or his or her representative, a representative of the administration of Allison Cancer Center, Social Services, Rehabilitation Services, Medical Records, Quality Management and the Tumor Registry.

13.13.2 DUTIES

The duties of the Cancer Committee shall be to oversee cancer care and radiation safety at the Hospital, including, but not be limited to:

(a) providing that patients have access to consultative services in all major disciplines;

(b) providing that educational programs include major cancer sites;

(c) evaluating the quality of care of patients with cancer;

(d) supervising the cancer data system;

(e) appointing Cancer Committee members to act as registry physician-advisors;

(f) acting upon recommendations received from the Chief of Staff, the MEC, departments, and other committees; and

(g) performing other related functions delegated to it by the MEC.

13.13.3 MEETINGS

The Cancer Committee and Radiation Safety Committee shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a written record of its activities and recommendations and shall report to the MEC quarterly via its chair.

13.14 PHYSICIAN/PRACTITIONER HEALTH AND REHABILITIATION COMMITTEE

13.14.1 COMPOSITION

The Physician/Practitioner Health and Rehabilitation Committee shall be composed of no less than three (3) members of the Active Staff, a majority of which, including the chair, shall be physicians. Except for initial appointments, each member shall serve a term of two (2) years. To the extent practicable, members of the Physician/Practitioner Health and Rehabilitation Committee shall have a particular interest and/or expertise in substance abuse, addiction medicine, psychiatry, or related subjects. To the extent practicable, members of the committee shall not serve as active participants on other peer review or quality assessment and improvement activities while serving on the committee.

13.14.2 DUTIES

The Physician/Practitioner Health and Rehabilitation Committee may receive and evaluate reports related to the health, well-being, disruptive behavior, or impairment of staff members and, as it deems appropriate, may investigate such reports in accordance with the Physician/Practitioner Health and Rehabilitation Policy attached to these Bylaws. With respect to matters involving individual staff members, the committee may, on a voluntary basis, provide such advice, counseling, or referrals as may seem appropriate. Such activities shall be confidential; however, in the event information received by the committee clearly demonstrates risk of harm to hospitalized patients, that information may be referred for corrective action. The Committee shall also consider general matters relating to the health and well-being of the Staff and, with the approval of the MEC, develop educational programs or related activities.

13.14.3 MEETINGS

The Physician/Practitioner Health and Rehabilitation Committee shall meet as often as necessary, but at least annually. The Committee shall maintain only such record of its proceedings as it deems advisable and shall report on its activities to the MEC.

13.15 MEDICAL ETHICS COMMITTEE

13.15.1 COMPOSITION

The Ethics Committee shall be composed of at least five (5) members of the Active Staff, with representatives from the Surgery and Medicine Departments, and the Family Practice, Pediatrics, and Neurology/Psychiatry Sections. Ex officio representatives shall include the Administrator or his or her representative, the Hospital chaplain, and a non-hospital employed layperson.

13.15.2 DUTIES

The Ethics Committee exists for the purpose of assisting in resolving issues of a medical ethical nature, which may arise in the course of the management of patients, and setting ethical and moral guidelines for patient care. The Ethics Committee shall also assure that the Medical Staff receives periodic and appropriate continuing education on current medical ethical matters.

13.15.3 MEETINGS

The Ethics Committee shall meet as often as necessary to perform its functions but at least quarterly. The Committee shall maintain a permanent record of its meetings and shall report to the Medical Staff Quality Council and the MEC.

13.16 ALLIED HEALTH PROFESSIONAL COMMITTEE

13.16.1 COMPOSITION

The members of the Allied Health Professional Committee (the "AHP Committee") shall be the Chief of Staff, Vice Chief of Staff, Chair of the Credentials Committee, Department Chairs, Administrator, director of Human Resources, Vice President of Patient Care Services, and five (5) members of the Allied Health Professional staff, who shall be selected by the Chief of Staff, Administrator, and Vice President of Patient Care Services.

13.16.2 DUTIES

The AHP Committee shall monitor the activities of Allied Health Professionals at the Hospital, including but not limited to:

(a) developing, in conjunction with the Credentials Committee, an application for use by applicants to the Allied Health Professional staff, incorporating any information required by law;

(b) reviewing completed applications to the Allied Health Professional staff, and making recommendations to the Credentials Committee regarding an applicant's request for clinical privileges, in accordance with provisions of the Hospital's Allied Health Professional policy;

(c) submitting periodic reports, upon request, to the Credentials Committee on its activities and the status of pending applications;

(d) providing written recommendations to the MEC concerning proposed amendments to the Hospital's Allied Health Professional policy;

(e) making recommendations to the MEC and the Administrator regarding granting clinical privileges to new categories of Allied Health Professionals;

(f) investigating, reviewing, and reporting on matters referred by the Chief of Staff or the Administrator regarding the qualifications, conduct, professional character, or competence of any applicant to the Allied Health Professional staff or Allied Health Professional staff member;

(g) coordinating quality improvement activities pertaining to the Allied Health Professional staff with nursing and the medical staff;

(h) treating in a confidential manner all matters brought before it insofar as possible without interfering with the duty of the committee to report its recommendations through official channels; and

(i) performing other related functions delegated to it by the Chief of Staff or the Administrator.

13.16.3 MEETINGS

The AHP Committee shall meet as often as necessary to perform its functions, The Committee shall maintain a permanent record of its meetings, and shall report to the Administrator, the MEC, and the Credentials Committee.

13.17 POINT OF CARE TESTING COMMITTEE (POCT)

13.17.1 COMPOSITION

The Point of Care Testing (POCT) Committee shall consist of at least three (3) members of the Active Staff, including but not limited to, the Medical Director of Laboratory Services; Medical Director of Cardiopulmonary Blood Gas Laboratory; and Medical Director of Emergency Services or designee. In addition, any staff that is identified as "director" on a CLIA certificate at Midland Memorial Hospital shall be considered a voting member of the Committee. The Medical Director of the Laboratory shall serve as Chairperson of the POCT Committee.

Non-voting participants include the Administrator or his or her designee, and representatives from Nursing Inpatient, Quality Management, Laboratory, Cardiopulmonary and Emergency Services. The Chief of Staff shall appoint, with the approval of the MEC, such other members of the Medical Staff in voting or non-voting capacity as he or she deems appropriate, or as may be required by regulatory agencies. Non-physician personnel shall be appointed by the Administrator.

13.17.2 DUTIES

The duties of the Point of Care Testing Committee shall include, but not limited to:

(a) developing and monitoring a Hospital-wide POCT program and monitoring surveillance over the program.
(b) reviewing POCT testing protocols
(c) reviewing utilization statistics for each POCT
(d) reviewing quality control and quality improvement performance data
(e) reviewing competencies, certifications and education provided as regarding POCT
(f) reviewing all Standard Operating Procedures (SOPs) that relate to POCT
(g) identify suitable trainees for each POCT procedure
(h) reviewing training and competency documentation for new employees
(i) reviewing requests for implementation of new POCT test and approve bid specifications prior to evaluation
(j) reviewing installation and maintenance records for each POCT instrument
(k) reviewing record keeping process of patient results
(l) preparing and maintaining readiness for unannounced inspection by laboratory accreditation agencies

Revised 4/25/07

13.17.3 MEETINGS

The Point of Care Testing Committee shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a written record of its proceedings and actions, and submit reports of its activities and recommendations to the MEC, the Administrator, and the Chief Nursing Officer.

13.18 LIAISON COMMITTEES

As needed.

ARTICLE XIV CONFIDENTIALITY, IMMUNITY, AND RELEASES

14.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising clinical privileges within the Hospital, an applicant:

(a) authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;

(b) authorizes persons and organizations to provide information concerning such practitioner to the Medical Staff;

(c) agrees to be bound by the provisions of this Article XIV and to waive all legal claims against any representative of the Medical Staff or the Hospital who acts in accordance with the provisions of this Article; and

(d) acknowledges that the provisions of this Article XIV are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of clinical privileges at the Hospital.

14.2 CONFIDENTIALITY OF INFORMATION; BREACH OF CONFIDENTIALITY

(a) Medical Staff, department, section, or committee minutes, files, and records, including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential. Dissemination of such information and records shall only be made where expressly required by law, pursuant to officially adopted policies of the Medical Staff, or, where no officially adopted policy exists, only with the express approval of the MEC or its designee.

(b) Because effective peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of

confidentiality of the discussions or deliberations of Medical Staff departments, sections, or committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the MEC may undertake such corrective action as it deems appropriate.

14.3 IMMUNITY FROM LIABILITY

14.3.1 FOR ACTION TAKEN

Each representative of the Medical Staff and the Hospital shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of his or her duties as a representative of the Medical Staff or Hospital.

14.3.2 FOR PROVIDING INFORMATION

Each representative of the Medical Staff and the Hospital and all third parties shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the Medical Staff or Hospital concerning such person who is, or has been, an applicant to or member of the Staff or who did, or does, exercise clinical privileges or provide services at the Hospital.

14.4 ACTIVITIES AND INFORMATION COVERED

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

(a) applications for appointment, reappointment, or granting or delineation of clinical privileges;

(b) corrective action, including summary or automatic suspension;

(c) hearings and appellate reviews;

(d) medical care evaluation;

(e) utilization reviews;

(f) other Hospital, department, section, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct;

(g) peer review organizations, TSBME, the National Data Bank pursuant to the Health Care Quality Improvement Act, and similar reports.

The acts, communications, reports, recommendations, and disclosure referred to in this Section 14.4 may relate to a practitioner's professional qualifications,

clinical competency, character, mental and emotional stability, physical condition, ethics, malpractice claims and suits, and any other matter that might directly or indirectly have an effect on patient care.

14.5 RELEASES

Each applicant or member shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article XIV. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article XIV.

ARTICLE XV
GENERAL PROVISIONS

15.1 RULES AND REGULATIONS

The Medical Staff shall initiate such Rules and Regulations as it may deem necessary for the proper conduct of its work and shall periodically review and revise its Rules and Regulations to comply with current Medical Staff practice. Recommended changes to the Rules and Regulations shall be submitted to the MEC for review, evaluation and adoption by a majority of those voting members present. Medical Staff Rules and Regulations shall become effective upon approval of the Board. Applicants and members of the Medical Staff shall be governed by such Rules and Regulations as are properly initiated and adopted. If there is a conflict between the Bylaws and the Rules and Regulations, the Bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Rules and Regulations.

15.1.1 HISTORY & PHYSICAL REQUIREMENT

The History and Physical (H&P) examination (if needed) must be completed within 24 hours after admission or before a planned surgical or other procedure, whichever happens first. The H&P may be recorded up to 30 days before the hospital encounter, but must be updated as to the patient's current medical condition. The update, which must be recorded in the Electronic Medical Record (EMR), must occur within 24 hours of admission or immediately prior to a surgical procedure, whichever happens first. *Revised 5/27/09*

15.2 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws. These Bylaws apply with equal force to both sexes wherever either term is used.

15.3 AUTHORITY TO ACT

Any member or members who act in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the MEC may deem appropriate.

15.4 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, or requests required or permitted to be mailed shall be in writing, properly sealed, and shall be sent through United States Postal Service, first-class postage prepaid. Notice to the Medical Staff or officers or committees thereof, shall be addressed as follows:

Name and proper title of addressee, if known or applicable
Name of Department, Section, or Committee
c/o Medical Staff Services
Midland Memorial Hospital
400 Rosalind Redfern Grover PKWY
Midland, Texas 79701

Mailed notices to a member, applicant, or other party, shall be to the addressee at the address as it last appears in the official records of the Medical Staff of the Hospital. Notice by posting shall be effective on the date posted.

15.5 WAIVER OF NOTICE

Whenever any notice, written notice, or special written notice (collectively "notice") is required to be given to any practitioner under the provisions of these Bylaws, the refusal of the practitioner to accept the notice, the receipt by the practitioner of the information required to be communicated by the notice irrespective of the manner of communication, the appearance of the practitioner at the meeting to which the required notice related, or a waiver of notice in writing signed by the practitioner entitled to notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice at the required time and in the required manner.

ARTICLE XVI ADOPTION AND AMENDMENT OF BYLAWS

16.1 ADOPTION

These Bylaws, together with any proposed Rules and Regulations, shall be considered at a regular or called meeting of the Medical Staff, and upon adoption by a majority of the voting members present, shall be forwarded to the Board for approval. These Bylaws shall become effective when approved by the Board.

16.2 PROCEDURE

Upon the request of the Chief of Staff, the MEC, the Administrator, the Bylaws Committee, or upon timely written petition signed by at least 10 percent of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to amendment of these Bylaws. Such action shall be taken at a regular or special meeting provided (a) written notice of the proposed change was sent to all members on or before the last regular or special meeting of the Medical Staff, and such changes were offered at such prior meeting, and (b) notice of the next regular or special meeting at which action is to be taken included notice

that a bylaw change would be considered. Both notices shall include the exact wording of the existing bylaw language, if any, and the proposed change(s).

16.3 ACTION BY BYLAW CHANGE

All proposed amendments, whether initiated by the Medical Executive Committee, another standing committee or by a member of the Active medical staff, must be reviewed and discussed by the Medical Executive Committee prior to a Medical Executive Committee vote. The amendment(s) may then be recommended to the Board by a majority voted provided that the amendment(s) was distributed first to the members of the Active medical staff at least twenty-one days prior to a Medical Executive Committee vote.

The Board may act upon the recommendation of the Medical Executive Committee unless ten percent (10%) or more of the Active medical staff members object. Such an objection will cause the Chief of Staff to hold a general staff meeting at which the proposed amendment(s) will be presented, discussed and voted upon. Recommendation of the amendments(s) will require an affirmative vote of a majority of those Active staff members present and voting (absentee ballots will be permitted). Neither the Medical Staff nor the Board may unilaterally amend the medical staff bylaws, rules and regulations.

16.4 APPROVAL

Bylaws changes adopted by the Medical Staff shall be subject to and become effective only following approval by the Board.

ADOPTED by the Medical Staff on **September 24, 2014.**

_____

Chief of Staff

APPROVED by the Board of Trustees on **September 24, 2014**

_____

Chair

APPENDIX A

PRINCIPLES OF PROFESSIONAL ETHICS

1. The MS Member shall be dedicated to providing competent medical/dental health care, with compassion and respect for patient dignity and rights.
2. The MS Member shall uphold the standards of professionalism, be honest in all of their professional and personal affairs, and strive to report practitioners deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
3. The MS Member shall respect and obey the law.
4. The MS Member shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law. MS members will at all times conduct themselves with decorum, respect and courtesy toward other MS members, and other staff and families with whom they interact in the hospital.
5. The MS Member shall continue to study, apply, and advance scientific knowledge, maintain commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
6. The MS Member shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.
7. The MS Member shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
8. The MS Member shall, while caring for a patient, regard responsibility to the patient as paramount.
9. It is inappropriate to substitute the services of an allied health professional for those of a physician when the allied health professional is not appropriately trained and duly licensed to provide the medical services being requested, and if the patient is reasonably expecting the services of a physician.
10. Free choice of health care providers is the right of every individual. One may select and change at will one's MS member health care provider, or one may choose a health care plan such as that provided by a closed panel or group practice or health maintenance or service organization.
11. The MS member's ethical responsibility is to provide patients with high quality services. This includes services that the MS member performs personally and those that are delegated to others.
12. The creation of the patient-health care provider relationship is contractual in nature. Generally, both the MS member and the patient are free to enter into or decline the relationship. A MS member may decline to undertake the care of a patient whose medical condition is not within the provider's current competence. However, MS members who offer their services to the public may not decline to accept patients because of race, color, religion,

national origin, sexual orientation, or any other basis that would constitute invidious discrimination. Furthermore, providers who are obligated under pre-existing contractual arrangements may not decline to accept patients as provided by those arrangements.

13. The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his or her own determination on treatment. The MS member's obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient's care and to make recommendations for management in accordance with good medical practice. The provider has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a basic social policy for which exceptions are permitted: (1) where the patient is unconscious or otherwise incapable of consenting and harm from failure to treat is imminent; or (2) when risk disclosure poses such a serious psychological threat of detriment to the patient as to be medically contraindicated. Social policy does not accept the paternalistic view that the provider may remain silent because divulgence might prompt the patient to forego needed therapy. Rational, informed patients should not be expected to act uniformly, even under similar circumstances, in agreeing to or refusing treatment.

14. From ancient times, physicians have recognized that the health and well being of patients depends upon a collaborative effort between physician and patient. Patients share with their health care providers the responsibility for their own health care. The patient-provider relationship is of greatest benefit to patients when they bring medical problems to the attention of their health care providers in a timely fashion, provide information about their medical condition to the best of their ability, and work with their providers in a mutually respectful alliance. MS members can best contribute to this alliance by serving as their patients' advocate and by fostering these rights:

    (1) The patient has the right to receive information from physicians and other health care providers, and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their health care provider as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their providers might have, and to receive independent professional opinions.

    (2) The patient has the right to make decisions regarding the health care that is recommended by the MS member. Accordingly, patients may accept or refuse any recommended medical treatment. Likewise, the health care provider may choose in such circumstances to transfer care of the patient to an alternative provider.

    (3) The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs.

    (4) The patient has the right to confidentiality. The MS member should not reveal confidential communications or information without the consent of the patient, unless in the course of treatment, or provided for by law or by the need to protect the welfare of the individual or the public interest.

    (5) The patient has the right to continuity of health care. The MS member has an obligation to cooperate in the coordination of medically indicated care with other health care

providers treating the patient. The health care provider may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.

(6) The patient has a basic right to have available adequate health care.