

**CHRISTUS St. Michael Health System
Texarkana and Atlanta Facilities**

Medical Staff Bylaws

and

Rules and Regulations

Revised

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PREAMBLE

Whereas, it is recognized that it is a responsibility of the Medical Staff of CHRISTUS St. Michael Health System/CHRISTUS St. Michael Hospital-Atlanta to have as its aim and goal to strive for an appropriate standard of patient care in the CHRISTUS Health Ark-La-Tex dba CHRISTUS St. Michael Health System/CHRISTUS St. Michael Hospital-Atlanta; hereafter referred to as "Hospital", subject to the ultimate authority of the CHRISTUS Health Ark-La-Tex Board of Directors, and whereas the best interests of the patient are protected by the concerted efforts of the Medical Staff, Administration and the Board of Directors in this goal; therefore, the physicians, dentists, and podiatrists practicing in the "Hospital", established for the care of the sick and injured, are hereby organized in conformity with the Articles and Bylaws of the "Hospital" and by the Bylaws, Rules and Regulations hereinafter stated.

Ethics and Ethical Relationship

The Principles of Medical Ethics of the American Medical Association, American Podiatric Medical Association, or the American Dental Association, whichever is applicable, shall govern the professional conduct of the Medical Staff. The Medical Staff, while practicing in the Hospital, shall adhere to the Ethical and Religious Directives for Catholic Health Care Facilities as promulgated by the National Council of Catholic Bishops.

ARTICLE ONE: DEFINITIONS

- 1.1 The term "Administrator" is defined as the chief executive officer responsible for the overall management of the "Hospital" and includes a duly appointed acting Administrator serving in the Administrator's absence.
- 1.2 The term "Adverse Action" means an action or recommendation which is adverse in any substantial manner to the particular Staff membership, Staff category, or clinical privileges that an applicant for appointment or reappointment to the Staff requested, including without limitation, a recommendation to reduce, restrict, suspend, or otherwise limit a Staff member's clinical privileges or membership. The term "adverse action" also includes but is not limited to an automatic or summary corrective action taken pursuant to these Bylaws.

An "Adverse Action" specifically does not include any of the following:

- a. An action or recommendation regarding an allied health professional or member of the House Staff;
 - b. Denial, suspension, limitation, or revocation of temporary privileges; A suspension or restriction of clinical privileges for a period of less than thirty (30) days, during which an investigation is being conducted to determine the need for a professional review action;
 - c. Termination of a contract with a Staff member, or with an entity that employs or contracts with a Staff member, as provided in the contract;
 - d. Refusal to process an incomplete application;
 - e. Rejection of an application because the applicant does not meet the Hospital's licensure, residency, or insurance requirements;
 - f. A recommendation of a Section Chief or the Credentials Committee;
 - g. A recommendation or decision to retain an Associate Medical Staff member for one additional one-year period on the Associate Medical Staff;
 - h. An automatic corrective action taken pursuant to Section 12.3;
 - i. A warning letter, a letter of admonition, or a letter of reprimand;
 - j. Denial of requested privileges if those privileges are not granted to any practitioner; and/or
 - k. Any other action specified in these Bylaws as not giving rise to a right to a hearing or appellate review.
- 1.3 The term "Annual Medical Staff Meeting" or "Annual Meeting" means the last general meeting of the Medical Staff held during the Medical Staff Year.
- 1.4 The term "days" means calendar days.

- 1.5 The term "Executive Committee" means the Executive Committee of the Medical Staff.
- 1.6 The term "ex officio" means an office or position that entitles the holder to serve on a committee, to vote, to be counted in determining a quorum, and to otherwise have all rights and privileges of a regular member.
- 1.7 The term "Hospital" means CHRISTUS St. Michael Health System, a general care hospital located in Texarkana, Texas, and CHRISTUS St. Michael Hospital-Atlanta, a general care hospital located in Atlanta, Texas.
- 1.8 The term "Board of Directors" or "BOD" means the persons to whom the CHRISTUS Health Ark-La-Tex Board of Directors has delegated authority, with reservations, to manage the business affairs and health care operations of the Hospital and shall include any duly appointed committee authorized to exercise the powers of the Board of Directors.
- 1.9 The term "Medical Staff" "Organized Medical Staff" or "Staff" means all physicians, dentists, and podiatrists, not including Allied Health Professional Staff, who qualify for Medical Staff membership, are appointed to a category of the Medical Staff, and who receive delineated clinical privileges to attend patients in the Hospital. Allied Health Professional Staff are not to be considered members of the Medical Staff.
- 1.10 The term "Medical Staff Bylaws" or "Bylaws" means these "Hospital" Medical Staff Bylaws adopted by the BOD after recommendation by the Medical Staff.
- 1.11 The term "Medical Staff Year" means the calendar year.
- 1.12 The term "Procedures" means those guidelines to implement the general principles in these Bylaws and Rules as adopted by the Executive Committee, subject to final approval by the BOD.
- 1.13 The term "Rules" means the guidelines to implement the general principles in these Bylaws as adopted by the Executive Committee, subject to final approval by the BOD.
- 1.14 The term "CHS" means the Texas nonprofit corporation, CHRISTUS Health System, Houston, Texas.
- 1.15 The term "Threshold Requirements" means those basic requirements that must be met on the Hospital's pre-application in order to qualify for receipt of an application, including, at a minimum, a completely filled in pre-application form, a valid license to practice in the State of Texas, DEA and DPS permits if controlled substances will be prescribed, and professional liability insurance coverage in form and amounts as the BOD may require.
- 1.16 The term "Physician Assistant" or "PA" meant an individual who meets the written requirements of the Texas State Board of Medical Examiners and the Texas State Board of Physician Assistant Examiners; who meet the applicable Texas State legal requirements for certification, licensure, or registration; and who is currently competent to practice medicine with physician supervision. The term "Advanced

Practice Nurse" or "APRN" is a licensed registered nurse who has been certified by a nationally recognized certifying body and who has met the criteria for an advanced practice nurse as established by the Texas State Board of Nursing and is competent to practice with physician supervision. An ANP shall include but not be limited to the following: Certified Nurse Midwife (CNM), Certified Registered Nurse Anesthetist (CRNA) and Nurse Practitioner (NP).

- 1.17 The term "VPMA" means the Vice President of Medical Affairs who has, with the CMO, delegated authority, with reservations, to manage the functions of the Medical Staff Office.
- 1.18 The terms "CMO" means the Chief Medical Officer who has, with the VPMA, delegated authority, with reservations, to manage the functions of the Medical Staff Office.
- 1.19 The term "he" or any variation refers to both the male and the female gender.

ARTICLE TWO: NAME

The name of this organization shall be the Medical Staff of the CHRISTUS St. Michael Health System/CHRISTUS St. Michael Hospital-Atlanta.

ARTICLE THREE: PURPOSES

The purposes of this Medical Staff are:

- 3.1 To treat individuals suffering from acute health conditions in a sensitive and compassionate manner utilizing an interdisciplinary team approach incorporating medical management and therapeutic treatment.
- 3.2 To insure that all patients admitted to or treated in any of the facilities, departments, or services of the Hospital shall receive a quality of care consistent with the practices and services in similar communities giving consideration to the geographic location, size and character of the community.
- 3.3 To insure an appropriate level of professional performance of all practitioners authorized to practice in the Hospital through the appropriate delineation of clinical privileges that each practitioner may exercise in the Hospital and through an ongoing review and evaluation of each practitioner's performance in the Hospital.
- 3.4 To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill.
- 3.5 To initiate and maintain rules and regulations for self-government of the Medical Staff with ultimate accountability to the BOD and also subject to the Articles and Bylaws of CHS.
- 3.6 To encourage Medical Staff participation in continuing education programs and assistance in providing education for Hospital personnel and Staff members.

ARTICLE FOUR: APPOINTMENT, REAPPOINTMENT AND CLINICAL PRIVILEGES

- 4.1 **General.** Membership on the Medical Staff of the Hospital is a privilege which shall be extended only to those practitioners who meet and continue to meet the standards and requirements set forth in these Bylaws without discrimination as to race, color, creed, national origin, age, sex or any other basis prohibited by law. All appointments and reappointments to the Medical Staff shall be made by the BOD after considering the recommendation of the Credentials Committee and Executive Committee.
- 4.1.1 The medical staff must be composed of doctors of medicine and osteopathy.
- 4.1.2 The medical staff may also include and in accordance with State law:
- A doctor of dental surgery or dental medicine
 - A doctor of podiatric medicine
 - A doctor of optometry
 - A chiropractor
 - A clinical psychologist
 - Other categories of non-physician practitioners who the governing body determines are eligible for appointment
- 4.2 **Qualifications for Membership.** All applicants to the Associate, Active, Courtesy, Consulting, or Active-Affiliate Medical Staff must satisfy the following conditions to qualify for initial Medical Staff membership and reappointment:
- a. must complete, for initial appointment to the Staff, a pre-application form, which indicates compliance with the Threshold Requirements;
 - b. must be licensed to practice in the State of Texas;
 - c. must possess a current license from the Drug Enforcement Agency, a certificate from the Texas Department of Public Safety, and Medicare or Medicaid provider numbers as deemed necessary;
 - d. must be able to arrive at the Hospital within thirty (30) minutes of being called which requires residence within a reasonable distance from the Hospital. (Exclusions: Consulting Staff, Emergency Department physicians, Hospitalists, Locum Tenens, Active-Affiliate Staff and exceptions made by the Executive Committee for good cause);
 - e. must sufficiently document the adequacy of their background, experience, training and demonstrated judgment and current competence;
 - f. must possess current, valid professional liability insurance coverage in such form and in amounts as the BOD may require and as set forth in Medical Staff Office Policies;
 - g. must adhere to the ethics of their profession; and

- h. must possess good reputation and character, including stable mental, physical, and emotional health sufficient to perform the essential functions of their professional duties with or without reasonable accommodations and ability to work harmoniously with others, with or without reasonable accommodation.
- i. have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, or a dental surgery training program accredited by the American Association of Oral and Maxillofacial Surgery and/or the Commission on Dental Accreditation of the American Dental Association ("ADA"), or a podiatric surgical residency program accredited by the Council on Podiatric Education of the American Podiatry Association; and
- j. become certified within five (5) years of completion of residency training by the appropriate specialty board of the American Board of Medical Specialties (ABMS), the American Osteopathic Association Board (AOA), the American Board of Oral and Maxillofacial Surgery, or the American Podiatry Association, as applicable. (This requirement is applicable only to those individuals who apply for initial staff appointment after the date of adoption of this rule. All individuals appointed previously shall be governed by the board certification requirements in effect at the time of their appointments.)

4.3 **No Entitlement to Membership.** No person shall be entitled to membership on the Medical Staff merely by virtue of the fact that he is duly licensed to practice in Texas or any other state, or that he is a member of any professional organization, or that he has had in the past, or presently has, such privileges at any health care facility. Individuals in administrative positions who desire Medical Staff membership or clinical privileges are subject to the same procedures as all other applicants for membership or privileges.

4.4 **Term of Initial Appointment.** All initial appointments shall be for a minimum period of one (1) year and the appointee shall be assigned to the Associate Medical Staff. Following this appointment, the appointee may be eligible for elevation to the Active Medical Staff. Appointment to the Medical Staff refers to the placement on the Staff and does not confer any clinical prerogatives, except those for which the applicant specifically applies, the Executive Committee specifically recommends, and the BOD specifically grants. Appointments to the Medical Staff shall be by the BOD when consistent with the capabilities of the Hospital in terms of its facilities and personnel; the priorities of the Hospital in terms of the hierarchy of the needs of the total patient community; and the ethical principles adopted for application within the Hospital.

4.5 **Procedure for Appointment.** Following receipt of a completed pre-application that indicates that an initial applicant meets the Threshold Requirements, Administration shall provide the applicant with an application form. The application for appointment to the Medical Staff of the Hospital shall be presented in writing to the Medical Staff Office or such other location designated by the BOD. It must be signed by the applicant and submitted on a form prescribed by the BOD, after consultation with the Executive Committee. The application for appointment shall include but shall not be limited to, the following:

- a. applicant's agreement to abide by the Bylaws and Rules of the Medical Staff and Hospital Bylaws, Rules, and policies;
- b. applicant's pledge to provide for the continuous care of all patients admitted to the Hospital;
- c. the applicant's professional qualifications as described in Section 4.2, including the names of three persons who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the professional competence and ethical character of the applicant;
- d. a government issued picture ID will be presented at orientation and a copy made for the physicians file (for identification verification); acceptable form of ID includes a passport or driver's license;
- e. information concerning previously successful or currently pending challenges to or voluntary relinquishment of any licensure, DEA or DPS registration, Medicare or Medicaid certification, voluntary or involuntary termination, limitation, reduction, or loss of medical staff membership or clinical privileges or withdrawal of an application at another healthcare facility;
- f. the applicant shall also indicate the clinical classifications desired, the category of Staff membership sought (all applicants desiring eventual Active Medical Staff membership shall apply initially for the Associate Medical Staff) and the location(s) at which Medical Staff membership and clinical privileges are desired;
- g. the names and complete addresses of the chiefs or chairpersons of each department of all hospitals or other health care facilities at which the applicant has worked or trained;
- h. information indicating that the applicant has currently in force appropriate professional liability insurance coverage, the name of the insurance company and the amount and classification of such coverage, and indicating insurance coverage covers the clinical privileges the applicant or appointee seeks to exercise in the Hospital;
- i. information concerning the applicant's professional liability litigation experience, specifically including information concerning pending litigation, final judgments or settlements;
- j. information concerning any professional misconduct proceedings and any malpractice actions involving the applicant in this state or any other state, including peer review panel proceedings, whether such proceedings are closed or still pending, including the substance of the allegations of such proceedings or actions, the ultimate disposition of any such proceedings or actions that have been closed, and any additional information concerning such proceedings or actions as the applicant may deem appropriate;

- k. information on the applicant's physical and mental health required to perform the essential functions of the requested clinical privileges;
 - l. information indicating whether the applicant has ever been named as a defendant in a criminal action and/or convicted of a crime, with details about any such instance; and
 - m. information on the citizenship and/or visa status of the applicant.
- 4.6 **Complete Application.** An application shall be deemed complete when (i) all required information is timely furnished by the applicant within ninety (90) days following the date noted on the dated application form initially provided to the applicant and (ii) all evidence required to support the qualifications asserted by the applicant has been gathered within ninety (90) days thereafter. Appropriate personnel shall confirm all information in the application, shall obtain written peer recommendations, and shall consult sources available, including but not limited to the appropriate State Board of Medical, Dental, Osteopathic or Podiatric Examiners, and the National Practitioner Data Bank; however, the applicant shall always have the responsibility of ensuring that all supporting evidence is provided. An application shall not be deemed complete if the applicant fails to provide all information requested, provides misrepresentations, withholds adverse information, or alters the application form. If the Administrator determines that the application is not complete, the Administrator shall so notify the applicant, and the application shall not be processed further unless and until all apparent deficiencies noted in the application have been corrected, and the application has been resubmitted. Such notice does not constitute an Adverse Action and shall not give rise to any right of review.
- 4.7 **Applicant's Burden.** The applicant shall have the burden of providing information for evaluation of his competence, ethics, ability to perform the essential functions of the requested clinical privileges, and other qualifications, and for resolving any doubts about such qualifications. The applicant shall also have the burden of updating any information during the credentialing process.
- 4.8 **Health Status.** An applicant for initial appointment or reappointment shall be required by the Executive Committee to submit reasonable evidence of the applicant's ability to perform the essential functions of the requested clinical privileges. At the request of the Executive Committee, this information shall be reviewed by a committee of three (3) physicians consisting of: one (1) physician designated by the Executive Committee; one (1) physician appointed by the applicant, and one (1) physician chosen by these two (2) physicians.
- 4.9 **Application Review Process Generally.** The Administrator or designee shall forward the completed application to the appropriate Section Chief for review and recommendation to the Credentials Committee. Upon completion of his review, the appropriate Section Chief shall forward the application to the Credentials Committee for consideration at its next meeting or as soon thereafter as possible.
- 4.9.1 **Credentials Committee Review.** The Credentials Committee shall review the application, the supporting documentation, the appropriate Section Chief's report and recommendations, and such other information available to it that may be relevant to consideration of the applicant's qualifications

for the Staff category and clinical privileges requested. Within ninety (90) days of the Hospital's receipt of the completed application, the Chairman of the Credentials Committee shall transmit to the Executive Committee a written report and recommendations as to Staff appointment and, if appointment is recommended, as to Staff category and Section, clinical privileges to be granted and any special conditions to be attached to the appointment. The reason for each recommendation shall be stated and supported by references to the completed application and all other documentation considered by the Credentials Committee, all of which shall be transmitted with the report. Any minority views shall also be reduced to writing, supported by reasons and references, and transmitted with the majority report.

- 4.9.2 **Executive Committee Review.** The Executive Committee shall review the qualifications and other information available to it regarding the applicant, including the recommendations of the appropriate Section Chief and Credentials Committee, and may interview the applicant. The applicant shall appear for any requested interview. After deliberation, the Executive Committee recommendation shall be either to recommend the appointment, defer the decision, or reject the application. The recommendation of the Executive Committee shall be made within thirty days of receipt of the report of the Credentials Committee.

If the recommendation is for appointment, the Administrator or designee shall forward the application to the BOD for final action. When the recommendation of the Executive Committee is adverse to the applicant, the Administrator shall promptly provide the applicant with written notice by personal delivery or by certified mail, return receipt requested. The adverse recommendation need not be forwarded to the BOD until the applicant exercises or waives the rights to a hearing and appellate review as provided in these Bylaws. The time parameters for processing the application shall be suspended pending waiver or completion of the hearing and/or appellate review.

- 4.9.3 **BOD Grants Appointment.** If the Executive Committee recommends that the applicant be appointed, the Administrator or designee shall forward the application to the BOD for final action at its next meeting, or the Executive Committee of the BOD for interim action pending final action by the BOD.
- 4.9.4 **BOD Takes Adverse Action.** At its next regular meeting after receipt of a favorable recommendation from the Executive Committee, the BOD shall consider the matter. If the BOD's decision results in an Adverse Action, the applicant shall be entitled to a notice and hearing as provided in Article Fourteen; provided, however, that the hearing committee shall consist of three Medical Staff members and two independent persons who need not be Medical Staff members but must be physicians. The time parameters for processing the application shall be suspended pending the review by the hearing committee.
- 4.9.5 **BOD Defers Final Action.** The BOD may also defer final determination by referring the matter to the Executive Committee for reconsideration of

specific points. Any such referral shall state the reason and shall set a time limit within which a subsequent recommendation to the BOD shall be made. At its next regular meeting after receipt of such subsequent recommendation the BOD shall make a decision to either appoint the applicant to the Staff or reject him for Staff membership.

- 4.9.6 **BOD Final Action.** When the decision of the BOD is final, it shall send notice of such decision through the Administrator to the Secretary of the Medical Staff, to the Chairperson of the Executive Committee, and by personal delivery or by certified mail, return receipt requested, to the applicant. Such notice shall be provided within twenty (20) days of the final decision of the BOD. The BOD's decision to accept or reject the application for membership or privileges shall be conclusive. All decisions to appoint shall include a delineation of clinical privileges which the applicant may exercise.
- 4.9.7 **Executive Committee of BOD.** Following the recommendation of the Executive Committee, if the BOD is next scheduled to meet such that the time parameters set forth in Section 4.10 cannot be met, then the Executive Committee of the BOD may make an interim decision pending a final decision of the BOD.
- 4.10 **Customary Processing Time.** Only complete applications shall undergo processing. A complete application shall customarily be processed within one hundred fifty (150) days. All general time parameters referenced in these Bylaws shall be measured from the time at which the applicant caused to be furnished all information that was reasonably requested in accordance with these Bylaws through the submission of a completed application. Such time parameters may, however, be suspended as provided in these Bylaws. The time parameters specified shall be for the guidance of the committee concerned and shall not be deemed to create any right for a Practitioner to require the processing of his application within such parameters, except that (subject to appropriate suspensions) the Credentials Committee must make a recommendation within ninety (90) days after receipt of a completed application, the BOD (or the Executive Committee of the BOD pending final action of the BOD at its next meeting) must then take final action within sixty (60) days after the Credential Committee's recommendation, and the Hospital must notify the applicant within twenty (20) days after the BOD and/or the Executive Committee of the BOD has made its decision.
- 4.11 **Reapplication after Denial.** An applicant may not reapply for one (1) year from the date of any final decision denying any initial appointment, reappointment, or following dismissal or resignation; however, in the event a denial was based on a legal deficiency such as suspension of licensure or limitation of DEA permit, an applicant may reapply at any time following removal of the legal deficiency, in accordance with the appropriate application procedures set forth in these Bylaws. If a dismissal is due to a medical record deficiency, an applicant may reapply following resolution of the medical record deficiency, in accordance with the appropriate application procedures set forth in these Bylaws and subject to restrictions as may be set forth in the Medical Staff Bylaws and Rules & Regulations.

4.12 **Reappointment.** Only applicants who satisfy the qualifications for Staff membership contained in Section 4.2 shall be eligible for reappointment. All reappointments require completion of the application for reappointment, and all applicants for reappointment must provide updated information of the items set forth in Subsections 5, 6, 8, 9, 10, 11, 12 and 13 of Section 4.5. There is absolutely no vested right of renewal or reappointment, such right resting solely at the discretion of the BOD, and all such renewals or reappointments are subject to suspension and termination in accordance with these Bylaws. Reappointments will be scheduled on a quarterly basis by Sections and/or Section (Specialties) sub-specialties and will be for a two-year period, or earlier if necessary to fall with the specialty reappointment schedule. Reappointment applications shall be submitted to the Administrator or designee in a timely manner such as to allow the Executive Committee to make written recommendation to the Board of Directors at its regularly scheduled meeting prior to any new beginning reappointment period. The Executive Committee shall make written recommendation to the BOD through the Administrator concerning the reappointment, non-reappointment, and delineation of clinical privileges of each applicant. Where non-reappointment or a reduction in clinical privileges is recommended, the reasons for such recommendation shall be stated and documented, and notice thereof shall be given in accordance with Article 14.3. Where non-reappointment, provisional reappointment, or a reduction in clinical privileges is recommended, the reasons for such recommendation shall be stated and documented, and notice thereof shall be given in accordance with Article 13.3. (14.3).

Each recommendation concerning reappointment of the Medical Staff members and the clinical privileges to be granted upon reappointment shall be based upon such members' professional competence and clinical judgment and the treatment of patients, quality management and utilization information, professional education, medical ethics and professional conduct, attendance at Medical Staff meetings, participation in Staff affairs, including service on Committees, and compliance with Medical Staff Bylaws and Rules. Applicants for reappointment will be required to submit reasonable evidence of their ability to perform the essential functions of the clinical privileges requested.

Provisional reappointments may be used by the Medical Executive Committee (MEC) when the Ongoing Professional Performance Evaluation (OPPE) process identifies ongoing and/or significant non-compliance with rule and/or rate based indicators or significant clinical events. The physician will be notified in writing by the MEC that they will be subject to Focused Professional Performance Evaluation (FPPE). The MEC will specify the FPPE time frame and the clinical quality indicators which are subject of review. At the end of the predetermined provisional period, the QI Coordinator will submit a written report to MEC for review. The MEC will review the information and forward a recommendation to the BOD for continued provisional reappointment or to be returned to previous medical staff status. The physician will be notified in writing of the determination.

4.13 **Procedure for Reappointment.** The Medical Staff shall be divided into Sections and/or Section sub-specialties with specific Sections/Section sub-specialties being reviewed in-depth each quarter by the Executive Committee to determine if any change should be made in the Staff members' privileges. A Staff member shall be afforded due process rights described in these Bylaws in the event of any adverse

recommendation of the Executive Committee, and prior to any final action by the BOD.

4.14 **Clinical Privileges**

4.14.1 **Grant by BOD.** Every Staff member shall be entitled to exercise only those clinical privileges that the BOD may specifically grant to the individual.

4.14.2 **Term.** Clinical privileges are granted for a period not to exceed two (2) years.

4.14.3 **Applicant's Burden.** Every application for Staff appointment and reappointment shall be accompanied by a request for the specific clinical privileges desired on such form as the Hospital may provide. The applicant bears the burden of providing documentation of training and experience sufficient to evaluate and support all clinical privileges requested, and to resolve any doubts concerning the requested clinical privileges.

4.14.4 **Basis for Award of Clinical Privileges.** The evaluation of all requests for initial clinical privileges and also for periodic reappointment of clinical privileges shall be based upon:

- the applicant's education, training, experience, current competence, references, peer recommendations, current ability to perform the essential functions of the clinical privileges requested, board certification, demonstrated ability, observed clinical performance and judgment, continuing education activities, review of patient records, any information concerning quality management, evaluation, and monitoring activities, and other relevant information. Information may be obtained from Hospital and Staff records and from other healthcare facilities where the individual rendered clinical services, licensing authorities, and all other relevant sources. Clinical privileges shall be awarded only within the scope of any license, certificate, or legal credential authorizing the individual to practice in Texas, consistent with any limitations or restrictions imposed.
- the availability of sufficient space, equipment, staffing and financial resources within the facility will be provided by the VPMA or CMO. The Board may at any time after considering the recommendation of the MEC direct that specific procedures or clinical practices not be performed at the Hospital if the Board determines that such practices or procedures are not medically acceptable, cannot be performed at the hospital, are inconsistent with the mission, operation or principles of the Hospital, or for any other reason determines that the procedures or services should not be performed within the Hospital. There shall be no appeal or hearing with regard to any decision by the Board that any practices or procedures are not permitted to be performed in the hospital.

4.14.5 **Procedure.** All requests for clinical privileges shall be processed in accordance with procedures similar to those used for appointment and reappointment.

4.15 **Continuing Education.** All Staff members must participate in continuing education activities as required by the Texas State Board of Medical Examiners.

4.16 **Temporary Privileges**

4.16.1 **Conditions for Temporary Privileges.** The granting of temporary privileges is a wholly discretionary action, to be exercised only when the information then available is determined to provide an adequate basis for judgment concerning the competence and ethical standing of the applicant. Temporary privileges will only be granted when the applicant's file is free of concerns and the applicant's membership is needed to provide a patient care service the facility could otherwise not provide. In all cases, state licensure and Texas DPS permit must be verified through primary sources (modem verification or a call to the Texas State Board of Medical Examiners or Texas Department of Safety is sufficient), and copies of DEA, a malpractice insurance policy summary, and demonstration of current competence in compliance with Medical Staff Office policies must be submitted before temporary privileges may be granted. In all cases, the individual requesting temporary privileges must, before any such privileges may be granted, acknowledge that he agrees to be bound by the terms of the Medical Staff Bylaws and Rules and by the rules of the Hospital in all matters relating to such temporary privileges. Individuals granted temporary privileges may not vote, hold office, or serve on committees, but shall attend such meetings and perform duties to which he is assigned.

The privileges requested:

- a. may be granted in whole or in part;
- b. may be exercised by the applicant under the supervision of a Staff member designated by the appropriate Section Chief or VPMA or CMO, unless the BOD specifically waives this requirement; and
- c. may be subject to any special requirements of supervision, reporting, and review by the Credentials Committee.

4.16.2 **Grant of Temporary Privileges.** The Administrator, the VPMA, the CMO, and the Chief of Staff, or their designees, upon the recommendation of the applicable Section Chief or his designee, shall have the authority and discretion to grant temporary privileges to an applicant who meets all requirements and desires such privileges. Temporary privileges may be granted for the following reasons:

- a. **During pendency of application:** Upon receipt of a completed application for Staff membership from an appropriately licensed practitioner who requests temporary privileges, including Locum Tenens, the requesting practitioner may be granted temporary privileges for a period of no more than 120 days.
- b. **To treat specific patients:** Upon receipt of a formal written request from an appropriately licensed practitioner to consult on one specific patient, temporary clinical privileges may be granted for a period not to exceed thirty (30) days.

4.16.3 Termination of Temporary Privileges. Temporary privileges shall automatically expire in accordance with the preceding sections under which they have been granted, unless terminated as hereinafter provided. After recommendation for termination of temporary privileges by the Executive Committee, the VPMA, the CMO, or by the Chief of Staff, based upon information or the occurrence of any event of a nature which raises questions regarding professional or ethical qualifications or ability to adhere to or exercise any or all of the temporary privileges granted, the Administrator may terminate any or all of the privileges. In the event of any such termination, the Chief of Staff shall assign that individual's patients then in the Hospital to a Staff member with appropriate clinical privileges. The wishes of the patient shall be considered, when feasible, in choosing a substitute.

4.16.4 No Due Process Rights. An individual is not entitled to the procedural rights set forth in these Bylaws because a request for temporary privileges is refused, or because all or any portion of the temporary privileges is terminated or suspended.

4.17 Emergency Privileges. For the purposes of this section, an "emergency" is defined as a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger. In the case of an emergency, any practitioner, to the degree permitted by his license and regardless of department, Staff category, Staff appointment or clinical privileges, shall be permitted to do, and be assisted by Hospital personnel in doing, everything possible to save the life of a patient or to save the patient from serious harm.

In the event of an emergency occurrence ("disaster") when the disaster plan has been implemented and the immediate needs of the patients cannot be met, the hospital may grant temporary disaster privileges to volunteers eligible to be Licensed Independent Practitioners and to dependent Allied Health Professionals (nurse practitioners and physician assistants) to provide care and treatment to patients. Temporary privileges may be granted to a practitioner who is not a member of the Staff in emergency situations by the Administrator On-Call, CEO, Vice President of Medical Affairs, Chief Medical Officer, or their designee. See Policy on "Privileging of Licensed Independent Practitioners during Disaster Events" and "Privileging of Dependent Allied Health Professionals During Disaster Events".

4.18 Change in Staff Status, Modification of Privileges. It is the responsibility of the appropriate Clinical Section Chief to make recommendations to the Credentials Committee regarding a request for modification of clinical privileges, or transfer from one Clinical Section to another. A Staff member having the appropriate qualifications and desiring modification of clinical privileges or a change to a different Staff category, shall submit a written request indicating the desired change and the reason for the change together with supporting documents as required by the Credentials Committee. Requests shall be processed in a manner similar to the appointment procedure. All additional privileges granted may include a required observation period, and the Credentials Committee has the discretion to condition the grant of additional privileges requiring a Staff member to take certain continuing medical education courses. Unless otherwise provided

in these Bylaws, when a decision denying a request for modification of clinical privileges occurs, a Staff member shall be entitled to the procedural rights set forth in Article Fourteen. After a final decision has been made, an individual may not request a substantially similar modification during the remainder of his two-year appointment period; provided, further, that any individual receiving a final decision denying a request for modification of clinical privileges during the last three (3) months of any appointment period may not submit a request for substantially similar modification during his next two-year appointment period. In the event that the Staff member obtains the necessary continuing medical education or additional training as required by the Credentials Committee to qualify for the requested modification of clinical privileges, such request will be processed upon receipt of all necessary documentation.

- 4.19 **Admission of Patients.** Dentists and podiatrists Medical Staff members may admit patients if a physician Staff member having appropriate clinical privileges performs the admitting history and physical except the portion related to dentistry or podiatry. Qualified oral surgeons Medical Staff members may admit patients, perform the admitting history and physical, and provide the medical management for their patients, but a physician Staff member shall be responsible for the overall medical condition of all patients admitted by a dentist or podiatrist.

The admitting physician shall be held responsible for the preparation of complete medical records to include timely entry of all significant information into the patient's medical record. The admitting Medical Staff member will provide a complete handwritten or dictated history and physical examination for all inpatient and observation patients regardless of length of stay.

When an H & P is completed within the 30 days before admission or registration, an updated medical record entry documenting an examination for any changes in the patient's condition is placed in the patient's medical record within 24 hours after admission or registration, but in all cases involving surgery or a procedure requiring anesthesia services, prior to the surgery or procedure. The examination must be conducted by a practitioner who is credentialed and privileged by the Medical Staff to perform and H & P.

The update note must document an examination for any changes in the patient's condition since the time that the patient's H & P was performed that might be significant for the planned course of treatment. The physician, oral maxillofacial surgeon, or qualified licensed individual uses his clinical judgment, based upon his assessment of the patient's condition and co-morbidities, if any, in relation to the patient's planned course of treatment to decide the extent of the update assessment needed as well as the information to be included in the update note in the patient's medical record.

The H & P must include the following elements to be considered complete (use of "noncontributory" is an acceptable entry if applicable):

INPATIENT ADMISSIONS	OUTPATIENT/AMBULATORY
a. Chief Complaint (reason for admission) b. Physical exam (must include all elements to be complete)	a. Chief Complaint (reason for admission) b. Physical exam (must include all elements to be complete)

<ul style="list-style-type: none"> • Details of Past History • EENT • Lungs/Heart • Abdomen • Pelvic/Rectal <p>c. Diagnosis/ Impression d. Treatment Plan</p>	<ul style="list-style-type: none"> • Details of Past History • EENT • Lungs/Heart • Abdomen • Pelvic/Rectal <p>c. Diagnosis/ Impression d. Treatment Plan</p> <p>MAY USE SHORT FORM H & P</p>
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4.20 **Employee or Independent Contractor.** The Staff appointment and clinical privileges of any Staff member who is a Hospital employee or who has a contractual relationship with the Hospital, or is an employee, or principal of, or partner in, an entity that has a contractual relationship with the Hospital, relating to providing services to the Hospital or services to patients at the Hospital, shall be subject to the same procedures, rights, and responsibilities set forth in these Bylaws for Staff members. The Medical Staff membership and clinical privileges may also be addressed in any contract or agreement with the Hospital. Unless the contract or agreement otherwise provides, the Staff membership and clinical privileges of a Staff member shall not terminate automatically upon any termination of the agreement or contract, and the Staff member shall retain all rights to a hearing or appellate review as provided in these Bylaws.

4.21 **Emergency Department Physicians.** Physicians who limit their practice to emergency service shall be subject to the same qualifications for appointment, reappointment, clinical privileges and assignment to Staff category as those required for other Medical Staff applicants, with the exception that they are not required to live within a 15-mile radius of the Hospital. ED Physicians may be members of the Active Staff and have privileges to initiate admitting orders and admit patients to the facility. The orders must be in consultation with the attending physician and shall direct the admission of patients to the service of the responsible attending physician. ED Physicians cannot serve as attending physicians.

ARTICLE FIVE: CATEGORIES OF THE MEDICAL STAFF

5.1 **General Staff.** The Medical Staff shall be divided into the Active, Associate, Courtesy, Consulting, Active-Affiliate, and Honorary categories. All Staff members are assigned to a Clinical Section.

5.2 **The Active Medical Staff.** The Active Medical Staff shall consist of physicians, dentists, and podiatrists (M.D., D.O., D.D.S., D.P.M.) who satisfy the basic qualifications set forth in Section 4.2, have satisfactorily served for not less than one (1) full year as members of the Associate Medical Staff, and are actively engaged and interested in the work of the Hospital. Except as otherwise provided in these Bylaws, the Active Staff shall transact all business for the Medical Staff. Active Medical Staff shall have voting rights at all staff meetings.

Participation by members of the Active Medical Staff at Medical Staff is encouraged. The Active Medical Staff shall have priority in the use of all Hospital facilities. Only members of the Active Medical Staff may be eligible to hold office on the Executive Committee. Active Medical Staff members may serve on all committees. Except as otherwise provided in the

Rules, the Active Medical Staff members shall serve on the Emergency Room General Call Roster. The Executive Committee has the authority to excuse members from this call roster based on age, disability, limitation of practice, or other good cause.

5.3 **The Associate Medical Staff.** New members of the Medical Staff who satisfy the basic qualifications set forth in Sections 4.2 and 5.2 shall be assigned to the Associate Medical Staff for not less than one (1) year. Associate Medical Staff members shall be assigned, by the Section Chief, one (1) or more preceptors from among the Active Medical Staff members in the appropriate Clinical Section. The preceptor shall submit a written evaluation(s) of the Associate Medical Staff member to the Section Chief during the Associate Medical Staff member's year of observation. The preceptor's recommendation shall be based on whether the individual is capable of performing the activities for which privileges have been granted, meets acceptable levels of quality, and is complying with these Bylaws and Rules. At the completion of the year, the Section Chief, CMO, or VPMA shall submit a recommendation to the Credentials Committee either to:

- a. Elevate the individual to the Active Medical Staff; or
- b. Retain the individual on the Associate Medical Staff, including any desired recommendation such as for additional observation or modification of clinical privileges for an additional period of up to one (1) year; or
- c. Terminate Staff membership and clinical privileges.

The recommendation of the Section Chief, VPMA, or CMO shall be based, at a minimum, on personal observations, completed written evaluations by the assigned preceptor, quality management information, and attendance at meetings. An individual shall have the right to a hearing and appeal as provided in these Bylaws in the event of a decision by the Executive Committee to terminate Staff membership and clinical privileges but not for a decision to retain him on the Associate Medical Staff. Members of the Associate Medical Staff must attend meetings with the same regularity as Active Medical Staff members. Associate Medical Staff members may serve on all committees except the Executive Committee and shall have the right to vote at Staff meetings and Clinical Section meetings.

They may not, however, hold any office, nor act as chairperson for any committee. Associate Staff members shall serve on the Emergency Room General Call Roster. Only those Associate Medical Staff members who meet the basic qualifications set forth in Sections 4.2 and 5.2 and who satisfactorily complete not less than one (1) full year on the Associate Staff shall be eligible for advancement to the Active Medical Staff. There is absolutely no right to automatic advancement.

5.4 **The Courtesy Medical Staff.** The Courtesy Medical Staff shall consist of physicians, dentists and podiatrists who are members of the Medical Staff and can admit patients to the Hospital but who act primarily in a consultative capacity. A Courtesy Medical Staff member who has more than 3 patient contacts at the Hospital per month will automatically be elevated to Active or Associate Medical Staff membership (whichever is appropriate), as recommended by the Credentials Committee and will be obligated to fulfill the duties as required by that level of Staff membership.

- 5.5 **The Consulting Staff.** The Consulting Staff shall consist of physicians, dentists and podiatrists who are qualified for Medical Staff membership but who only act in a consultative capacity. These members will be required to reside outside a 30-mile radius of this facility and will provide clinical services that are not otherwise available at this facility. Consulting Staff members shall designate only Active members of the Medical Staff who will agree to serve as attending physicians for all admissions.
- 5.6 **The Honorary Medical Staff.** The Honorary Medical Staff shall consist of those physicians, dentists, and podiatrists who are not active in the Hospital and who are honored by emeritus position. These may either have outstanding professional reputations, may or may not be residents of the community, or may have retired from active Hospital service. The Honorary Medical Staff shall be appointed by the BOD on recommendation of the Executive Committee and shall have no assigned duties or responsibilities. Attendance of Honorary Medical Staff members at meetings of the Medical Staff is invited but not required. Members of the Honorary Medical Staff may not vote or hold office, nor shall they be included for the purpose of establishing a quorum. They also may not be granted clinical privileges at the Hospital.
- 5.7 **The Active-Affiliate Staff.** The Active-Affiliate Staff shall consist of practitioners who meet Section 4.2.(a),(b),(g),(h), and (i) of the Qualifications for Medical Staff membership. There is no activity requirement for this category. Active-Affiliate Staff members regularly refer to other members of the medical staff for patient care and treatment, may visit patients they referred for admission and review charts but shall not make entries in the medical record, and may observe procedures with the specific consent of the practitioner performing the procedure. The Active-Affiliate Staff shall attend General Staff and Section Meetings as desired as a non-voting member and may serve on committees upon request of the Medical Executive Committee. An Active-Affiliate staff member who actively serves on a committee shall be granted voting rights during their tenure as a committee member.

ARTICLE SIX: CLINICAL SECTIONS

- 6.1. **Clinical Sections.** Each Clinical Section shall be organized as a division of the Medical Staff as a whole, and each Section shall have a Section Chief and a Vice Section Chief. The Section Chief is responsible to the Chief of Staff and the VPMA or CMO for the functioning of his Section and has general supervision of the clinical work occurring within the Section. The Section Chief's duties shall include presiding over Section meetings, assuring that the quality and appropriateness of care rendered by that Section is monitored, and insuring that all records that include the results and conclusions, recommendations and actions made during a Section meeting are maintained. The Section Chief may appoint such committees deemed necessary to accomplish Section responsibilities. The Vice Section Chief is responsible for assuming all the duties of the Section Chief in his absence and for attending the Performance Improvement Committee meetings.

The Section Chief is accountable for all clinically related and administrative activities within the Section. He shall insure that continuing surveillance of the professional performance of all individuals who have delineated clinical privileges

in the section is carried out. The Section Chief shall recommend to the Credentials Committee the criteria for clinical privileges in his Section, and he shall recommend clinical privileges for each member of that Section. Further, he shall initiate the recommendations for the reappointment of members of his Section. The Section Chief shall assess and recommend to Administration off-site sources for needed patient care services not provided by the Section or the Hospital.

Each Section Chief is also responsible for the integration of the Section into the primary functions of the Hospital; the coordination and integration of intersectional and intrasectional services; the development and implementation of policies and procedures that guide and support the provision of services in the Section; the recommendations for a sufficient number of qualified and competent persons to provide care or service; the determination of the qualifications and competence of Section personnel who are not licensed independent practitioners and who provide patient care services; the continuous assessment and improvement of the quality of care and services provided in the Section; the maintenance of quality control programs, as appropriate; the orientation and continuing education of all persons in the Section; and recommendations for space and other resources needed in the Section.

6.2 **Qualifications, Selection, Removal & Tenure of Section Chief and Vice Chief.** Each Section Chief and Vice Chief shall be a member of the Active Medical Staff qualified by training, experience, and demonstrated ability for the position. Each Section Chief must be certified by an appropriate specialty board recognized by the American Board of Medical Specialists or must affirmatively establish competence comparable to that of an individual with board certification. Each Section Chief and Vice Chief shall be elected by a majority vote of the Section members eligible to vote, at the last regular Section meeting of the Medical Staff Year at which a quorum is present. The election shall be subject however to final approval of the BOD. The Chief and Vice Chief shall each serve a two (2) year term and shall be eligible to succeed himself at the will of the electorate. Removal of a Chief during his term may occur only by a petition signed by two-thirds (2/3) of all voting members of the Section (not including the Chief), but no such removal shall be effective unless and until it has been ratified by the Executive Committee and is further subject to final decision of the BOD. In the event that all Section members are new Staff members appointed to the Associate Medical Staff, an Associate Staff member may be elected Chief.

6.3 **Clinical Section Meetings and Attendance.** Department meetings will be held as called by the Department Chairperson. Section meetings may be called by the Chairperson of the Department or the Chief of the Section as necessary. A special meeting of any Department may be called by the Chairperson or the Chief of Staff.

All Medical Staff members are encouraged to attend their Section meetings. A member of the Staff who has attended a case that is to be presented for discussion at any Section meeting shall be notified in advance and shall be expected to be present. Should the Staff member be absent, the case will be discussed nevertheless, unless the Staff member involved has requested that the discussion be postponed. In no case shall postponement be granted for a period longer than that of the next regular meeting.

- 6.4 **Quorum; Manner or Action.** Thirty percent (30%) of the total membership of a Section or 5 members (whichever is the lesser) shall constitute a quorum. Except as these Bylaws may otherwise specify, action shall be valid when taken by a majority vote at a meeting at which a quorum is present. Only those present may vote; no proxies are permitted.

ARTICLE SEVEN: OFFICERS

- 7.1 **Officers: Election and Removal.** The officers of the Medical Staff shall be the Chief of Staff, the Vice Chief of Staff, and the Secretary, who must be members of the Active Medical Staff. All members of the Active Medical Staff are eligible to hold an officer position and to be nominated in accordance with these Bylaws. They shall be elected by a simple majority of all votes of Active and Associate Medical Staff members cast at the last regular Medical Staff meeting of the Medical Staff Year at which a quorum is present; provided, however, that election of the Chief of Staff is subject to confirmation or rejection by the BOD. If no candidate receives a majority of votes on the first ballot, a runoff election shall be held between the two (2) candidates receiving the highest number of votes. The officers shall hold office for the next Medical Staff year and until their successors is elected or until his sooner resignation or removal; officers may be reelected to their office at the will of the electorate. Any officer may resign at any time by giving written notice to the Chief of Staff or to the Secretary. Any officer may be removed by the Medical Staff whenever, in its judgment, the best interests of the Medical Staff would be served. Removal must be based on failure to perform duties and responsibilities as defined by these Bylaws or failure to maintain qualifications required to be a member of the Medical Staff. This removal shall require a petition of a two-thirds (2/3) majority of all Active and Associate Medical Staff members.
- 7.2 **Chief of Staff.** The Chief of Staff shall act in coordination and cooperation with the CMO, VPMA, Administrator and BOD in all matters of mutual concern within the Hospital and shall enforce these Bylaws and the Rules. The Chief of Staff shall call and preside at meetings of the Medical Staff, serve as Chairman of the Executive Committee, serve as an ex-officio member of all committees, serve on the BOD, grant temporary privileges with the CMO, VPMA and/or Administrator, oversee the Section Chiefs, act as the spokesman for the Medical Staff, and perform such other functions as may be assigned by these Bylaws, the BOD, the Medical Staff, or the Executive Committee. The Chief of Staff shall appoint all members of the standing committees of the Staff, as well as the chairperson of each committee. The Chief of Staff shall serve a one (1) year term; with the option of serving 2 years.
- 7.3 **Vice Chief of Staff.** The Vice Chief, in absence of the Chief, shall have the authority and assume all duties of the Chief. The Vice Chief is expected to perform such duties as may be assigned by the Chief of Staff. Because the Vice Chief may become the Chief of Staff, he shall be expected to learn and understand the responsibilities and duties of the Chief of Staff. The Vice Chief of Staff will attend and chair the Performance Improvement Council and provide a report to the Medical Executive Committee at their meetings. The Vice Chief shall serve a one (1) year term; with the option of serving 2 years.

- 7.4 **Secretary.** The Secretary shall assure that accurate minutes of all meetings are kept, attend to all correspondence, and excuse absences from Medical Staff meetings. If there are funds to be kept, the Secretary shall also act as Treasurer. The Secretary shall serve a one (1) year term; with the option of serving 2 years.
- 7.5 **Succession of Officers.** In the absence of the Chief of Staff or failure of the Chief of Staff to serve for any reason, those duties shall be performed and such authority exercised during the Chief's absence throughout the remainder of the term by the first available individual in the following sequence: Vice Chief of Staff, Secretary. In the absence of the Vice Chief of Staff or failure of the Vice Chief to serve for any reason, those duties shall be performed and such authority exercised during the remainder of the Vice Chief's term by the Secretary; provided however, the Secretary may not simultaneously serve as both the Vice Chief and Chief. Any vacancy not filled by this procedure shall be filled at a special meeting of the Medical Staff at which a quorum is present by majority vote of Staff members eligible to vote.

ARTICLE EIGHT: MEDICAL STAFF COMMITTEES

- 8.1 **Types of Committees and Procedures.** Committees may be standing or Ad Hoc. Unless procedures are otherwise prescribed by these Bylaws, the current edition of Roberts Rules of Order will be followed in all committee meetings.

8.2 Standing Committees

- 8.2.1 **The Executive Committee.** The Executive Committee shall consist of the current Medical Staff Officers, the immediate past Chief of Staff and the Clinical Section Chiefs. The CEO and the Officers of the Medical Executive Committee may nominate up to four at large positions to serve 1 year terms. These at large members must be approved by a majority of the MEC and the Board of Directors and may be reappointed for additional 1 year terms.

Podiatrists and dentists are eligible to serve on the Executive Committee; however, a majority of members must always be physicians. The Administrator or his/her designee and the VPMA and CMO shall be ex-officio members; provided, however, the Administrator or his designee, the VPMA, and the CMO may not vote, nor may be counted for the purpose of determining a quorum. Other persons may be invited to attend as necessary.

The Executive Committee shall meet at least monthly and shall maintain a permanent record of its proceedings.

The duties of the Executive Committee shall be to act for the Staff as a whole in the interval between Medical Staff meetings under such limitation as may be imposed by the Medical Staff; to coordinate the activities and general policies of the Clinical Sections; to adopt Rules and Procedures; to provide a liaison between the Medical Staff, Administration, and the BOD;

to conduct peer review activities; and, to receive and act upon reports of such other committees as are appropriate.

The Executive Committee shall review the reports such as the Credentials Committee regarding new applicants for the Medical Staff, as well as for reappointment, and it shall make appropriate recommendations to the BOD. Further recommendations may include the following: the structure of the Medical Staff; the mechanism used to review credentials and to delineate individual clinical privileges; recommendations of individuals for Medical Staff membership; recommendations for delineated clinical privileges for each eligible individual; the organization of the performance improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities; the recommendations for corrective action concerning Staff members; mechanisms by which membership on the Medical Staff may be terminated; the mechanism for fair hearing procedures; and, such other recommendations to the BOD as it deems appropriate.

In the performance of its duties, the Executive Committee shall receive and act on reports and recommendations from Medical Staff committees, Sections, and assigned activity groups.

The Organized Medical Staff has the ability to adopt medical staff bylaws, rules and regulations, and policies, and amendments thereto, and to propose them directly to the Board of Directors per policy "Access to the Board of Directors by the Organized Medical Staff". However, outside of the use of this policy, the Organized Medical Staff delegates to the Medical Executive Committee the ability to adopt and amend the rules and regulations, privilege forms, and/or policies.

At least 2 weeks prior to the Medical Executive Committee meetings, all items on the agenda (along with details adequate for explanation) that require a vote by the MEC (i.e. rules and regulations, policies, procedures, and privilege forms) shall be posted in the Physician's Dining Room for review by the organized medical staff. If members of the organized medical staff have questions, concerns or opposition to those items, they should contact the Medical Staff Office.

No action of the Executive Committee shall be valid unless taken at a meeting at which a quorum is present, except that action may be taken without a meeting if consent in writing setting forth the action so taken shall be signed by each person serving on the Executive Committee. In appropriate circumstances determined by the Chairperson, meetings may also be conducted by telecommunication, provided a quorum is connected either in person or by telecommunication linkage and the Executive Committee is in audio communication during the duration of the meeting. A quorum shall consist of one-half (1/2) of the Executive Committee members. The use of proxies is not permitted.

8.2.2 Nominating Committee. The Nominating Committee shall consist of the three (3) most recent past Chiefs of Staff who are still on the Medical Staff and the Administrator. The Nominating Committee shall present one (1) or

more candidates for each office to be filled by vote of the Medical Staff. Such nominations shall be reported to the Executive Committee at its last regular meeting immediately preceding the last meeting of the Medical Staff Year. Nominations for such offices may also be made by a petition signed by twenty percent (20%) of the Active Medical Staff and filed with the Secretary and the Administrator at least five (5) days before such annual meeting of the Medical Staff at which elections are to take place.

- 8.2.3 **Bylaws Committee.** The Bylaws Committee shall consist of the three (3) most recent past Chiefs of Staff, who shall serve staggered three-year terms. The member with the most seniority on the Bylaws Committee shall serve as chair, unless otherwise designated by the Chief of Staff. The Bylaws Committee shall meet at least annually and also at the call of the chairperson. The responsibility of the Bylaws Committee is to review Medical Staff Bylaws, Rules and Regulations and make recommendations to the Executive Committee for any updating or amending of these as is appropriate.
- 8.2.4 **Ad Hoc Committee.** An Ad Hoc Committee is one so constituted by the Chief of Staff, the VPMA, CMO, or the Executive Committee to deal with a specific problem or situation; and, the constituting authority shall appoint a chairperson from among the members of the Active Medical Staff. When the problem is resolved, the committee is disbanded unless the Staff chooses to make the committee a Standing Committee by amending these Bylaws. Ad Hoc committees shall meet at the call of the Chairperson.
- 8.3 **Frequency of Meetings.** The annual meeting shall be the last meeting of the Medical Staff Year. Except where these Bylaws specify otherwise, all committees shall meet at least quarterly and also at the call of the Chairperson with sufficient frequency to promptly discharge committee duties.
- 8.4 **Membership.** Except where otherwise specifically provided, the Chief of Staff shall, with the consent of the Executive Committee, appoint the members of all Medical Staff standing committees from among the members of the Active or Associate Medical Staff. The Chief of Staff shall designate a member of the Active Medical Staff as Chairperson of each committee except when the Bylaws otherwise specifically designate a Chairperson. The Chairperson of each committee shall insure that minutes for each meeting are maintained, including a record of the attendance of committee members. Any member of the Medical Staff may, in the same manner, be appointed as an ex-officio member on one or more committees. The Chief of Staff, the VPMA, the CMO, and the Administrator or his designee shall be ex-officio members of all Medical Staff committees.
- 8.5 **Term of Office.** Except where otherwise specifically provided, a committee member shall serve until the last regularly scheduled committee meeting of the Medical Staff Year, and until a successor is appointed, unless such member is sooner removed or the committee is terminated.
- 8.6 **Removal.** Any Medical Staff committee member may be removed upon the recommendation of the Chief of Staff, with or without cause, whenever the best interests of the Hospital will be served by such removal, unless overruled by two-thirds (2/3) majority vote of the Executive Committee.

- 8.7 **Vacancies.** The Chief of Staff may fill any vacancies in the membership of any Medical Staff committee.
- 8.8 **Action; Quorum.** Except as these Bylaws may otherwise specify an action shall be valid when approved by a majority of committee members at a meeting at which a quorum is present. Only those members in attendance may vote; "in Absentia" and "proxy" votes are not permitted. Thirty percent (30%) of the total membership of a committee shall constitute a quorum; provided, however, that fifty percent (50%) of the total membership of a committee shall constitute a quorum if that committee has five or fewer members.
- 8.9 **Minutes.** Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. Each committee shall maintain a permanent file of the minutes of each meeting. It shall be the responsibility of the Administrator to designate an individual to record minutes in compliance with this section.

ARTICLE NINE: MEDICAL STAFF MEETINGS

- 9.1 **Regular Medical Staff Meetings.** The objectives of Staff meetings are to ensure the care and treatment of patients in the Hospital and the conduct of the business of the Staff. These regular meetings of the Medical Staff shall be held quarterly. In addition to the matters of organization, the program at such meetings shall include reports of the Executive Committee and other pertinent committee reports.

At the last regular Medical Staff meeting of the calendar year, officers and committees shall make such reports as necessary for the ends of their terms and the officers for the coming terms shall be elected.

- 9.2 **Called Meetings.** Special meetings of the Medical Staff may be called at any time by the Chief of Staff, the Executive Committee, the VPMA, the CMO, or the Administrator. Written notice of special meetings must be delivered at least five (5) working days in advance in each physician's mailbox at the Hospital. In addition, a telephone call must be placed to the physician's office at least two (2) working days in advance of the meeting (a telephone call to a multi-provider clinic shall be deemed given to all physicians who practice at such clinic). At any special meeting, no business shall be transacted except that stated in the notice. Such notice shall state the exact time and location of the meeting.
- 9.3 **Attendance at Meetings.** Attendance by members of the Medical Staff is encouraged at all meetings, scheduled or called.
- 9.4 **Quorum; Action.** Five (5 %) of the total membership of the Active Medical Staff and Associate Medical Staff shall constitute a quorum for regular or special Medical Staff meetings. Only those present may vote; "in absentia" and "proxy" votes are not permitted. Except as these Bylaws may otherwise specify, an action shall be valid when taken by a simple majority vote at a meeting at which a quorum is present. Members of the Courtesy and Consulting Staffs cannot vote.

Members of the Active-Affiliate Staff cannot vote except for the duration they are serving on a committee.

ARTICLE TEN: MISCELLANEOUS

- 10.1 Rules. The Executive Committee shall adopt, amend, or repeal rules and regulations as may be necessary to implement the general principles within these Bylaws. Any such rules and regulations shall become effective on final approval of the BOD.
- 10.2 Policies and Procedures. In furtherance, and not in contradiction, of these Bylaws and Rules of the Medical Staff, the Executive Committee may adopt implementing policies and procedures which shall become effective upon approval by the BOD. Such implementation shall be subject to revocation by vote of a majority of the members of the Active and Associate Medical Staff at a meeting at which a quorum is present, or by the BOD.
- 10.3 Adoption and Modification of the Bylaws. Recommendations for amendment are made to the Medical Executive Committee by the Bylaws Committee, and may originate from that Committee or be proposed to the Medical Executive Committee by any member of the Active or Associate Medical Staff or the Hospitals President/CEO. These recommended amendments to the Bylaws, Rules and Regulations, and Policies & Procedures may be approved or amended and approved by the Medical Executive Committee after a simple majority vote. The amendments will then be distributed to the Active and Associate members of the medical staff at least 14 days prior to the next Medical Executive Committee meeting. If 10% or less of those active staff members objects, the amendments will be forwarded to the Board of Directors for approval. Such amendment(s) shall be effective when approved by the Board of Directors.

The Medical Executive Committee's recommendation may be acted upon by the Board of Directors unless more than 10% of the active staff members object. If more than 10% of the active and associate staff members object to a proposed amendment, the Chief of Staff or the Medical Executive Committee will schedule and hold a general staff meeting at which the proposed amendment will be presented, discussed, and acted upon. The affirmative vote of a majority of those active or associate staff members present and voting is required for passage. Such amendment(s) shall be effective when approved by the Board of Directors.

The Medical Executive Committee shall have the power to adopt such amendments to the Bylaws, Rules and Regulations, and Policies & Procedures as are, in the committee's judgment, technical or legal modification or clarifications; reorganization or renumbering; or amendments needed because of punctuation, spelling, or other errors of grammar or expression. Such amendment(s) shall be effective when approved by the Board of Directors.

- 10.4 The Medical Staff Bylaws, rules and Regulations, and Policies and Procedures will be reviewed bi-annually for updates and/or amendments as deemed necessary or appropriate.

ARTICLE ELEVEN: ALLIED HEALTH PROFESSIONAL PERSONNEL

11.1 **Allied Health Professional Personnel Categories.** Allied Health Professionals (AHPs) are divided into two categories: Independent and Dependent. AHPs shall not be considered to be members of the Medical Staff. If requested, AHP may serve on Staff Committees.

11.1.1 **Independent AHP.** Independent AHPs may qualify to practice their profession in the Hospital, and/or conduct approved research, service, and educational activities in the Hospital within the limitations as provided by law and the practice privileges granted by the BOD. The medical condition of the patient shall be the responsibility of a physician member of the Medical Staff having appropriate clinical privileges. For example, this category shall include psychologists.

11.1.2 **Dependent AHP.** Termination of the supervising member of the Medical Staff terminates all duties of the dependent Allied Health Professional.

11.1.2.1 **Physician Assistants.** A Physician Assistant may be granted Core Job Duties consistent with all applicable Texas State laws and regulations and with the Medical Staff Bylaws and Rules and Regulations, and that are within the scope of practice of the supervising Medical Staff member of the Active Staff. Physician Assistants may be granted membership under the category of Dependent Allied Health Professional Staff and may provide services under the scope of practice set forth in the Physician Assistant-Job Description MS-PP-28.

11.1.2.2 **Advanced Practice Nurses.** An Advanced Practice Nurse (APRN) is a licensed registered nurse who has been certified by a nationally recognized certifying body and who has met the criteria for an advanced practice nurse as established by the Texas State Board of Nursing. An APRN shall include but not be limited to the following: Certified Nurse Midwife (CNM), Certified Registered Nurse Anesthetist (CRNA) and Nurse Practitioner (NP). The APRN participates as part of the medical or surgical team and is responsible for working in collaboration with and under the supervision of physician(s) in the maintenance and management of patients. Advanced Practice Nurses may be granted membership under the category of Dependent Allied Health Professional Staff and may provide services under the scope of practice set forth in the Advanced Practice Nurse-Job Description MS-PP-27.

11.2 **Qualifications for Allied Health Professional Staff.** AHPs are not eligible for Medical Staff membership. Such AHPs are eligible for practice core job duties in the Hospital only if they hold a license, certificate or other legal credential in a category of AHPs identified as eligible to apply for practice privileges; document their experience, background, training, demonstrated ability, judgment, and ability to perform the essential functions of their duties with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency established by the Hospital and that they are qualified to exercise practice privileges within the Hospital;

maintain professional liability insurance having such limits as the BOD shall require; and are determined, on the basis of documented references, to adhere strictly to the lawful ethics of their respective professions; to work cooperatively with others in the Hospital; and to be willing to commit to and regularly assist the Hospital in fulfilling its obligations related to patient care, within the areas of their professional competence and credentials.

- 11.3 **Responsibilities.** AHPs are required to abide by all applicable provisions of the Medical Staff Bylaws, Hospital Bylaws, Rules, policies, BOD directives, professional ethics, and the Ethical and Religious Directives for Catholic Health Facilities. AHPs shall prepare medical records in accordance with applicable Hospital rules; provide care to medically indigent patients on request of the Administrator; participate in quality management programs; retain appropriate responsibility for the care and supervision of his patients; participate in patient care audits, evaluations, and monitoring activities of initial AHP appointees; and discharge such other functions as may be required.
- 11.4 **Application for Initial Appointment and Renewal.** Individuals desiring AHP status must apply and qualify for practice privileges, and Medical Staff appointees who desire to supervise or direct AHPs who provide dependent services must apply and qualify for privileges to supervise approved AHPs. Completed applications for initial granting and renewal of practice privileges shall be submitted and processed in a parallel manner to that provided in these Bylaws concerning Medical Staff appointees, unless otherwise specified in these Bylaws or the Rules. AHPs may exercise only those practice privileges as approved by the BOD.
- 11.5 **Appointment, Reappointment.** Appointment to AHP status shall be for a maximum period of two (2) years. All appointments and renewals confer absolutely no vested rights, nor any right to reappointment, and shall be subject to suspension or termination, with or without cause, at any time by the BOD.
- 11.6 **Due Process.** Physician Assistants and Advanced Practice Nurses will be provided written notification of any final actions regarding their application for initial appointment or reappointment and modification or revocation of privileges, including any reason for denial or restrictions of privileges. In the event that any adverse action is taken regarding any of the above, the Physician Assistants or Advanced Practice Nurses shall have the right to request a meeting with the Credentials Committee. All other AHP, however, shall not be afforded the due process set forth in these Bylaws; provided, however, an Independent AHP may request an interview with the Chief of Staff, the VPMA, CMO, or his designee.

ARTICLE TWELVE: CORRECTIVE ACTION

- 12.1 **Routine Corrective Action.** Whenever, in the opinion of the Executive Committee, the activities or professional conduct of any Staff member are considered to be threatening, inflammatory, unacceptably lower than the standards of the Medical Staff, or to be disruptive to the operations of the Hospital, the Executive Committee may institute corrective action against the individual. Requests for corrective action may originate from the Administrator, the VPMA, the CMO, any member of the BOD, an officer of the Medical Staff, or any Clinical Section Chief. All requests for such actions shall be in writing, and shall be made to the Executive Committee,

and shall be supported by reference to specific activities or conduct that constitutes grounds for the request.

The Chairperson of the Executive Committee shall promptly notify the Administrator in writing of all requests for corrective action received by the Executive Committee, and shall continue to keep him fully informed of all actions taken in conjunction therewith. In the event that the Staff member is a member of the Executive Committee, the staff member shall be excluded from all deliberations by the Executive Committee relating to the case.

The Executive Committee shall act upon the request for corrective action. Such actions may include without limitation:

- a. Investigation by the Executive Committee or an ad hoc committee appointed by the Executive Committee;
- b. Rejection of the request for corrective action; or
- c. Imposition of appropriate corrective action as follows:
 1. Issuance of a warning letter, a letter of admonition, or a letter of reprimand.
 2. Recommendation to the BOD that:
 - a. Clinical privileges be reduced, limited, modified, suspended, or revoked, and/or
 - b. That the Medical Staff appointment be suspended or revoked.

If the recommended action of the Executive Committee is an Adverse Action, the individual shall be afforded the due process rights set forth in these Bylaws.

12.2 Emergency Corrective Action. Whenever a Staff member's conduct is so threatening, inflammatory, unacceptably lower than the standards of the Medical Staff, or disruptive to the operations of the Hospital, that action must be taken immediately to protect the life of an actual or prospective patient or to reduce the substantial likelihood of injury or damage to the health, safety, or well-being of any actual or prospective patient, employee, or other person in the Hospital, the Chief of Staff, the Executive Committee, the BOD, the VPMA, the CMO, and the Administrator shall have the authority to summarily suspend the Medical Staff membership and all or any portion of the clinical privileges of the Staff member.

A summary suspension shall become effective immediately upon imposition but shall be subject to review. The authority imposing the summary suspension shall ensure that the Chief of Staff, the VPMA, the CMO, and the Administrator are notified and the Administrator shall promptly give notice of the suspension to the Staff member. If the Chief of Staff, VPMA, CMO, or Administrator imposed the summary suspension, then the Executive Committee shall be convened within seven (7) days to review the action. The Executive Committee may continue or terminate the summary suspension. If the Executive Committee terminates a summary suspension, then the BOD may re-impose the suspension. Upon an adverse decision by the Executive Committee, the suspended Staff member shall be afforded the due process rights set forth in these Bylaws.

In the event of a summary suspension, the Chief of Staff, the VPMA, or the CMO shall ensure that the suspended Staff member's patients then in the Hospital shall

be assigned to another Staff member. The wishes of the patient shall be considered wherever feasible in choosing the substitute Staff member.

12.3 **Automatic Corrective Action.** In certain events, the Administrator, the VPMA, the CMO, or the Chief of Staff may order modification of Staff membership and clinical privileges subject to final confirmation of the BOD.

12.3.1 **Licensure.**

1. **Revocation.** Whenever a Staff member's license or other legal credential authorizing him to practice in Texas is revoked, his Staff membership and the clinical privileges shall be immediately and automatically revoked.
2. **Suspension.** Whenever a Staff member's license or other legal credential is suspended, his Staff membership and clinical privileges shall be automatically suspended effective upon, and at least for, the term of suspension. If a suspension under this section remains in effect for greater than 12 months, the staff member's privileges and membership terminate.
3. **Limitation.** Whenever a Staff member's license or other legal credential is limited or restricted by his certifying authority, those clinical privileges that he has been granted that are within the scope of said limitation or restriction shall immediately and automatically be restricted. In the event that the limitation is probationary, appropriate action shall be taken for the term of the probation.

12.3.2 **Federal or State Drug Permit**

1. **Revocation.** Whenever a Staff member's required federal or Texas permit is revoked, he shall immediately and automatically be divested of any of his rights to prescribe any medications covered by the number.
2. **Suspension.** Whenever a Staff member's required federal or state permit is suspended, he shall be divested at least of the right to prescribe medications covered by the revocation effective upon and for at least the term of suspension. If a suspension under this section remains in effect for greater than 12 months, the staff member's privileges and membership terminate.
3. **Limitation.** Whenever a Staff member is placed on probation, affecting any required Texas permit, he shall immediately and automatically be divested of any rights to prescribe any medications covered by the suspension.

12.3.3 **Insurance.** Whenever a Staff member's insurance expires, staff membership and clinical privileges shall be automatically suspended until written proof of insurance in such form and in amounts as the BOD may require and as set forth in Medical Staff Office Policies is provided.

12.3.4 **Criminal Activity.** Any member of the Medical Staff or AHP Staff who has been convicted of any felony, to include violations of the law pertaining to

controlled substances, illegal drugs, or Medicare, Medicaid, or other federally funded healthcare program, or insurance fraud or abuse, or any member who pleads guilty or nolo contendere to felony charges will automatically relinquish his/her Medical Staff appointment and all clinical privileges/core job duties, pending any appeal of the conviction. Should the conviction be upheld, the loss of the membership and privileges/core job duties will be permanent.

Any Member of the Medical Staff or AHP Staff who has been convicted of any misdemeanor involving violations of the law pertaining to controlled substances, illegal drugs, or insurance fraud or abuse, or any member who pleads guilty or nolo contendere to charges pertaining to the same or is sanctioned by Medicare, Medicaid, or other federally funded healthcare program will automatically relinquish his/her appointment and all clinical privileges/core job duties, pending a review and a decision by the Administrator, VPMA, CMO, and/or Chief of Staff. Depending on the seriousness of the misdemeanor, the Administrator, VPMA, CMO, and/or Chief of Staff may, at their discretion, reinstitute clinical privileges/core job duties and appointment.

Any member of the Medical Staff or AHP staff who is or has been excluded, suspended, debarred or deemed ineligible to participate in Medicare, Medicaid, or any other federally funded healthcare program will automatically relinquish his/her appointment and all clinical privileges/core job duties. The loss of the appointment and privileges/core job duties will be permanent.

12.3.5 **Medical Records.** Failure to complete medical records in a timely fashion, as further specified in Section 15 of the Rules of the Medical Staff, shall result in an automatic suspension. A suspended Staff member may attend patients already hospitalized in the Hospital at the time of suspension, including the performance of elective procedures that were scheduled prior to the imposition of the suspension.

12.3.6 **Leave of Absence.** The failure to reapply for reinstatement or to provide a summary of activities prior to termination of a leave of absence shall result in an automatic termination, as set forth in Section 9 of the Rules. The Staff member must reapply as a new member.

ARTICLE THIRTEEN: CONFIDENTIALITY, IMMUNITY AND RELEASE

13.1 Special Definitions

For the purposes of this Article, the following definitions shall also apply in addition to the definitions previously set forth in these Bylaws:

- a. **Information:** records of proceedings, minutes, records, reports, memoranda, statements, recommendations, data and other disclosures whether in written, electronic, or oral form relating to any of the activities listed in Section 13.5.

- b. **Malice:** the dissemination of a knowing falsehood or with a reckless disregard for whether or not it is true or false.
- c. **Representative:** the BOD and any director or committee thereof; the Administrator, the VPMA, the CMO, the Associate and Assistant Administrators, and their designees; a Medical Staff organization and any member, officer, Section, or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.
- d. **Third Parties:** both individuals and organizations providing information to any representative.

13.2 **Authorizations and Conditions.** By applying for, or exercising clinical privileges or providing specified patient care services within this the Hospital, a healthcare professional, whether a new applicant or a member:

- a. authorizes Representatives to solicit, provide and act upon information bearing on his professional ability and qualifications, licensure, experience, current competence, and ability to perform the essential functions of his duties;
- b. agrees to be bound by the provisions of this Article and to waive all legal claims against CHS, the Hospital, any Representative and any Third Party who acts in accordance with the provisions of this Article; and
- c. acknowledges that the provisions of this Article are express conditions to any application for, or acceptance of, Medical Staff membership or AHP Personnel Staff, the continuation of such membership, or to the exercise of clinical privileges or provision of specified patient services at the Hospital.

13.3 **Confidentiality of Information.** Information with respect to any applicant or member of the Medical Staff or AHP Personnel Staff submitted, collected or prepared by any Representative for the purpose of achieving and maintaining patient care, performing peer review activities, reducing morbidity and mortality, or contributing to clinical research shall, to the fullest extent permitted by law, be confidential and privileged and shall not be disseminated to anyone other than a Representative nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to information of like kind that may be provided by third parties. Any unauthorized dissemination of confidential information shall be deemed disruptive to Hospital operations and shall be subject to corrective action pursuant to these Bylaws. Confidential information shall not become part of any particular patient's file or of the general Hospital records.

13.4 **Immunity from Liability**

13.4.1 **For Action Taken.** No Representative and no Third Party shall be liable for damages or other relief for any action taken or statement or recommendation made within the scope of his/her duties in accordance with the standards of applicable federal or state law.

- 13.4.2 **For Providing Information.** No Representative and no Third Party shall be liable for damages or other relief for providing information, including otherwise privileged or confidential information, to a Representative of or to any other health care entity or organization of health professionals, unless the information was false and the Representative or Third Party knew it was false.
- 13.4.3 **Defense.** Legal defense and protection will be provided to any Representative in connection with the Representative's activities pursuant to this Article according to the BOD's policies for the Representative's acts made in good faith and without malice.
- 13.5 **Activities and Information Covered.** The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or authorized disclosures performed and information received, disclosed, or made in connection with the Medical Staff's, Hospital's or any other health care entity's activities concerning, but not limited to:
- a. applications for appointment, clinical privileges or specified services;
 - b. periodic reappraisals for reappointment, clinical privileges or specified services;
 - c. corrective action;
 - d. hearings and any appellate reviews;
 - e. patient care audits;
 - f. utilization review; or
 - g. other Hospital, department, committee or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.
- 13.6 **Information.** The acts, communications, reports, recommendations, disclosures and other information referred to in this Article may relate to (i) a Staff member, applicant for Staff membership or clinical privileges, or an applicant or member of the AHP Personnel Staff or, (ii) their qualifications, provision of specified patient services, clinical ability, judgment, character, current ability to perform essential functions of their professional duties, professional ethics, or any other matter that might directly or indirectly affect patient care.
- 13.7 **Releases.** Each Staff member, applicant for Staff membership or clinical privileges, applicant or member of the AHP Personnel Staff shall upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of the State of Texas or the United States. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.
- 13.8 **Cumulative Effect.** Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protection provided by law and not in limitation thereof, and in the event of conflict, the applicable law shall be controlling.

ARTICLE FOURTEEN: HEARING AND APPELLATE REVIEW

- 14.1 **Purpose.** The hearing procedures are for the purpose of resolving, on an intra-professional basis, matters concerning professional competence and conduct. As used throughout this Article, the term "affected practitioner" refers to the applicant or Staff member who is entitled by the Bylaws to request a hearing and appellate review for the purpose of reviewing an Adverse Action.
- 14.2 **Right to Hearing.** In the event that an Adverse Action is recommended or taken against a Staff member, the affected practitioner shall be entitled to a hearing before a hearing committee (appointed pursuant to Section 14.5) before the matter is brought before the BOD for its final decision in the matter. The term "Adverse Action" is defined in Section 1.2 of these Bylaws. An individual is entitled to only one hearing and possibly one appellate review concerning the Adverse Action.
- 14.3 **Notice of Adverse Action.** Upon recommending or taking an Adverse Action, the BOD or the Executive Committee, as appropriate, shall immediately notify the Administrator of its action. The Administrator shall promptly notify the affected practitioner and the notice shall also include the following information:
- a. the Adverse Action that is being recommended or taken;
 - b. reasons for the Adverse Action;
 - c. the right to request a hearing on the Adverse Action within thirty (30) days of receipt of the notice of the Adverse Action;
 - d. a summary of the rights in the hearing, including:
 1. a hearing held before a panel of individuals who are not in direct economic competition with the affected practitioner;
 2. a statement that a right to a hearing may be forfeited if the affected practitioner fails to appear without good cause;
 3. a statement of the right to be accompanied by a Staff member, or when timely requested, by an attorney;
 4. the affected practitioner's right to call, examine, and cross-examine witnesses (provided that a Staff member's representative, but not an attorney, may call, examine, and cross-examine witnesses on the affected practitioner's behalf), and the requirement that the affected practitioner prior to commencement of the hearing notify the Administrator of any witnesses expected to testify on his behalf;
 5. a statement of the right to present evidence deemed relevant by the hearing officer or Chairperson of the hearing committee regardless of admissibility in a court of law;

6. a statement of the right to request that a record be made of the proceedings with a copy for the affected practitioner, which shall be arranged by the Administrator, upon payment of any reasonable charges;
 7. a statement of the right to submit a written statement at the completion of the hearing; and a statement of the practitioner's right upon completion of the hearing to receive the written recommendation of the hearing committee including the basis for the recommendation, the final recommendation of the Executive Committee (if applicable), and the written decision of the BOD, including a statement of the basis for the final decision.
- 14.4 **Request for Hearing.** An individual entitled to a hearing may request a hearing only by filing a timely written request that is received by the Administrator within thirty (30) days after the date of the affected practitioner's receipt of the written notice of Adverse Action described in Section 14.3. Failure to timely request a hearing shall be deemed an acquiescence of the Adverse Action and shall constitute a waiver of all rights to a hearing. The Administrator shall promptly notify the Chief of Staff and the VPMA of a request for a hearing.
- 14.5 **Appointment of Hearing Committee.** The Chief of Staff, the VPMA, the CMO, or their designee shall appoint a hearing committee within fourteen (14) days following receipt of a request for hearing; provided, however, that the Administrator may appoint the hearing committee if the BOD took the Adverse Action. Except as otherwise provided herein, the hearing committee shall consist of at least five (5) members from among the Medical Staff. No member of the hearing committee shall be in direct economic competition with the affected practitioner, or have participated in the formation of the Adverse Action that is the subject of the hearing. In the event that it becomes burdensome to appoint a hearing committee from among the Staff members, practitioners or physicians who are not Staff members may be appointed in the interest of justice by providing them with temporary peer review privileges.
- 14.6 **Hearing Date.** Once appointed, the hearing committee shall promptly select a hearing time, location and date, which shall be not less than thirty (30) days from the date of receipt of the notice of hearing described in the following Section. In the event that the affected practitioner is subject to a summary corrective action, the hearing date shall be as soon as arrangements may reasonably be made with the consent of the affected practitioner, but no earlier than five (5) days following receipt of the request for hearing. The hearing committee shall immediately notify the Administrator, the VPMA, and the CMO of the hearing date selected.
- 14.7 **Notice of Hearing.** The Administrator shall promptly notify the affected practitioner of the date, time, and location of the hearing and the names of any witnesses expected to testify in support of the Adverse Action.
- 14.8 **Representation.** Given that the purpose of the proceeding is to obtain an intra-professional review and resolution of the matter, the affected practitioner shall be entitled to be accompanied only by a Staff member in good standing as determined by the hearing committee. In compliance with the Health Care Quality Improvement Act of 1986, the affected practitioner may consult an attorney throughout the hearing process provided timely written notice is provided

to the hearing committee at least twenty (20) days before the hearing commencement date. If the Staff member desires to consult an attorney during the hearing process, then the representative of the Executive Committee or the BOD, whichever recommended or took the Adverse Action, may also have an attorney to assist in the presentation. Participation by the attorneys shall consist solely of providing private advice and counsel to their respective clients, but shall not include presenting evidence, examining or cross-examining witnesses, making statements directly to the hearing committee or otherwise participating directly in the proceedings. The presiding officer shall have the authority to ensure that all attorneys conduct themselves in accordance with these standards.

14.9 **Conduct of Hearing.** The hearing shall be conducted in accord with the following process.

14.9.1 **Quorum for the Hearing Committee.** There shall be at least a majority of the members of the hearing committee present in person when the hearing takes place and no member may vote by proxy.

14.9.2 **Record of Hearing.** An accurate record of the hearing must be kept using a mechanism that the hearing committee shall establish. Copies of such record may be obtained by the affected practitioner upon payment of a reasonable charge with respect to the preparation of such record.

14.9.3 **Personal Appearance.** The personal presence of the affected practitioner for whom the hearing has been scheduled shall be required. An affected practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his rights to a hearing and appellate review and to have accepted the prior adverse recommendation or decision involved.

14.9.4 **Extension of Time.** Postponement of hearings beyond the time set forth in these Bylaws shall be made only for good cause as determined in the sole discretion of the hearing committee.

14.9.5 **Presiding Officer.** Either a hearing officer, if one is appointed by the hearing committee, or the Chairperson of the hearing committee shall preside over the hearing to determine the order of procedure, to assure that all participants have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum. The chairperson of the hearing committee may participate in the deliberations of the hearing committee, but shall not vote except in the event of a tie vote. A hearing officer may not participate in the deliberations but may respond to procedural questions asked by the hearing committee.

14.9.5.1. **Hearing Officer Appointment.** Use of a hearing officer to preside at the hearing is optional, as determined by the hearing committee after consultation with the Administrator, the CMO, or the VPMA. The hearing officer may be, but is not required to be, an attorney, but must be experienced in conducting hearings.

- 14.9.6 **Evidence.** The hearing need not be conducted strictly in accord with the rules of law. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered. The affected practitioner shall, prior to or during the hearing be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record. The affected practitioner also shall have the right to make a verbal summary statement and submit a written statement at the close of the hearing, and such written statement shall become a part of the record. Each member of the hearing committee may interrogate the affected practitioner or any other witnesses appearing before the hearing committee. The hearing committee may also consider all available information relating to the matter(s) comprising the subject of the hearing.
- 14.9.7 **Representative of the Executive Committee or BOD.** The Executive Committee or BOD (whichever recommended or took the Adverse Action), shall appoint a representative to present the facts in support of its adverse recommendation or decision, to examine or cross-examine witnesses, and to respond to any questions or requests for information from the hearing committee.
- 14.9.8 **Obligations of the Representative and the Affected Practitioner.** It shall be the obligation of the representative of the BOD or Executive Committee to present appropriate evidence in support of the Adverse Action, but the affected practitioner shall thereafter be responsible for supporting his challenge to the Adverse Action by an appropriate showing that the involved charges or grounds lack any factual basis or that such basis of any action based thereon is either arbitrary, unreasonable, or capricious.
- 14.9.9 **Rights of the Representative and the Affected Practitioner.** The representative of the BOD or Executive Committee and the affected practitioner shall have the following rights: to call and personally examine witnesses, to introduce other relevant evidence, to cross-examine any witness on any matter relevant to the issue of the hearing, to challenge any witness for prejudice or bias, to rebut any evidence, to make a verbal summary statement, and to submit a written statement at the close of the hearing. If the affected practitioner does not testify in his own behalf, he still may be called and examined as if under cross-examination by any member of the hearing committee, the hearing officer (if any), and the representative of the BOD or Executive Committee.
- 14.9.10 **Recesses and Adjournment.** The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation among its members. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the affected practitioner.

14.10 **Hearing Committee Report; Notice.** Within fourteen (14) days following adjournment of the hearing, the hearing committee shall issue to the Executive Committee or the BOD (whichever recommended or took the Adverse Action) and to the Administrator, the VPMA, or the CMO a written report of its recommendations and findings comprising the basis for the recommendations. Within fourteen (14) days following receipt of the report by the hearing committee, the Executive Committee or BOD shall deliver its final recommendation or decision to the Administrator. The Administrator shall promptly provide notice of the hearing committee report and the final recommendation or decision to the affected practitioner, and the notice shall include a statement of the right to appeal the final recommendation of the Executive Committee.

14.11 **Circumstances Providing a Right to Compel Mediation.** A Practitioner is entitled to request mediation in either of two circumstances:

- a. The Practitioner is subject to an adverse recommendation under the Bylaws, and the Practitioner believes that mediation is desirable; or
- b. The Practitioner can provide credible evidence of the Credentials Committee's failure to take action within ninety (90) days of its receipt of the Practitioner's completed application.

14.11.1 **Mediation Request.** The Practitioner's written request for mediation must be delivered to the Administrator and state the reasons the Practitioner believes mediation is desirable or provide credible evidence of the Credentials Committee's failure to take action on the Practitioner's completed application within the required time period. If a hearing pursuant to the Procedural Review Plan has already been scheduled, the request must be received at least ten (10) days prior to the hearing date. Mediation conducted pursuant to an appropriate request must be completed prior to the date of the hearing. Under no circumstances may a request for mediation or the mediation process delay an already scheduled hearing, unless the delay is mutually agreed to by the parties. Neither a request for mediation nor the actual mediation process may delay the filing of any report required by law.

The Administrator or his designee also has the right to ask the Practitioner who is the subject of an adverse recommendation if he would agree to attempt to solve the issues that are the subject of the adverse recommendation by mediation prior to the use of the fair hearing process. If no agreement is reached through mediation, the affected Practitioner's right to a hearing and appellate review shall not be waived. If mediation is agreed to by the Practitioner, the time deadlines established by the Procedural Review Plan shall not be binding until or unless the hearing process begins.

14.11.2 **Mediator Selection.** The mediator shall be selected by the Administrator, the VPMA or their designee, in consultation with the requesting Practitioner. The mediator must have the qualifications required by state law. The fees of the mediator shall be paid jointly by the requesting Practitioner and the Hospital.

- 14.11.3. **Agreement to Participate in Mediation.** The Administrator and the Practitioner, or their legal representatives, shall sign an agreement to participate in mediation if required by the mediator. The agreement to mediate may not require that the Credentials Committee, the Executive Committee, the Board, or the Hospital violate any Bylaws, legal, or accreditation requirement or take any action not permitted by law; provided, however, the mediation agreement shall include provisions regarding confidentiality and protection from discovery. The Administrator may participate in the mediation and shall designate another individual, to participate in the mediation as the representative of the Credentials Committee, the Executive Committee, or the Board.
- 14.11.4. **Proposed Settlement.** During the course of the mediation, the mediator will encourage an agreement which will constitute a proposed settlement. The proposed settlement is not binding and may be accepted or rejected by either party. The proposed settlement may not require that the Credentials Committee, the Executive Committee, the Board, or the Hospital violate any Bylaws, legal, or accreditation requirement or take any action not permitted by law. If the proposed solution is acceptable, it shall be presented for final approval at the next meeting of the Executive Committee and/or Board. If the proposed solution is rejected by either party, the Practitioner may request a hearing, if appropriate under this Procedural Review Plan, or move forward with any hearing already scheduled.
- 14.11.5. **Mediation Recommendation.** The terms and conditions of any proposed settlement acceptable to both parties shall be set forth in writing as a recommendation to be forwarded to the Executive Committee and/or the Board but shall have no force and effect and shall not be considered binding on the Hospital until presented and approved at a meeting of the Executive Committee and/or the Board. The use of the mediation process, as required under Texas law, shall not constitute a waiver, by any participant, of the medical peer review privileges. The parties may be accompanied in the mediation by counsel of their choice.
- 14.12 **Final Decision of the BOD.** The BOD's decision following the hearing committee's recommendation shall be the final decision in the matter, without appeal. In addition, if the affected practitioner fails to request or pursue an appellate review of the final recommendation of the Executive Committee in accordance with these Bylaws, the BOD shall render a final decision in the matter and shall provide a copy of its final decision, including the basis for the final decision, through the Administrator to the affected practitioner, the Chief of Staff, and the hearing committee.
- 14.13 **Right to an Appellate Review; Waiver.** Within seven (7) days after the date of written notice of the hearing committee's report and the final recommendation of the Executive Committee, the affected practitioner may file with the Administrator a written request for an appellate review by the Appeals Committee of the BOD. If such request for appellate review is not made within the specified period, the affected practitioner shall be deemed to have waived his right to such appellate review and to have accepted the final recommendation of the Executive Committee. The request shall also include any request for oral argument. Any such

oral argument shall be permitted or not in the sole discretion of the Appeals Committee.

- 14.14 **Scope of the Appellate Review.** The scope of the appellate review shall include only the record comprising the basis for the Adverse Action, any written or oral evidence presented to the hearing committee, the written statement of the affected practitioner as provided below, the written statement of the Executive Committee, and any oral argument that the Appeals Committee may permit.
- 14.15 **Notice of Appellate Review.** The Administrator shall select a date, time, and location for the appellate review by the Appeals Committee, and shall notify the affected practitioner. The appellate review shall ordinarily commence not less than thirty (30) days nor more than forty (40) days following the date of receipt of the request for appeal. The Appeals Committee may in its discretion provide for any earlier or later time that the affected practitioner may request.
- 14.16 **Appeals Committee.** The appellate review shall be conducted by the BOD or a committee of not less than five (5) members duly appointed by the BOD, but shall not include any individual who was a member of the hearing committee, the Executive Committee, or who is in direct economic competition with the affected practitioner.
- 14.17 **Appellate Review Recommendation.** The appellate review shall be conducted in accord with the procedure set forth below. If the appellate review is conducted by a committee appointed by the BOD, the committee shall provide its written recommendation to the BOD for final action within seven (7) days following adjournment of the appeal.
- 14.18 **Procedure for Appellate Review.**
- 14.18.1 **Hearing on Record.** The appellate hearing shall be conducted by the Appeals Committee. It shall be in the nature of a formal appellate review based upon the record of the hearing before the hearing committee.
- 14.18.2 **Written Submission.** The affected practitioner shall have the right to prepare and submit a written statement in his own behalf, in which he shall list those findings of fact, matters of procedure, and elements of the hearing and the hearing committee's written recommendation or the final recommendation with which he or she disagrees and his reasons for such disagreement. Legal counsel may assist in preparing the written statement. The affected practitioner shall submit the statement to the Appeals Committee through the Administrator at least fourteen (14) days prior to the scheduled date for the appellate review. A written statement in reply may be submitted by the Executive Committee at any time prior to the appellate review and, if submitted, the Administrator shall send a copy thereof to the affected practitioner as soon after receipt thereof as conveniently may be.
- 14.18.3 **Powers.** Without limiting the powers granted to the Appeals Committee herein, the Appeals Committee and its presiding officer shall also have all powers granted to the hearing committee and its presiding officer, and

such additional powers as are reasonably appropriate to the discharge of its responsibilities.

- 14.18.4 **Presiding Officer.** The presiding officer, who shall be appointed by the Administrator, shall preside over the appellate review, shall be entitled to determine the order and content of procedure, shall make all rulings with respect to matters of law and procedure, and shall be entitled to issue orders reasonably appropriate to maintenance of decorum and for the production of evidence. The presiding officer may participate in the deliberations of, and act as an advisor to, the Appeals Committee and shall be entitled to vote only in the event of a tie.
- 14.18.5 **Considered and Actions Taken.** Only under unusual circumstances shall new or additional matters not raised during the evidentiary hearing, in the report based on such hearing, in the report of the hearing committee, or in the final recommendations of the Executive Committee be introduced at the appellate hearing; and the Appeals Committee shall act as an appellate body, reviewing the procedure of the original hearing and assuring that the report and recommendation of the hearing committee and all subsequent action founded thereupon were based upon the evidence presented and were not arbitrary, unreasonable or capricious. The Appeals Committee may affirm, modify or reverse the final recommendations of the Executive Committee, or in its discretion, remand the matter directly to the Executive Committee for further review and recommendation and direct a return to the Appeals date of the recommendations of the Appeals Committee render a final decision, and the Administrator shall send notice thereof to the Chief of Staff and the affected practitioner Committee.
- 14.18.6 **Final Decision.** Within seven (7) days after the conclusion of the appellate review, the recommendations of the Appeals Committee shall be forwarded to the BOD through the Administrator. The BOD shall within fourteen (14) days after the date of the recommendations of the Appeals Committee render a final decision, and the Administrator shall send notice thereof to the Chief of Staff and the affected practitioner.

If the appellate review was conducted by the BOD, its decision shall be final and notice shall be sent as provided in the preceding paragraph within seven (7) days following adjournment of the appeal.

14.19 **General**

- 14.19.1 **Release.** By petitioning for a hearing or appeal, the affected practitioner:
- a. specifically requests all persons with any information relating to the subject matter of the hearing or appeal or to the assessment of his qualifications for the alleged deficiencies to provide such information to the hearing committee or Appeals Committee and the BOD directly or through the employees or agents of the Hospital and the Staff;

- b. covenants that he will use his best efforts to cause, and assumes the burden of causing, all such information to be presented, including the execution of specific written requests, releases; and
- c. does specifically release from liability and hold harmless all individuals and organizations who submit or consider such information for their statements made and actions taken in good faith and without malice.

14.19.2 **Waiver.** If at any time after receipt of notice of an Adverse Action, the affected practitioner fails to go forward, fails to discharge any obligation required by this Article or otherwise fails to comply with this Article, he shall be deemed to have consented to such Adverse Action and to have voluntarily waived all rights otherwise accruing to him under the Bylaws with respect to matters concerned. Failure to object to any event, to any evidence submitted to any procedures utilized, or to any action taken at the time thereof shall constitute a waiver of such objection.

14.19.3 **Amendments.** The provisions of this Article may be amended, supplemented, or otherwise modified only by action that complies with these Bylaws concerning amendments.

14.19.4 **Notice.** Any notice required in this Article shall be in writing and delivered to the designated individual either by certified mail return receipt requested or by personal delivery.

ARTICLE FIFTEEN: ACCESS TO THE BOARD OF DIRECTORS

15.1 **Organized Medical Staff Access to the Board of Directors:** The Organized Medical Staff may access the Board of Directors directly without first accessing the Medical Executive Committee as per policy "Organized Medical Staff Direct Access to the Board of Directors".

ARTICLE SIXTEEN: CONFLICT MANAGEMENT BETWEEN THE ORGANIZED MEDICAL STAFF, MEDICAL EXECUTIVE COMMITTEE, AND THE BOARD OF DIRECTORS

16.1 At times when conflicts arise between the Organized Medical Staff, Medical Executive Committee, and the Board of Directors, the Administration policy "Conflict Management" #AD-PP-22 is followed.

ARTICLE SEVENTEEN: PERFORMANCE EVALUATION AND MONITORING OF ORGANIZED MEDICAL STAFF

17.1 **General Overview of Performance Evaluation and Monitoring Activities.** The credentialing and privileging processes described in Article 4, Procedures for Appointment and Reappointment, and Article 4.14, Privileges, require that the Medical Staff develop ongoing performance evaluation and monitoring activities to ensure that decisions regarding appointment to membership on the Medical Staff and granting or renewing of privileges are, among other things, detailed, current, accurate, objective and evidence-based. Additionally, performance

evaluation and monitoring activities help assure timely identification of problems that may arise in the ongoing provision of services in the hospital. Problems identified through performance evaluation and monitoring activities are addressed as described in Article 12, Performance Improvement and Corrective Action.

17.2 Performance Monitoring Generally.

17.2.1 Except as otherwise determined by the Medical Executive Committee and Governing Body, the Medical Staff shall regularly monitor all member's privileges in accordance with the provisions set forth in these Bylaws and such performance monitoring policies as may be developed by the Medical Staff and approved by the Medical Executive Committee and the Governing Body.

17.2.2 Performance monitoring is not viewed as a disciplinary measure, but rather as an information-gathering activity. Performance monitoring does not give rise to the procedural rights described in Article 14, Hearings and Appellate Reviews (unless the form of monitoring is Level III proctoring and its imposition becomes a restriction of privileges because procedures cannot be done unless a proctor is present and proctors are not available after reasonable attempts to secure a proctor).

17.2.3 The Medical Staff shall clearly define how information gathered during performance monitoring shall be shared in order to effectuate change and additional action, if determined necessary.

17.2.4 Performance monitoring activities and reports shall be integrated into other quality improvement activities.

17.2.5 The results of any practitioner-specific performance monitoring shall be considered when granting, renewing, revising or revoking clinical privileges of that practitioner.

17.3 Ongoing Professional Performance Evaluations.

17.3.1 Each department or The Medical Staff shall recommend, for Medical Executive Committee and Governing Body approval, the criteria to be used in the conduct of Ongoing Professional Performance Evaluations for its practitioners.

17.3.2 Methods that may be used to gather information for Ongoing Professional Performance Evaluations include, but are not limited to:

- a. Periodic chart review;
- b. Direct observation;
- c. Monitoring of diagnostic and treatment techniques; and
- d. Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing and administrative personnel.

17.3.3 Ongoing performance reviews shall be factored into the decision to maintain, revise or revoke a practitioner's existing privilege(s).

17.4 **Focused Professional Practice Evaluation**

17.4.1 **Development of Process.** The Medical Staff is responsible for developing a focused professional practice evaluation process that will be used in determined situations to evaluate, for a time-limited period, a practitioner's competency in performing specific privilege(s). The Medical Staff may supplement these Bylaws with policies, for approval by the Medical Executive Committee and the Governing Body, that will clearly define the circumstances when a focused evaluation will occur, what criteria and methods should be used for conducting the focused evaluation, the duration of the evaluation period, requirements for extending the evaluation period, and how the information gathered during the evaluation process will be analyzed and communicated.

17.4.2 **Information Gathered.** Information for a focused evaluation process may be gathered through a variety of measures including, but not limited to:

- a. Retrospective or concurrent chart review;
- b. Monitoring clinical practice patterns;
- c. Simulation;
- d. External peer review;
- e. Discussion with other individuals involved in the care of each patient; and
- f. Proctoring, as more fully described at Bylaws, Section 17.4.4, below.

17.4.3 **Situations of When to Use.** A Focused Professional Practice Evaluation shall be used in at least the following situations:

- a. All initial appointees to the Medical Staff and all members granted new privileges shall be subject to a period of focused professional evaluation in accordance with these Bylaws and the Rules of the department in which the applicant or member will be exercising those privileges. Such focused evaluation will generally include a period of Level I proctoring in accordance with Bylaws, Section 17.4.4(a), below, unless additional circumstances appear to warrant a higher level of proctoring, as described below.
- b. In special instances, focused evaluation will be imposed as a condition of renewal of privileges (for example, when a member requests renewal of a privilege that has been performed so infrequently that it is difficult to assess the member's current competency in that area). Such evaluation will generally consist of Level I proctoring in accordance with Bylaws, Section 17.4.4(a) (1) below, unless additional circumstances appear to warrant a higher proctoring level, as described below.

- c. When questions arise regarding a practitioner's competency in performing specific privilege(s) at the hospital as a result of specific concerns or circumstances, a focused evaluation may be imposed. Such evaluations may include either Level II or III proctoring, in accordance with these Bylaws, Sections 17.4.4(a) (1) or (2).
- d. As otherwise defined in these Bylaws or applicable Focused Professional Practice Evaluation policies.

17.4.4. Proctoring

a. Overview of Proctoring Levels

Level I proctoring shall be considered routine and is generally implemented as a means to review initially requested privileges in accordance with Bylaws, Section 17.4.3(a), above, and for review of infrequently used privileges in accordance with Bylaws, Section 17.4.3(b), above.

Level II proctoring is appropriate in situations where a practitioner's competency or performance is called into question, in accordance with Bylaws, Section 17.4.3(c), above, but where the circumstances do not involve a "medical disciplinary" cause or reason or where the proctoring does not constitute a restriction on the practitioner's privilege(s) (i.e., the practitioner is required to participate in proctoring, and to notify either the proctor or other designated individual(s) prior to providing services, but is permitted to proceed without the proctor if one is not available).

Level III proctoring is appropriate in situations where a practitioner's competency or performance is called into question due to a "medical disciplinary" cause or reason in accordance with Bylaws, Section 17.4.3, above, and where the form of proctoring is a restriction on the practitioner's privilege(s) (because the practitioner may not perform a procedure or provide care in the absence of the proctor). Upon imposition of Level III proctoring, that practitioner is afforded such procedural rights as provided at Article 14, Hearing and Appellate Review.

- b. **Overview of Proctoring Procedures.** Whenever proctoring is imposed, the number (or duration) and types of procedures to be proctored shall be delineated.

During the proctoring, the practitioners must demonstrate they are qualified to exercise the privileges that were granted and are carrying out the duties of their Medical Staff category.

In the event that the new applicant has privileges at a neighboring hospital where members of this hospital's Medical Staff are familiar with the member to be proctored, and familiar with that neighboring hospital's peer review standards, privileging and proctoring information

from the neighboring hospital may, at the discretion of the appropriate Department Chair, be acceptable to satisfy a portion of the focused professional practice evaluation required for this hospital.

- c. **Proctor: Scope of Responsibility.** All members who act as proctors of new appointees and/or members of the Medical Staff are acting at the direction of and as an agent for the department, the Medical Executive Committee and the Governing Body. When possible, no business relationship shall exist between the proctor and the proctored.

The intervention of a proctor shall be governed by the following guidelines:

1. A member who is serving as a proctor does not act as a supervisor of the member or practitioner he or she is observing. His or her role is to observe and record the performance of the member or practitioner being proctored, and report his or her evaluation to the Department and/or the Credentials Committee.
 2. A proctor is not mandated to intervene when he or she observes what could be construed as deficient performance on the part of the practitioner or member being proctored.
 3. In an emergency situation, a proctor may intervene, even though he or she has no legal obligation to do so, and by intervening in such a circumstance, the proctor acting in good faith should be deemed a Good Samaritan within the "Good Samaritan" laws of the State of Texas.
- d. **Completion of Proctoring.** The member shall remain subject to such proctoring until the Medical Executive Committee has been furnished with: A report signed by [the Chair of the department to which the member is assigned] describing the types and numbers of cases observed and the evaluation of the member's performance, a statement that the member appears to meet all of the qualifications for unsupervised practice in the hospital, has discharged all of the responsibilities of Medical Staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made; and

A report signed by the Chair of such other department(s) in which the member may exercise clinical privileges, describing the types and number of cases observed and the evaluation of the member's performance and a statement that the member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments.

- e. **Effect of Failure to Complete Proctoring**

Failure to Complete Necessary Volume. Any practitioner or member undergoing Level I or Level II proctoring who fails to complete the required number of proctored cases within the time frame established

in the Bylaws and Rules shall be deemed to have voluntarily withdrawn his or her request for membership (or the relevant privileges), and he or she shall not be afforded the procedural rights provided in Bylaws, Article 14, Hearings and Appellate reviews. However, [the department] [other responsible official or committee] has the discretion to extend the time for completion of proctoring in appropriate cases subject to ratification by the Medical Executive Committee. The inability to obtain such an extension shall not give rise to procedural rights described in Bylaws, Article 14, Hearing and Appellate Reviews.

- f. **Failure to Satisfactorily Complete Proctoring.** If a practitioner completes the necessary volume of proctored cases but fails to perform satisfactorily during proctoring, he or she may be terminated (or the relevant privileges may be revoked), and he or she shall be afforded the procedural rights as provided in Article 14, Hearing and Appellate Reviews. In the event procedural rights are invoked, the practitioner who has not successfully completed proctoring shall be deemed an "applicant".

- g. **Effect on Advancement.** The failure to complete proctoring for any specific privilege shall not, by itself, preclude advancement from provisional staff. If advancement is approved prior to completion of proctoring, the proctoring will continue for the specified privileges. The specific privileges may be voluntarily relinquished or terminated, pursuant to Section E, if proctoring is not completed thereafter within a reasonable time.

- END -

**CHRISTUS ST. MICHAEL HEALTH SYSTEM
MEDICAL STAFF RULES AND REGULATIONS**

Section 1 - Admissions/Discharges:

1. No patient shall be admitted to the Hospital until a provisional diagnosis has been stated.
2. Medical Staff members admitting patients to the Hospital shall be expected to furnish such information as may be necessary to assure the protection of other patients, as well as the Hospital personnel, from those who are a source of danger from any cause whatsoever, or to assure protection of the patient from self-harm.
3. Members of the Medical Staff shall attend all patients, and only physician members of the Medical Staff may independently admit to, or discharge patients from, the Hospital. Patients applying for admission who have no attending physician shall be referred to the appropriate member of the Medical Staff on general call.
4. Patients shall be discharged only on order of the attending physician. If the patient decides to leave the Hospital against the advice of the physician, he shall be requested to sign an AMA Form releasing the attending physician and the Hospital from responsibility for the consequences of such action. In the event a patient refuses to sign the designated form, two witnesses will state that the AMA Form was offered but the patient refused to sign it and place it in patient chart. After the time of discharge, the attending physician shall see that the record is complete by providing the information necessary on the discharge summary sheet within 21 days from the time the patient is discharged. (Exceptions to the discharge summary: When individuals are seen for minor problems or interventions (less than a 48 hours stay) as defined by the medical staff, a final progress note may be substituted for the discharge summary. When individuals are transferred to a different level of care within the hospital, and the caregivers change, a transfer summary may be substituted for a discharge summary. When the caregivers are the same, a progress note may be used.
5. Patients may be released on Surgical Pass/Leave of Absence prior to discharge only upon order of the attending physician. Patients shall be requested to sign the proper form releasing the physician and the Hospital from responsibility for any actions arising to the patient during absence from the Hospital. The patient's record must document the patient's condition at the time of the Pass/Leave, the date that the patient is to return and why the Pass/Leave was requested.

Section 2 – Anesthesia:

1. The Anesthesia department will function as a subsection of the Surgical Section and will meet with that Section. In cooperation with the Surgery Section, the Anesthesia Department; under the direction of the Medical Director of Anesthesia; will formulate policies and procedures for the operating room and the recovery room. The Medical Director of Anesthesia shall be a member of the Active Medical Staff qualified by training, experience and demonstrated ability for the position. The Anesthesia Department will report findings from the ongoing monitoring of the quality improvement activities and appropriateness of care provided to patients

by members of this Department to the appropriate team/committee as defined by the Quality Plan.

2. Types of anesthesia used are:
 - a. General
 - b. Spinal
 - c. Other Major Regional Anesthesia and Analgesia
 - d. IV and IM Sedation (used for an invasive procedure) which may result in loss of the patient's protective reflexes).
 - e. MAC (Monitored Anesthesia Care).
3. The anesthesiologist and/or anesthetist shall assure that there has been a pre-anesthesia assessment of all patients before administering an anesthetic. The evaluation must be completed within 48 hours prior to surgery or a procedure requiring anesthesia services. However, some individual elements may be performed prior to that period, so long as they are reviewed and appropriately updated within the 48-hour timeframe. Pre-op anesthesia form needs to be reviewed to make sure that it includes items of the medical history, exam of the patient, ASA risk, tests, potential problems and plans for care while the patient is under the anesthesia service.
4. The anesthesiologist and/or anesthetist shall assure that all appropriate laboratory data is completed before administering an anesthetic.
5. Notations shall be made by the anesthesiologist and/or anesthetist of any difficulties encountered during the administration of the anesthetic and of the condition of the patient at the end of the procedure.
6. The anesthesiologist or nurse anesthetist shall maintain a close observation of all patients during post-anesthetic follow-up and documentation must be present on those charts. This may be completed after a patient is moved to another inpatient location within the hospital, or is discharged, so long as the evaluation is completed and documented within 48 hours. Post-op anesthesia form needs to include an assessment of O2 sat, respiratory function, cardiovascular function, mental status, temp, pain, N/V, and post-op hydration.
7. The CRNA's supervising anesthesiologist must be readily available within the facility when any nurse anesthetist administers surgical anesthesia. It is also expressly understood that the CRNA's supervising anesthesiologist must be available in the facility within 15 minutes of being called in case of an emergency when the CRNA is administering a labor epidural.
8. All entries in the medical record recorded by anesthetists require a co-signature by the supervising anesthesiologist.
9. When an anesthetic is to be administered by an anesthesiologist and/or an anesthetist, he shall be responsible for the physical status of the patient as pertains to anesthesia.
10. Physicians, dentists and podiatrists who are fully trained and experienced may use IV sedation/analgesia after pre-anesthesia assessment, followed with monitoring

of the physiologic status during the operative/invasive procedure. Post-procedure status is established and documented before discharging the patient.

11. Consequently, each hospital that provides anesthesia services must establish policies and procedures, based on nationally recognized guidelines that address whether specific clinical situations involve anesthesia versus analgesia. These Rules and Regulations will be based on guidelines from the American Society of Anesthesiologists. It is acknowledged that under certain circumstances, the Emergency Department physician can determine the need to deep sedation. The Director of Anesthesia may delegate the supervision of deep sedation to the Emergency Department medical director. Deep Sedation will be credentialed separately.

It is expected that the sedation typically provided in the emergency department or procedure rooms by non-anesthesia personnel would be considered analgesia. Analgesia involves the use of a medication to provide relief of pain through the blocking of pain receptors in the peripheral and/or central nervous system. The patient does not lose consciousness, but does not perceive pain to the extent that may otherwise prevail. Moderate sedation is covered separately under Policy AD-PP-93-54 and will be credentialed separately.

12. Anesthesiology is a discipline within the practice of medicine dealing with, but not limited to, and specializing in:
 - a. The preoperative, intraoperative and postoperative evaluation and treatment of patients who are rendered unconscious and/or insensible to pain and emotional stress during surgical, obstetrical, therapeutic and diagnostic or other medical procedures;
 - b. The protection of life functions and vital organs (e.g. brain, heart, lungs, kidneys, liver, endocrine, skin integrity, nerve (sensory and muscular) under the stress of anesthetic, surgical and other medical procedures;
 - c. Monitoring and maintenance of normal physiology during the perioperative period;
 - d. Diagnosis and treatment of acute, chronic and cancer-related pain;
 - e. Clinical management of cardiac and pulmonary resuscitation;
 - f. Evaluation of respiratory function and application of respiratory therapy;
 - g. Management of critically ill patients.

Section 3 - Autopsies and Notification of Medical Examiner:

1. Autopsies should be requested in such cases as deemed necessary by the Medical Staff.
2. Those deaths where autopsy examinations are especially indicated are:
 - Unexplained deaths
 - Unexpected deaths
 - Those deaths presenting a potential hazard to the community
 - Death that meets criteria for referral to the Medical Examiner
 - Deaths of neonates
 - Maternal deaths

3. No autopsies shall be performed without the consent of the next of kin or the legally authorized agent. Hospital personnel shall notify the attending physician of any impending autopsy.
4. All autopsies shall be performed by the Hospital pathologist or by a physician to whom this responsibility has been properly designated. The individual performing the autopsy will notify the attending physician when an autopsy is being performed and provide adequate notice so that physician may attend the autopsy if so desired.
5. The Hospital shall report the following deaths to the County Medical Examiner:
 - When a patient dies within twenty-four hours after admission;
 - When any person dies an unnatural death;
 - When the circumstances of the death of any patient lead to suspicion that the death was by unlawful means;
 - When any patient commits suicide or the circumstances of the death of any patient lead to suspicion that the death was by suicide;
 - When the patient is a child who is younger than six years of age and the death is by other than a motor vehicle accident; and
 - When a person dies who has been attended immediately preceding his death by a duly licensed and practicing physician(s), and such physician or physicians are not certain as to the cause of death and are unable to certify with certainty the cause of death. In case of such uncertainty, the physician or physicians, or the manager of the Hospital, shall report to the medical examiner and request an inquest.

Section 4 - Casualty/Disaster Assignments:

1. The Hospital Safety Committee, in consultation with the Administrator or his designee, will work as a team with the Medical Staff to coordinate activities and directions.
2. All Medical Staff members may be assigned to posts, either in the Hospital or other hospitals, and it is their responsibility to report at their assigned stations. No physician Staff member will perform any duties other than those assigned.
3. In cases of evacuation from Hospital premises, the Chairperson of the Hospital Environment of Care Committee, at the direction of the Administrator in direct consultation with the Chief of Staff, shall coordinate the activities necessary to complete the transfer with the maximum of patient care possible under the circumstances.

Section 5 - Change of Attending Physicians:

1. Any patient shall have the freedom to change physicians, should they so desire.
2. The physician being released from a particular case must be notified by the patient, or his agent, before a second physician may accept care of the patient.
3. In no instance may a physician be released from a case until another physician has agreed to accept the case.

4. When a change of physician occurs, all previous orders for treatment shall automatically be canceled.
5. When arrangements have been made for the transfer of care of the patient from one physician to another, such transfer shall be in the form of a written order on the chart, and the physician to whom the patient is being transferred is to be so informed by the transferring physician.
6. A patient's record must document the change of attending physician with the signatures of both physicians.

Section 6 - Consultations:

1. A consultation request should specify whether the attending physician wishes only the opinion of the consultant, whether he wishes co-management of the patient with him, or whether he wishes the consulting physician to assume care of the patient. A satisfactory consultation includes the consultant stating his findings, diagnosis and recommendations. When operative procedures are involved, the consultation notes, except in emergency, shall be recorded prior to operation.
2. The Administrator or his designee, and the VPMA after discussion with the Chief of Staff shall at all times have the right to call in a consultant or consultants.
3. All intentional drug overdose and suicide attempts shall be offered psychiatric consultation and care.
4. Active and Associate Active physicians are expected to respond to consultations within 24 hours of the request unless otherwise specified by the requesting physician.
5. Physicians are encouraged to personally contact the physician member consulted.

Section 7 - Emergency Department/General Call Duty:

1. Active and Associate Medical Staff members are required to serve on General Call to attend patients in the Hospital and in the Emergency Department until they reach the age of fifty-five (55), unless this responsibility has been delegated to an appropriate accepting physician or physician group. General Call requirements include consultation on those patients after admission to the hospital, which in the opinion of the attending physician, requires a specialist's recommendations or interventions. It is expected that this consultation, as circumstances dictate, be completed within twenty-four (24) hours of notification of the consultation by the attending physician to the consulting physician. If circumstances justify, the Executive Committee may choose to excuse certain Staff member(s), before reaching the age of 55, from serving on General Call. Staff members may continue to provide emergency General Call coverage beyond the age of 55, if they so choose.
2. Physicians listed on the General Call Schedules shall serve on a weekly or daily rotation basis beginning at 7:00 a.m. on Mondays. Sections and Departments may

amend their call schedules regarding rotation and beginning times. The General Call patient will be assigned to the physician who is on general call at the exact time they are called by the Emergency Department, or notified of a consultation request regardless of what time that physician's General Call rotation begins or ends.

3. An EMTALA compliant medical screening examination will be offered to any individual who comes to the emergency department for treatment of a medical condition. Categories of personnel qualified to perform medical screening examinations in addition to physicians include physician assistants and nurse practitioners regularly providing services in the emergency department.
4. Should that Emergency Department physician determine that the patient requires further consultation or admission, he/she will personally contact the physician member who is listed on the General Call Schedule for that date in the specialty area necessary for the patient's stabilization or treatment. Once contacted, the General Call physician shall be responsible for the care of that patient and copies of all records concerning that patient will be forwarded to that physician member for his use. If a General Call patient is assessed and/or treated by the Emergency Department physician and requires no emergency follow-up by the physician who is on the General Call Schedule at that time, there is no obligation by the physician who is on general call to follow this patient in the office setting. It is the responsibility of the patient to obtain a physician to provide medical treatment outside the hospital setting. Pre-partum, postpartum, and patients in active labor who present to the Emergency Department without a designated attending physician are also subject to a medical screening exam by a designated provider in the hospital. When appropriate, telephone consultation with the OB physician may be utilized to confirm false labor.
5. When patients with attending physicians arrive in the Emergency Department and have not been seen by their attending physicians within two hours after arrival, the Emergency Department physician will call the attending to inform them that the patient will be assessed and an evaluation, beyond the required medical screening examination, will be made whether to render treatment or to admit the patient.
6. It will be the duty of the physicians to be available on the dates they are listed on the General Call Schedule or to name another designated physician in order that patients may receive prompt attention. If, for any reason, a member of the Medical Staff cannot be available as required by the General Call Schedule, it shall be his responsibility to arrange with another member of the Medical Staff to serve in his place and notify the Emergency Department and the Medical Staff Office.
7. All members of the Medical Staff, although not on General Call, shall be responsible for providing coverage for their Hospital patients, both inpatient and outpatient, and shall name another member of the Medical staff for that coverage. The covering physician must meet the following guidelines:
 - Have privileges in the same specialty as the physician for who they are covering.

- Physician should have sufficient training to attend all patients who would normally be admitted or followed by the physician for whom they are covering.
 - If credentialed in a specialty different from the requesting physician, the Medical Staff office must be notified. The covering physician must possess clinical privileges sufficient to attend all patients who would normally be admitted or followed by the physician for whom they are covering. (The Credentials Committee must approve such different specialty coverage on the applicant's original application or the Section Chief must approve such different specialty coverage). Criteria for clinical privileges are recommended to the Credentials Committee by the Section Chief as set forth in section 6.1 of the medical Staff Bylaws.
8. The Emergency Department will function as a Clinical Section and will meet quarterly. It is the responsibility of the Section Chief of the Emergency Department to organize the Emergency Department physicians, to formulate policies, and to advise Administration and the Medical Staff regarding quality issues, staffing and equipment; as set forth in Bylaws Section 6.
 9. The Emergency Department will report findings from the ongoing monitoring of the quality improvement activities and appropriateness of care provided to patients by members of this Department to the appropriate team/committee as defined by the Quality Plan. The Emergency Department will operate in accordance with applicable Texas and federal laws.
 10. Patients under the age of 18 years, who present to the Emergency Department and who have no attending physician, will be considered a pediatric patient and will be assigned to the pediatrician on general call. Exceptions to this rule will be: pregnant minors who would then be referred to an OB/GYN on call.

Section 8 — General:

1. Advance directives policies and procedures of the Hospital will be respected by the Medical Staff members.
2. When a member of the Medical Staff reaches the age of 70 or will turn 70 during the reappointment period and wishes to continue his Medical Staff privileges, shall be reappointed for not more than one (1) year.
3. Any member of the Medical Staff who shall find fault with a member of the Hospital personnel shall report the deficiency to the Service Line Director or Manager immediately. If the Medical Staff member feels that he has not gained any satisfaction by reporting this, he should then report the deficiency directly to the VPMA, the Administrator or his designee. In no case shall a Medical Staff member discipline an employee except in cases where patient harm may occur.
4. All Medical Staff members are urged to take an active part in the training of medical students, physicians, nurses, and other health care personnel.
5. Requirements of the TJC, State Department of Health and the Medicare Conditions of Participation for Hospitals will be adhered to.

6. Patients may request access to information contained in the open medical record through their attending physician or designee.
7. Members of the medical staff (or their designated partners or Locum Tenens) are expected to visit their patients at least once every 36 hours.
8. Board certification, as required by accreditation standards and as approved by the Medical Executive Committee, may be waived for those physicians who have met board eligibility requirements, and who have had greater than ten (10) years' experience practicing in a specialty.

Section 9 - Leave of Absence:

1. The Executive Committee shall have the authority to grant a written request for a leave of absence for due cause:
 - a. Absences for the purpose of treatment or rehabilitation for inappropriate professional behavior or conduct, drug or alcohol addiction, etc., and Armed Services (Military Duty) shall require a request for a leave of absence, regardless of the length of absence;
 - b. Absences due to vacation, sabbaticals, pregnancy, routine medical treatment/surgeries, missionary work, etc. shall not be considered cause to require a leave of absence, unless the cause poses a potential problem that affects professional performance, then a review by Administration and the Medical Staff may be warranted. However, if an absence of more than 30 days is expected, the Medical Staff member should notify the Medical Staff Office.
2. A leave of absence shall be for ninety (90) days, but the Executive Committee shall have the authority to amend this as it deems appropriate. No leave of absence shall last for more than one year except in the cause of Armed Services (Military Duty).
3. If a Staff member incurs an absence and fails to request a leave of absence in accordance with these Rules, the member's clinical privileges and Staff membership will automatically terminate - after a period of 30 days of absence is identified by the Medical Staff Office. This shall be deemed a voluntary resignation from the Staff, resulting in automatic termination of Staff membership and clinical privileges. Any subsequent request for reinstatement shall be treated in accordance with the procedures applicable to initial appointment.
4. At any time prior to return from a leave of absence, the Staff member shall request termination of the leave of absence, reinstatement of privileges and furnish to the Medical Staff Office documentation from the treating physician/program or Military Duty that he/she is released to resume Medical Staff practice. Upon provision of these requirements, the Administrator may grant a temporary reinstatement after consideration of the recommendation of the Chief of Staff or the VPMA, without such Staff member being required to reapply for Staff membership and privileges. This temporary reinstatement will be considered at the next scheduled Executive Committee meeting.

5. Failure to return or request reinstatement prior to the termination of an approved leave of absence or to provide the appropriate treatment documentation shall be deemed a voluntary resignation from the Staff, resulting in automatic termination of Staff membership and clinical privileges. Any subsequent reinstatement shall be treated in accordance with the procedures applicable to initial appointment. Staff members shall be reminded of this rule whenever they apply for a leave of absence.

Section 10 - Licensure and other Documentation:

1. All Medical Staff members shall furnish to the Medical Staff Office copies of their current state licensure, DEA certificates and certificates of professional liability insurance as they are renewed.
2. Those Medical Staff members who have office staff with Dependent AHP Personnel privileges at the Hospital and who are covered under their professional liability insurance are responsible for providing copies of proof of this coverage on an annual basis.

Section 11 — Meetings/Committees/Sections/Quality Improvement Activities:

Committee members and officers are encouraged to attend a majority of scheduled meetings of their committee and be a member of the Medical Staff in good standing. Committee members may be removed from committee membership by approval of a majority of members of the committee and may be removed due to 1) lack of participation, 2) disruptive behavior, or 3) any action deemed inappropriate for a medical staff leader as determined by the committee members.

1. **Cancer Committee.** The Cancer Committee shall be a multi disciplinary, standing committee. It shall consist of representatives from Surgery, Medical Oncology, diagnostic and therapeutic Radiology, Pathology, Family Practice, Internal Medicine, Gynecology, Pediatrics and Urology. It shall also include the Field Liaison Physician, who shall be an ex-officio member, provided he is a member of the Medical Staff member. A Field Liaison Physician who is not a Staff member may not vote or be counted for the purpose of determining a quorum. Representatives from Administration, Nursing, Social Service, Quality Management, Rehabilitation and the Cancer Registry shall also participate on the Committee but may not vote and are not counted for the purpose of determining a quorum. The Cancer Committee shall meet quarterly as a policy-advisory and administrative body, and the recommendations of this Committee shall be forwarded to the appropriate team/committee as defined by the Quality Plan. Duties of the Cancer Committee:
 - a. Provide consultative services to patients; make certain that patients have access to consultative services in all major disciplines.
 - b. Make certain that educational programs include major cancer sites; ascertain that educational programs, conferences, and clinical activities include the major sites of cancer seen at this institution.

- c. Evaluate the quality of care of patients with cancer; monitor and evaluate patient care, either directly or by interaction with and review of audit data from other committees.
 - d. Supervise the cancer data system; supervise actively the cancer registry for quality control of abstracting, staging, and reporting.
 - e. Appoint Cancer Committee members to act as registry physician- advisors.
2. **Credentials Committee.** The Credentials Committee shall consist of members of the Active Medical Staff selected by the Executive Committee, on a basis that promotes representation of the Sections and the Staff at large. The Credentials Committee shall consist of the current Executive Committee Secretary, the Immediate Past Chief of Staff, one Past Chief, and up to two (2) members who are not currently on the Executive Committee. In addition, the Executive Committee may appoint one (1) representative from the Allied Health Professional Staff, to serve without voting rights. Duties of the Credentials Committee:
- a. The duties involved in coordinating and performing credentials investigations and recommendations are to: review and evaluate the qualifications, competence and performance of each applicant for initial appointment, reappointment or modification of appointment and for clinical privileges and make appropriate recommendations; review and evaluate the qualifications, competence and performance of applicants and Staff members in accordance with Article IV and make appropriate recommendations; submit a report, to the Executive Committee on the qualifications of each applicant for appointment or reappointment or particular clinical privileges; investigate, review and report on matters, including the clinical or ethical conduct of any practitioner assigned or referred to it by the Chief of Staff, the VPMA, the Executive Committee, or the BOD; establishing volume standards for performance appraisal of certain procedures; and document the performance of these functions, which shall be reflected in the appropriate committee minutes.
 - b. The Credentials Committee shall meet bi-monthly and additionally as necessary in the discretion of the Chairman. The Credentials Committee shall maintain a permanent record of its proceedings and actions.
 - c. The Credentials Committee will review initial appointment and reappointment applicants' credentials files in accordance with the Medical Staff Policies entitled Fast Track Appointment and Reappointment Process Policies. These policies allow for more efficient and expeditious processing of applicants through the committee process by use of a categorization system that meet approved criteria.
3. **Infection Control Committee.** The Infection Control Committee shall consist of four members, of who at least two must be from the Active Medical Staff representing a broad cross section of the services of the Hospital and including infectious disease. Representatives of other clinical services of the Hospital may also be members with the approval of the Chief of staff. The Committee shall review all reports of infection, especially with regard to type, patterns of occurrence, and drug resistances. The Infection Control Committee shall review all isolation

techniques and methods of sterilization and will be monitored. The Committee shall recommend any policy or procedure as needed for the prevention and control of infection. The recommendations of this Committee shall be forwarded to the Quality Steering Team. The Committee will report findings from the ongoing monitoring of quality improvement activities to the appropriate team/committee as defined by the Quality Plan.

4. **The Pharmacy and Therapeutics/Drug Utilization Review Committee.** The Pharmacy and Therapeutics Committee shall consist of at least four members, of whom at least two must be from the Active Medical Staff and shall serve two year staggered terms. The Administrator, or his designee, the VPMA and a member from the Nursing Service shall serve as ex-officio members, but they shall not be entitled to vote nor be counted for the purpose of determining a quorum. The pharmacist in charge will serve as a full voting member. The committee will recommend policies and deal with matters of a pharmaceutical nature as they arise and undertake quality management activities. They will report findings from the ongoing monitoring of quality improvement activities to the appropriate team/committee as defined by the Quality Plan.
5. **Performance Improvement Council (PIC).** The PIC oversees, prioritizes coordinates, and directs clinical and administrative quality improvement activities by receiving reports of the quality activities of Section Quality Teams, Functional Teams, and Service Lines. The PIC includes representatives from Administration, Chief of Staff Elect, Continuum of Care Secretary, the Director of Continuum of Care, Section Vice Chiefs, the Residency Program Director, Resident Representative(s), and a Quality Coordinator. All are voting members. Reports are received from teams/committees as defined by the Quality Plan for PIC review. The PIC meets quarterly and reports to the BOD. When the need arises, information is shared with the Executive Committee. This committee may appoint working sub-committees as needed.
6. **Sections:** The Sections of Family Practice, Internal Medicine, Surgery, Radiology, Pediatrics and OB/Gynecology shall hold meetings not less than semi-annually, or as needed, to conduct the business of the Sections and report findings from the ongoing monitoring and evaluation of the quality improvement activities and appropriateness of the care provided to patients by members of these Sections. These findings will be reported to the appropriate team/committee as defined in the Quality Plan. Peer review data will be reported to the Credentials Committee.
 - a. **Section Credentials Sub-Committees.** The Chief of each Section shall chair a Credentials Subcommittee consisting of three members of their appropriate Section which shall meet upon request of the Credentials Committee. The responsibility of these committees shall be to assist the Credentials Committee in determining qualifications and/or competency of applicants to their respective Sections to perform their requested privileges.
7. **Purpose:** All committees, standing or special, shall confine their work to the purpose for which they were appointed. These committees shall make appropriate recommendations to the Executive Committee.

8. **Medical Records Review Committee.** The Medical Records Review Committee shall consist of at least the following: Health Information Manager, Chief Nurse Executive, Director of the Continuum of Care, Manager of Outreach Services; one member from the Active Medical Staff; representatives from Nursing to include Medical/Surgical ICUs. The Committee shall meet monthly and additionally as necessary to conduct the business of the Committee.
- a. The Committee is responsible for providing ongoing oversight for concurrent and retrospective review of the medical records for compliance with regulatory standards and Hospital policy, The Committee will also identify and facilitate resolutions related to medical records issues including: timelines of transcription, legibility; charting of results; loose reports; retrieving of old records, optical storage, and filing of incomplete records.
9. **Practitioner Health Committee.** The functions of the Practitioner Health Committee shall include the following:
- Addressing Practitioner health as it relates to patient safety;
 - Educating the Medical Staff regarding illness and impairment recognition issues specific to Practitioners;
 - Encouraging self-referral by Practitioners and referral by other members of the Medical Staff and Administration;
 - Evaluating the credibility of a complaint, allegation, or concern;
 - Determining whether a Practitioner's problem is best addressed through a disciplinary measure or via the physician-health route;
 - Working confidentially with the Bowie County Medical Society and the State Board of Medical Examiners with the procedural deadlines and reporting obligations set forth in the Corrective Action Procedures provided for in the Medical Staff Bylaws;
 - Monitoring the affected Practitioner and the safety of patients until the rehabilitation or any disciplinary process is complete; and
 - Reporting to the Medical Staff leadership when the Practitioner is providing unsafe treatment.
- a. **Composition.** The Practitioner Health Committee shall consist of five members of the Active Staff who are appointed by the Chief of the Staff or the VPMA. One of the members shall be designated as the Chair. An attempt shall be made to include a distinguished senior member of the Medical Staff, a Practitioner knowledgeable in the treatment of addiction, a psychiatrist, a representative from anesthesiology, surgery, or emergency medicine, and a physician with personal recovery experience.
- b. **Meetings.** The Practitioner Health Committee shall meet as needed to address issues related to a Practitioner's health. All physician information discussed at the meeting shall be confidential, unless limited by law, ethical obligation, or when the safety of a patient is threatened.
- c. **Failure to complete program.** The practitioner will not be reinstated until he establishes that he has successfully completed a program which meets the satisfaction of the CHRISTUS St. Michael Health System and the Practitioners Health Committee in addition to any and all conditions which may be imposed as part of an approved treatment program.

10. **Conflict Management Committee**

The purpose of the Conflict Management Committee is to address and resolve conflicts that arise between the Organized Medical Staff, physician leadership, and the governing board.

The Conflict Management Committee shall consist of 2 members of the Organized Medical Staff, 1 member from the Medical Executive Committee, 1 member from the Credentials Committee, and 1 physician member of the Board of Directors. The members representing the Organized Medical Staff will be chosen by popular vote at the December General Staff Meeting to serve the following calendar year. The representatives from the Credentials, Medical Executive Committees, and the Board of Directors will be appointed by their respective committees at the last regular meeting of each year to serve the following calendar year.

The VPMA and/or CMO or their designee will also attend the Conflict Management Committee meeting but will not have a vote and will be present only to provide assistance, guidance, and support as needed.

The Committee will meet on an "as needed" basis. The Conflict Management Committee can be called to meet by any member of the Organized Medical Staff, Medical Executive Committee, or Board of Directors. Requests to meet by anyone as specified above will be sent in writing using the appropriate form (attached Exhibit A) to the Medical Staff Office. The Medical Staff Office will schedule the committee meeting at the earliest available time and notify the requesting party in writing of the date, time, and location of the meeting. The individual requesting the meeting **MUST BE PRESENT** at the meeting. Resolutions and/or recommendations of the committee will be provided in writing to the physician initiating the Conflict Management meeting. A record of the meeting will be maintained in the Medical Staff Office.

Section 12 - Pathology Department:

The Department of Pathology is composed of the Clinical Pathology Laboratory, Tissue Pathology Laboratory, Blood Bank, and Morgue and is a subsection of the Surgery Section. The Department of Pathology shall be responsible for advising Hospital Administration on the procurement of proper equipment to perform tests and examinations relevant to the diagnoses and treatment of patients. They are further charged with personnel training and the maintenance of standards of quality in the various laboratories of the Department.

Reports of tests or examinations, in addition to being recorded in the patients' records, shall be maintained in duplicate in the Department of Pathology and shall be made available to authorized physician Staff members. The Department of Pathology shall maintain statistical records of tests performed, surgical specimens examined, and autopsies performed. The Department shall submit for tissue review appraisal those cases pertinent to the tissue review activities. The Pathologists shall attend all clinical pathology conferences and participate in teaching.

The Pathology Department reports findings from the ongoing monitoring of the quality improvement activities of this Department to the appropriate team/committee as defined in the Quality Plan.

Section 13 - Physician Orders:

Orders of Authorized Individuals: Every medical record is dated, its author identified, and, when necessary, authenticated according to applicable regulatory agencies. Verbal orders can be accepted and transcribed by an R.N., an L.P.N., a P.A., and an A.P.N., and by the following individuals in relation to their respective disciplines: physical therapist, respiratory therapist, occupational therapist, social worker, dietician, x-ray technician, or pharmacist.

Only the recognized abbreviations and symbols as listed in the Hospital's Approved List of Abbreviations shall be accepted in written orders.

Drugs used shall be those listed in the United States Pharmacopoeia, National Formulary, New and Non-Official Remedies, and as designated by the Pharmacy & Therapeutics Committee. Generic substitutions will be permitted as approved by the Pharmacy & Therapeutics Committee and/or the Medical Staff.

An automatic stop order, as defined by the Pharmacy & Therapeutics Committee, on dangerous drugs will be placed on the charts. These will include, but not necessarily be limited to, narcotics, anticoagulants, corticosteroid, chemotherapeutic agents, and antibiotics.

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

Whenever a patient is transferred into, or out of, one of the Intensive Care Units, all physicians' orders will be reviewed and rewritten as necessary.

Section 14 - Radiology Section:

The Section of Radiology's primary purpose shall be to conduct all radiological procedures, both diagnostic and therapeutic. The Section shall make a written record of all such procedures and shall file all records for future reference. The Section of Radiology shall be responsible for advising Administration about procuring and maintaining radiological equipment to be utilized in the diagnosis and treatment of patients. Further, the Section shall be responsible for the training of personnel within their Department and the setting of standards to maintain quality care.

The radiologists shall participate in all clinical pathology conferences where radiological procedures are involved, and participate in teaching. The Section shall also be responsible for the supervision and operation of the nuclear medicine department and any other imaging or radiotherapy departments under their control.

Section 15 - Records Keeping:

1. All medical records shall be complete before being filed, except at the recommendation of the Medical Record Review Committee.
2. All records are the property of the Hospital and shall remain confidential. They shall not be removed without the permission of the Administrator or his designee, in accordance with a court order, subpoena, or applicable statute. In cases where records, or copies of records, are removed for other than routine purposes, the attending physician shall be notified as a matter of professional courtesy.
3. In cases in which the Hospital has seen fit to participate in the Medicare- Medicaid Programs and other health care-related programs, it is understood that Staff members will assist the Hospital by providing necessary information.
4. The Medical Staff member will record a note containing pertinent clinical information at the time that the patient is admitted. The patient's medical record includes certain documentation that is entered prior to the patient's discharge: a signed inpatient admission order and a physician's "certification" that the admission is medically necessary. The medical record also must include specific reasons why the inpatient admission is medically required and a care plan that includes discharge planning instructions.
5. Progress notes/Reassessment notes from the attending physician shall be written, at least daily (midnight to midnight), or as frequently as necessary to provide a level of continuity of care and describe in detail the events of patient care, including pertinent information relative to the course of treatment while in the Hospital.
6. Surgery can be performed only after recording a history and physical examination and the preoperative diagnosis, along with any diagnostic tests that have been completed. The admitting surgeon will provide a durable, legible copy of a complete history and physical examination for the patient medical record prior to surgical procedure. If a history and physical examination has been performed within 30 days before admission, a durable, legible copy of this report may be used in the patients' medical record, if an update is done prior to surgical procedure. When the chart does not reflect that the history and physical examination has been done and recorded, the nursing staff will be responsible for contacting the attending surgeon. If a history and physical cannot be obtained prior to an elective procedure, the procedure will be canceled, unless the physician states in writing the procedure is an extreme emergency. A handwritten operative progress note or a complete authenticated electronic operative report is required in the medical record immediately after the procedure. A dictated operative report or other high risk procedure report should be entered into the record immediately after the operation or procedure. "Immediately after surgery" is defined as "upon completion of surgery, before the patient is transferred to the next level of care". This is to ensure that pertinent information is available to the next caregiver. In addition, if the surgeon accompanies the patient from the operating room to the next unit or area of care, the operative note or progress note can be written in that unit or area of care. The operative progress note

should include sufficient information that the patient can be cared for until the operative report is placed on the chart.

7. Operative reports dictated and/or written immediately after a procedure should record the name of the primary surgeon and assistants, findings, procedures performed and description of the procedure, estimated blood loss; if any, specimens removed; if any, and postoperative diagnosis. The completed operative report shall be dictated & authenticated by the surgeon and filed in the medical record as soon as possible after surgery. (Refer to Bylaws 12.3.5)
8. Disciplinary action from incomplete or delinquent medical records will be taken in accordance with the Medical Staff Policy MS-PP-10; Notification of Suspension for Delinquent Records.

Section 16 - Surgery:

1. A surgical procedure shall be performed only on the written informed consent of the patient or his legally authorized representative. In emergencies involving a minor or unconscious patient in whom consent for surgery cannot be immediately obtained from parents, guardian, or next of kin, these circumstances should be explained on the chart. A consultation is desirable before such emergency operative procedures are undertaken.
2. Surgeons must be in the operating room and ready to commence operation at the time scheduled. The operating room will be held no longer than fifteen (15) minutes after the scheduled time. If the surgeon knows he is to be delayed, he should notify the operating room as soon as possible.
3. Before being anesthetized, the patient shall be identified by the operating surgeon or anesthesiologist and before surgery by the operating surgeon.
4. The operating surgeon shall have a qualified physician assistant in surgical procedures that involve unusual hazards to life and in any case where, for the benefit of the patient, additional assistance is needed. The determination as to what constitutes unusual hazards rests with the operating surgeon and is part of his responsibility to the patient. The surgeon must be prepared to defend his decision before the Medical Executive Committee. In appropriate cases, the operating surgeon may be assisted by a properly trained non-physician, such as an R.N., L.P.N., Nurse Assistant, P.A. or A.P.N. All members of the surgical team must be appropriately privileged.
5. All tissues removed at operation, with the exception of those on the exclusion list, shall be sent to the Pathology Department where such examinations may be made as considered necessary to arrive at a pathologic diagnosis.
 - a. Gross only Surgical Specimens are as follows:
 - Children tonsils and adenoids (less than 14 years of age)
 - Bunions
 - Hammertoe bone
 - Teeth
 - Resected lens of the eye
 - Bone Chips
 - Foreign objects

- Femoral head for osteoarthritis
 - Knee joint for osteoarthritis
 - Renal calculi
 - Bladder stones
 - Gallstones
- b. Specimens not requiring Pathology Examination, but may be subject to examination at the Physician's request:
- Cataract
 - Orthopedic appliance
 - Portion of rib removed to enhance operative exposure
 - Routine placenta
 - Therapeutic radioactive sources
 - Bullets
 - Foreskin from the circumcision of a newborn
 - Teeth
 - Catheters
6. No procedure which is banned by the code of Ethical and Religious Directives for Catholic Health Facilities shall be allowed. Should a questionable breach of this code of Ethics occur, surgical cases may be canceled or delayed by the operating room supervisor until a completed chart with acceptable consultation is furnished.
7. Any invasive procedure fits the broad category of surgery, whether done in X-Ray, the G.I. Lab, ICU or other patient care areas and shall require the same consent forms and documentation as other surgical procedures.
8. The Dental, Podiatry, Anesthesia, Pathology, and Emergency Department Staff are subsections of the Surgery Section and meet with this Section.

Section 17 - House Staff:

1. **AHEC Residents Supervising Policy - Refer to Policy MS-PP-22**
2. **AHEC Residents Supervisory Responsibility Policy - Refer to Policy MS-PP-17**

Section 18 - Resolution of Medical Staff Issues:

In the event that a majority of the Active and Associate Medical Staff present at a General Staff meeting or a called meeting, has a disagreement with Administration or the Board of Directors in regard to a policy or other significant decision, the process will be followed as outlined in the Conflict Resolution Policy maintained in the Administrative/Medical Staff Offices. It is stipulated that neither the Medical Staff nor Administration shall unilaterally amend the Conflict Resolution Policy.

- END -