BYLAWS of
THE MEDICAL STAFF of
COVENANT HOSPITAL PLAINVIEW

TABLE OF CONTENTS

BYLAWS

of

THE MEDICAL STAFF

of

COVENANT HOSPITAL PLAINVIEW

PREAMBLE

Covenant Hospital Plainview (the "Hospital") is a non-profit corporation organized under the laws of the State of Texas. These Bylaws are adopted in order to provide for the organization of the Medical Staff of the Hospital and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving quality patient care, treatment, services, and patient safety, and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital's Board of Directors through the cooperative efforts of the Hospital's Chief Executive Officer.

The physicians, dentists, and podiatrists practicing in the Hospital shall carry out the functions delegated to the Medical Staff by the Board of Directors in conformity with these Bylaws.

DEFINITIONS

Active Medical Staff means the Active category of the Medical Staff as defined in Article V.B of these Bylaws.

Allied Health Professional ("AHP") means an individual, other than a licensed physician, oral surgeon, dentist, or podiatrist who provides direct patient care, treatment, and services at the Hospital under a defined degree of supervision by a Medical Staff Member who maintains clinical privileges at the Hospital.

Board means the Board of Directors of the Hospital or its designee.

Business Day means all days other than Saturdays, Sundays or legal holidays or the equivalent for the Hospital.

Chief Executive Officer or CEO means the Chief Executive Officer of the Hospital.

Committee means a division of the Medical Staff as described in Article VIII.A of these Bylaws.

Hospital means Covenant Hospital Plainview, and the Board, its members and committees, its president, other officers and employees, all Medical Staff Members, Departments and committees and all authorized representatives of the foregoing.

Medical Executive Committee or MEC means the Medical Staff Executive Committee.

Medical Staff consists of those Members with privileges to attend to Patients in the Hospital.

Member means any physician, dentist, or podiatrist appointed to, and maintaining membership in, any category of the Medical Staff in accordance with these Bylaws.

Officer means an officer of the Medical Staff as defined in these Bylaws.

Patient means an individual (i) seeking medical treatment who may or may not be under the immediate supervision of a personal attending physician, has one or more undiagnosed or diagnosed medical conditions, and who, within reasonable medical probability, requires immediate or continuing hospital services and medical care; or (ii) is admitted to the Hospital as a patient.

Patient Contact means an inpatient admission, consultation, or an inpatient or outpatient surgical procedure.

Privileges mean the permission granted to a Medical Staff Member or AHP, as described in these Bylaws, to render specific patient services.

I. NAME

The name of this organization is the Covenant Hospital Plainview Medical Staff.

II. PURPOSE

The purpose of the Medical Staff is to organize the activities of qualified physicians and other clinical practitioners who practice at the Hospital in order to carry out, in conformity with these Bylaws, the functions delegated to the Medical Staff by the Board. The Medical Staff provides oversight of care, treatment, and services provided by practitioners with Privileges at the Hospital. The Members of the Medical Staff work together as an organized body to promote a uniform standard of quality patient care, treatment, and services and to offer advice, recommendations, and input to the Chief Executive Officer of the Hospital (the “CEO”) and the Board. The Medical Staff promulgates bylaws, policies, and procedures to determine its governance and administrative structures and the processes for carrying out its work, subject to the ultimate authority of the Board.

III. AUTHORITY

Subject to the authority and approval of the Board, the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these Bylaws and under the corporate bylaws of the Hospital.

IV. MEDICAL STAFF MEMBERSHIP

A. Nature of Medical Staff Members

Membership on the Medical Staff of the Hospital is a privilege that shall be extended only to professionally competent physicians, dentists, and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated policies of the Medical Staff and Hospital.

B. Responsibilities of Membership

Each Member will:

1. Direct the care of his Patients and will supervise the work of any AHP under his direction;

2. Be encouraged to assist the Hospital in fulfilling its responsibilities for providing charitable care, to the degree they are able;

3. Act in an ethical, professional and courteous manner;

4. Treat employees, Patients, visitors and other Medical Staff Members in a dignified and courteous manner;

5. Assume and carry out all of the functions and responsibilities of membership in the appropriate category as described in these Bylaws.

6. Abide by the Bylaws and the Rules and Regulations and by all other lawful standards, policies and rules of the Hospital;

7. Prepare and complete medical and other required records in a timely manner as defined in applicable Rules, Regulations, policies and procedures for Patients the Member admits or in any way provides care, treatment, and services in the Hospital; and

8. Participate in Hospital peer review activities.

C. Non-Discrimination

Membership and Privileges shall not be based upon race, color, religion, sex, national origin, age, disability, sexual orientation, or employment status with the Hospital.

D. Basic Qualifications for Membership

1. It is the policy of the Hospital to grant and maintain Medical Staff membership and clinical privileges only to those practitioners who continuously meet the following criteria:

   a. Demonstrate the background, experience, training, current competence, knowledge, judgment, ability to perform, and technique in his or her specialty for all privileges requested.

   b. Upon request of MEC, provide evidence of both physical and mental health that does not impair the fulfillment of his or her responsibilities of Medical Staff membership and the specific privileges requested by and granted to the applicant.

   c. Maintain appropriate personal qualifications, including applicant's consistent observance of ethical and professional standards. These standards include, at a minimum:

      1) Abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referrals or patient service opportunities. Legal co-management is acceptable.

      2) A history of consistently acting in a professional manner with others in clinical and professional settings.

   d. Possess appropriate written and verbal communication skills.

   e. Whenever the practitioner has the occasion to attend to patients at the Hospital and/or offer hospital-related services, demonstrates the capability to provide continuous care to patients. This includes providing evidence of acceptable patient coverage to the MEC.

2. No practitioner shall be entitled to membership on the Medical Staff or to clinical privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization.

3. Before an application may be processed, all applicants for appointment and reappointment to the Medical Staff must provide evidence of the following

qualifications for membership and privileges, unless the Board allows a specific exemption after consultation with the MEC:

a. Demonstration of successful graduation from an approved school of medicine, osteopathy, or dentistry or other professional education program appropriate to the clinical specialty of the applicant.

b. A current license as a physician or dentist required for the practice of his or her profession within the State of Texas, or the legal permission to practice in Texas as a member of the armed forces or a federal employee.

c. Possession of a current, valid, United States Drug Enforcement Agency (DEA) number, if applicable.

d. Demonstration of competence in the area in which clinical privileges are sought, by recent experience or recent approval by the MEC.

e. Evidence of skills to provide a type of service that the Board has determined to be appropriate for the performance within the Hospital and for which a need exists.

f. Evidence of professional liability insurance of a type and in an amount established by the Board.

g. A record that is free from current Medicare, Medicaid, and Tricare sanctions. The applicant may not be listed on the Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals/Entities.

h. A civil or criminal record that is free of any felony convictions within the last three (3) years, or occurrences that would raise questions of undesirable conduct, or repetitive misdemeanor convictions that raise ethical concerns as defined by the MEC.

i. A physician applicant (MD or DO) must have successfully completed an allopathic or osteopathic residency program of at least two (2) years, certified / approved by the Accreditation Council for Graduate Medical Education, appropriate for the area of medicine they intend to practice, and are board eligible or board certified.

j. Applicants for initial appointment to the Medical Staff must be board eligible or board certified recognized by the American Board of Medical Specialties. Notwithstanding the above requirement, only applicants for privileges in the Emergency Department may be

accepted if they have demonstrated significant previous experience in emergency medicine or are a senior resident in good standing.

k. Dentists must have graduated from an American Dental Association (ADA)-approved school of dentistry accredited by the Commission of Dental Accreditation (CDA).

l. Oral and maxillofacial surgeons must have graduated from an ADA-approved school of dentistry accredited by the CDA, have successfully completed an ADA-approved residency program, and be board certified or board admissible by the American Board of Oral and Maxillofacial Surgery.

m. A podiatric physician must have successfully completed a two (2) year residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association, and be board certified or board admissible by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedic and Primary Podiatric Medicine.

n. A psychologist must have earned a doctorate degree (PhD or PsyD in psychology) from an educational institution accredited by the American Psychological Association (APA); have completed at least two years of clinical experience in an organized healthcare setting supervised by a licensed psychologist, one year of which must have been post-doctorate; have completed an internship endorsed by the APA; and have received board certification as appropriate to the area of clinical practice.

E. Duration of Appointment

Initial appointment to the Medical Staff shall be 13 to 24 months, aligning to the last day of the birth month of the applicant. Reappointment to the Medical Staff will be for no more than twenty four (24) months and will align to the birth month.

V. CATEGORIES OF THE MEDICAL STAFF

The Medical Staff shall include Active, Courtesy, Consultative, Honorary, and Telemedicine Medical Staff categories.

A. Active Medical Staff

1. Qualifications: In addition to the qualifications described in Article IV, Members assigned to the Active Medical Staff must be appointees of the Medical Staff, be involved in twenty-four (24) Patient Contacts at the Hospital in a twenty-four (24) month period and document their efforts to support the Hospital's patient care mission to the satisfaction of the MEC and the Board. In the event that an appointee to the Active Medical Staff does not meet the qualifications for reappointment to the Active Medical Staff, and if the appointee is otherwise abiding by all Bylaws, rules, regulations, and policies of the Medical Staff, the appointee may be appointed to the Courtesy category of the Medical Staff.

2. Prerogatives: Appointees to the Active Medical Staff may:

   a. exercise such Privileges as are granted by the Board

   b. vote on all matters presented by the Medical Staff and by the appropriate Department and committee(s) to which the appointee is assigned

   c. hold office and sit on or be the chairperson of any committee in accordance with any qualifying criteria set forth elsewhere in the Medical Staff Bylaws or Medical Staff policies

3. Responsibilities: Appointees to the Active Medical Staff shall:

   a. contribute to the organizational and administrative affairs of the Medical Staff

   b. actively participate as requested or required in activities and functions of the Medical Staff, including quality/performance improvement and peer review, credentialing, risk and utilization management, medical records completion, monitoring activities, and the discharge of other staff functions as may be required

   c. fulfill any meeting attendance requirements as established by these bylaws or by action of the MEC

   d. fulfill or comply with any applicable Medical Staff or hospital policies or procedures

   e. fulfill any Emergency Services call coverage as established by the Medical Staff Rules and Regulations or by a decision of the MEC

B. Courtesy Staff

1. Qualifications: In addition to the qualifications described in Article IV, the Courtesy Staff is reserved for Medical Staff Members who have 1-23 patient contacts in a 24-month period. When a member has 24 or more patient contacts in a 24-month period, the member will automatically be changed to active medical staff.

2. Prerogatives: Appointees to the Courtesy Staff may:

   a. exercise such Privileges as are granted by the Board

   b. attend Medical Staff meetings and Committee meetings, as a non-voting member; as well as attend any staff or hospital education programs. Members of the Courtesy Staff may not vote or hold office.

3. Responsibilities: Appointees to the Courtesy Staff shall:

   a. contribute to the organizational and administrative affairs of the Medical Staff

   b. actively participate as requested or required in activities and functions of the Medical Staff including quality/performance improvement and peer review, credentialing, risk and utilization management, medical records completion, monitoring activities, and the discharge of other staff functions as may be required

   c. fulfill any meeting attendance requirements as established by these bylaws or by action of the MEC

   d. fulfill or comply with any applicable Medical Staff or hospital policies or procedures

   e. fulfill any Emergency Services call coverage as established by the Medical Staff Rules and Regulations or by the decision of the MEC

C. Consultative Staff

1. Qualifications: The Consultative Staff Members must meet the qualifications described in Article IV.

2. Prerogatives: The Consultative Staff status is awarded to a physician whose practice and privileges are hospital-based, episodic, or outpatient in scope, such as anesthesiologists, emergency physicians, pathologists, and radiologists. Such members shall have no admitting privileges at the

Hospital, no operating room privileges, and are not required to fulfill any Emergency Services obligations.

3. Responsibilities: Each Member of the Consultative Staff may attend meetings of the Medical Staff but are not entitled to vote or hold office, but may serve on Medical Staff Committees as non-voting members.

D. Honorary Staff

1. Qualifications: The honorary category is restricted to individuals recommended by the MEC and approved by the Board. Appointment to this category is entirely discretionary and may be rescinded at any time. Reappointment to this category is not necessary, as appointees are not eligible for clinical privileges. Appointees to the honorary category shall consist of members who have retired from active hospital practice, who are of outstanding reputation, and who have provided distinguished service to the hospital.

2. Prerogatives: Appointees to the Honorary category may attend Medical Staff meetings and continuing medical education activities, and may be appointed to committees. Members of the honorary category need not meet the requirements for professional liability insurance. They shall not hold office, be eligible to vote, or be required to take emergency services call.

E. Telemedicine Staff

Telemedicine is the practice of medicine at the Hospital by a person who is physically located outside of the Hospital and, through the use of any medium, including an electronic medium, performs an act that is part of a patient care service initiated at the Hospital, including the reading of an x-ray, that would affect the diagnosis or treatment of a Patient. Practitioners providing telemedicine services to a Hospital Patient must have Privileges at the Hospital. Practitioners providing telemedicine services limited to interpretation and second opinions require Temporary Privileges and / or appropriate credentialing by the contracted entity.

1) Telemedicine Staff shall consist of those members who are: (1) credentialed and privileged through the process described in Sections IX of these Bylaws; and (2) provide patient care or services solely through a telemedicine link.

2) An applicant to the Telemedicine Staff must submit a complete application to the Medical Staff in accordance with Section IX of these Bylaws, which will be processed by the Medical Staff office in the same manner as other applications for membership pursuant to Section IX of these Bylaws, except as otherwise provided in these Bylaws.

3) Telemedicine Staff members:

i) Shall abide by the Bylaws, Rules and Regulations, and/or Policies to the extent they pertain to the exercise of any Telemedicine Clinical Privileges;

ii) Shall be entitled only to exercise those Telemedicine Clinical Privileges granted in accordance with these Bylaws; and

(iii) Are not eligible to participate in the following activities: (1) attending department and medical staff meetings; (2) voting for department and medical staff officers; and (3) voting on revisions to these Bylaws.

VI. OFFICERS OF THE MEDICAL STAFF

A. The Officers of the Medical Staff shall consist of:
   1. President of the Medical Staff
   2. Vice President of the Medical Staff

B. Qualifications of Officers

Officers must be members in good standing on the Active Medical Staff at the time of election and must remain so in good standing during their term of office; have previously served in a significant leadership position on a Medical Staff, either as a Department Chair, committee chair, MEC member, or Officer; indicate a willingness and ability to serve; have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges; have a history of attendance at continuing education relating to Medical Staff leadership or be willing to attend during his or her term of office; have demonstrated both an ability to work well with others and in compliance with the professional conduct policies of the hospital; and have good administrative and communication skills. The Medical Staff nominations committee will have discretion to determine if a staff member wishing to run for office meets these qualifying criteria.

C. Election of Officers

1. Regular Elections

The regular election of Officers will be held every other year at the annual meeting of the Medical Staff.

2. Nominations by Nominating Committee

Prior to the first day of the month of May of an election year, the Nominating Committee shall submit to the President of the Medical Staff one nomination for the President of the Medical Staff and one nomination

for the Vice President of the Medical Staff. The President of the Medical Staff shall cause the names of such nominees to be reported to the Active Medical Staff by written notice not less than twenty (20) days prior to the Annual (June) meeting of the Medical Staff. The Nominating Committee will consist of the immediate past President of the Medical Staff who serves as Chairperson, one Member of the MEC elected by the MEC, and one non-MEC member of the Active Staff appointed by the President of the Medical Staff.

3. Nominations may also be made by a petition signed by at least fifteen percent (15%) of the Members of the Active Medical Staff. Such a petition must be submitted to the Chair of the Nominating Committee at least fourteen (14) Business Days prior to the election for the nominee to be placed on the ballot. The candidate nominated by petition must be confirmed by the Nominating Committee as meeting the qualifications for office enumerated in these Bylaws before being placed on the ballot.

4. Any Member of the Active Medical Staff may cast a vote of the top 2 candidates. No proxy voting is permissible. The candidate who receives the most votes for a position will be elected. In the event of a tie vote, the Medical Staff office will make arrangements for a repeat vote until one candidate receives a majority of votes cast. All elections of Officers will require confirmation by the Board.

D. Term of Office

All Officers serve a term of two (2) years. Officers will take office on the first day of month of July, except that an Officer elected to fill a vacancy will assume office immediately. An Officer may be reelected to a position without limitation.

E. Vacancies of Office

1. A vacancy in the office of the President of the Medical Staff will be filled by the Vice President of the Medical Staff.
2. A vacancy in the office of Vice President of the Medical Staff will be filled by a vote of the Active Medical Staff.

F. Duties of Officers

1. President of the Medical Staff:

   a. Oversee the administrative functions of the Medical Staff.

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

c. Serve as the Chair of the MEC.

d. Be responsible for the enforcement of these Bylaws and the Medical Staff Rules and Regulations.

e. Represent the views, policies, needs, and grievances of the Medical Staff to the Board, the CEO, and all others within the Hospital.

f. Interpret the policies of the Board to the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the Medical Staff's responsibility for the provision of quality patient care, treatment, and services.

g. Participate in the organization and coordination of the Medical Staff's quality improvement programs.

h. Be the spokesperson for the Medical Staff in its external, professional, and public relations.

2. Vice President of the Medical Staff: In the absence of the President of the Medical Staff, the Vice President of the Medical Staff shall assume all the duties and have the authority of the President of the Medical Staff. He or she shall perform such further duties to assist the President of the Medical Staff as the President of the Medical Staff may from time to time request. The Vice President of the Medical Staff chairs the Physician Peer Review Committee.

3. Immediate Past President: The Immediate Past President will serve as a consultant to the President of the Medical Staff and provide feedback on an annual basis to the Officers regarding their performance of assigned duties. He or she shall serve as Chair of the Nominating Committee and perform such further duties to assist the President of the Medical Staff as the President of the Medical Staff may from time to time request.

G. Removal from Office

An Officer may be removed from office by the Board acting on its own initiative or by the Medical Staff by a two-thirds (2/3) supermajority vote by written ballot of the Active Medical Staff. Automatic removal shall be for failure to conduct those responsibilities assigned within these bylaws or in the Medical Staff organization and functions manual; failure to comply with policies and procedures of the Medical Staff; conduct or statements damaging to the hospital, its goals, or its programs; or an automatic or summary suspension of clinical privileges that lasts for more than thirty (30) days. The Board will determine the existence of such failures after it consults with the MEC.

VII. MEDICAL EXECUTIVE COMMITTEE

A. Composition: The Medical Executive Committee ("MEC") shall be the principal standing committee of the Medical Staff. It shall consist of the President and Vice President of the Medical Staff. The immediate past President shall serve as a non-voting ex-officio member. The MEC shall also have five (5) members of the Active Medical Staff: the chairs of the Medicine Committee, the OB/Pediatric Committee, the ER Committee,and the Surgery Committee; and one at-large member, elected by the general medical staff. These Members represent the overall professional diversity of the Medical Staff. Election of Officers and Members should follow Medical Staff policies and procedures. The President of the Medical Staff will serve as the Chair of the MEC and preside at meetings. The CEO or his/her designee(s) shall be ex-officio members of the MEC.

B. Duties: The MEC shall:

1. Serve as the final decision-making body of the Medical Staff in accordance with the Medical Staff bylaws, and provide oversight for all Medical Staff functions

2. Coordinate the implementation of policies adopted by the Board

3. Submit recommendations to the Board concerning all matters relating to appointments, reappointments, staff categories, clinical Committee assignments, clinical privileges, and corrective actions

4. Account to the Board and to the Medical Staff for the overall quality and efficiency of professional patient care services provided in the hospital by individuals with clinical privileges, and coordinate the participation of the Medical Staff in organizational performance improvement activities

5. Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of the staff appointees, including collegial and educational efforts and investigations, when warranted

6. Make recommendations to the Board on medico-administrative and hospital management matters

7. Keep the Medical Staff up-to-date concerning the licensure and accreditation status of the hospital

8. Participate in identifying community health needs and setting hospital goals, and in implementing programs

9. Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these bylaws

10. Credentialing activities

    a. Perform ongoing professional practice evaluation of all Medical Staff members and recommend action on all applications and reapplications for membership on the Medical Staff

    b. Review and recommend action on all requests for clinical privileges from practitioners who currently hold other privileges at the Hospital

    c. Recommend to the Board criteria for the granting of Medical Staff membership and Privileges for the Hospital

    d. Develop, recommend, and consistently implement policy and procedures for all credentialing activities at the Hospital

11. Provide leadership for measuring, assessing, and improving processes that depend primarily on the activities of one or more licensed independent practitioners and other practitioners credentialed and privileged through the Medical Staff process

12. Understand the adopted approach to and methods of performance improvement

13. Ensure that important processes and activities are measured, assessed, and improved systematically across all disciplines throughout the hospital

14. Communicate any performance-improvement findings, conclusions, recommendations, and actions to appropriate staff members and the governing body; define in writing the responsibility for acting on recommendations for improvement

15. Participate in ensuring that the processes are defined and implemented for identifying and managing sentinel events and events that warrant intensive analysis

16. Ensure the implementation of an integrated, hospital-wide patient safety program

17. Ensure that ongoing, proactive programs for identifying risks to patient safety and reducing medical/healthcare errors are defined and implemented

18. Provide for mechanisms to measure, analyze, and manage variation in the performance of defined processes that affect patient safety

19. Measure and assess the effectiveness of efforts to improve performance and patient safety

C. Delegation and Removal of Duties: In addition to those duties and responsibilities of the MEC set forth herein, the MEC is empowered to act for the organized Medical Staff between meetings of the organized Medical Staff.

D. Accountability: The MEC shall report and be primarily accountable to the Medical Staff and to the Board via the President.

E. Removal from Membership: An Officer who is removed from his or her position in accordance with Article (VI), Section (G), above will automatically lose his or her membership on the MEC. Where the chair of the Surgery Committee, the Medicine Committee, the OB/Pediatric Committee, or the Emergency Department Committee is removed or resigns this position, his or her replacement will serve on the MEC. Other members of the MEC may be removed by a two-thirds (2/3) affirmative vote of MEC members. Where such a removal takes place, the MEC will arrange for an at-large election for a replacement to serve out the remainder of the term vacated. Such election will follow procedures established by the MEC and must take place within sixty (60) days of the removal of an MEC member.

F. Meetings: The MEC will meet 10 times per medical staff year and maintain a permanent record of its proceedings and actions.

VIII. MEDICAL STAFF ORGANIZATION

A. Organization: The Medical Staff shall be organized into the following Committees:

Medicine Committee
OB/Pediatric Committee
Surgery Committee
Emergency Services/Trauma Committee

B. Assignment: Each person appointed to the Active Medical Staff shall be assigned to the Committee appropriate to their medical specialty, privileges, and call coverage as assigned by the MEC.

C. Changes: When deemed appropriate, the Medical Staff and the Board, by their joint action, may add, delete, combine or sub-divide a Committee.

D. Committee Chairs: The designation of "Committee Chair" refers to the physician's administrative role within the Hospital's governance and operational structure as a Member of the Medical Staff and related to the Hospital's inpatient and outpatient clinical activities. Committee Chairs report to the MEC.

E. Appointment of a Committee Chair: All Committee Chairs will be elected by Members of the relevant Committee, subject to approval by the Board upon receipt of a recommendation of the MEC. Committee Chairs will serve for two (2) year terms.

F. Committee Chair Duties: Each Committee Chair shall:

1. Assume responsibility for the implementation within the Committee of actions taken by the Board and MEC.

2. Assume responsibility for enforcement within the Committee of the Bylaws of the Medical Staff, Rules and Regulations of the Medical Staff, policies and procedures of the Medical Staff and Hospital.

3. Transmit to the MEC recommendations concerning the appointment, reappointment and delineation of Privileges for all individuals in and applications to his/her Committee.

4. Monitor all clinically related activities of the Committee and all members of the Medical Staff assigned to the Committee with delineated Privileges.

5. Monitor all admission-related activities of the Committee.

6. Integrate the Committee into the primary functions of the Hospital.

7. Assume responsibility for the Committee's establishment of written criteria for the assignment of Privileges to Medical Staff Members assigned to such Committee. Such criteria shall be approved by the MEC and the Board and may be amended from time to time upon the approval of the MEC and the Board.

8. Make recommendations to MEC regarding initial privileges of new committee members, based on the results of focused professional practice evaluation.

9. Assume responsibility for the Committee's development and implementation of policies and procedures that guide and support the provision of care, treatment and services.

10. Assume responsibility for the Committee's continual assessment and improvement of the quality of care, treatment and services within the Committee.

11. Assume responsibility for the Committee's maintenance of quality control and improvement programs.

12. Assume responsibility for the Committee's orientation and continuing education for Hospital related activities.

13. Assess and recommend to the relevant Hospital authority off-site sources for needed patient care, treatment and services not provided by the Committee or the Hospital.

14. Coordinate and integrate services between, among and within the Committees.

15. Determine the qualifications and competence of the AHP under the delegation and supervision by a committee member.

16. Recommend space and other resources needed by the Committee.

G. Removal of a Committee Chair: The removal of a Committee Chair during his term of office may be initiated by the President of the Medical Staff, the Board or a two-thirds (2/3) majority vote of all Active Medical Staff Members of the Committee, but no such removal will be effective unless and until it has been ratified by the Board.

IX. APPOINTMENT AND REAPPOINTMENT

A. General Procedure

The Medical Staff, through its designated committees and Officers, shall investigate and consider each application for appointment or reappointment to the Medical Staff and each request for a modification of Privileges and shall adopt and transmit recommendations thereon to the Board, which shall be the final authority on appointment, reappointment, extension, termination or reduction of Privileges. Equal consideration shall be given regarding the granting of medical staff membership and privileges, regardless of the physician's employment relationship with the hospital.

B. Application Request Procedure

All requests for applications for appointment to the Medical Staff and requests for Privileges will be forwarded to the Medical Staff Services office. Upon receipt of a written request for an application, the Medical Staff office or their designee will provide the potential applicant with an application. A copy of the Bylaws

overview or a complete set of the Bylaws and rules and regulations will be provided or made available to the applicant.

Any applicant not meeting the Board's criteria for membership outlined in the cover letter to the applicant will not have his or her application processed and will not be entitled to a fair hearing or any of the rights and due process provided under the Medical Staff bylaws.

C. Application for Initial Appointment

1. The application package will be provided to Inquirers
2. The applicant must sign the application and/or attestation form. This signature will signify the applicant's agreement to all of the following:

   a. Attestation to the accuracy and completeness of all information on the application or accompanying documents and agreement that any inaccuracy, omission, or misrepresentation —whether intentional or not—will be grounds for termination of the application process without the right to a fair hearing or appeal. If the inaccuracy, omission, or misstatement is discovered after an individual has been granted appointment and/or clinical privileges, the individual's appointment and privileges shall lapse effective immediately upon notification of the individual, without the right to a fair hearing or appeal.

   b. Consent to appear for any requested interviews in regard to his or her application.

   c. Authorization of hospital and Medical Staff representatives to consult with prior and current associates and others who may have information bearing on his or her professional competence, character, ability to perform the procedures, etc., for which privileges are requested, ethical qualifications, ability to work cooperatively with others, and other qualifications for membership and the clinical privileges requested. This includes requesting information from previous professional liability carrier(s) that have insured the applicant.

   d. Consent for hospital and Medical Staff representatives' inspection of all records and documents that may be material to an evaluation of his or her professional qualifications and competence to carry out the clinical privileges requested, of his or her physical and mental health status to the extent relevant to the capacity to fulfill requested privileges, and of his or her professional and ethical qualifications.

   e. That applicant releases from liability, promises not to sue, and grants immunity to the hospital, its Medical Staff, and its representatives for acts performed and statements made in connection with the evaluation

of the application and his or her credentials and qualifications to the fullest extent permitted by the law.

f. That applicant releases from liability and promises not to sue all individuals and organizations providing information, including otherwise privileged or confidential information, to the hospital or the Medical Staff concerning his or her background, experience, competence, professional ethics, character, physical and mental health to the extent relevant to the capacity to fulfill requested privileges, emotional stability, utilization practice patterns, and other qualifications for staff appointment and clinical privileges.

g. Authorization of the Medical Staff and administrative representatives to release to other hospitals, medical associations, licensing boards, and other organizations concerned with this provider's performance and the quality and efficiency of this provider's patient care any information relevant to such matters that the Hospital may have concerning him or her and the release of the Hospital's representatives from liability for so doing. For the purposes of this provision, the term "hospital representatives" includes the Board, its directors and committees, the CEO or his or her designee, registered nurses and other employees of the Hospital, the Medical Staff organization and all Medical Staff appointees, clinical units, and committees that have responsibility for collecting and evaluating the applicant's credentials or acting upon his or her application, and any authorized representative of any of the foregoing.

h. That applicant agrees to cooperate with any credentials verification organization (CVO) that the Hospital may use to obtain credentialing information regarding the applicant. Any application materials provided by such a CVO will be fully completed and submitted according to instructions provided by the CVO or the Hospital.

i. That applicant has been oriented to the current Bylaws, including its associated manuals and all rules, regulations, policies, and procedures of the Medical Staff, and agrees to abide by their provisions. Such orientation will include at least one of the following: receiving a copy of the bylaws and associated manuals, or receiving a summary of the expectations of Medical Staff members and having the Bylaws and manuals made available to the applicant.

j. A period of focused professional practice evaluation, delineated by the MEC, implemented for all initially requested privileges.

3. Application Processing:

a. A completed application includes, at a minimum:

1) A completed, signed, and dated application form

2) A completed request for Privileges

3) Copies of all documents and information necessary to confirm that the applicant meets the criteria for membership and/or Privileges

4) All applicable fees, which can be waived by the CMO or Chief of Staff.

5) All requested references

An application shall be deemed incomplete if any of the above items are missing or if the need arises for new, additional, or clarifying information in the course of reviewing the application. An incomplete application will not be processed.

b. Applications must be completed within 60 days. Inactivity for 30 days will result in the automatic withdrawal of the application.

c. The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that the Medical Staff office receives all required supporting documents verifying information on the application and providing sufficient evidence, as required at the sole discretion of the Hospital, and that the applicant meets the requirements for Medical Staff membership and the Privileges requested. If information is missing from the application—or if new, additional, or clarifying information is required — a letter requesting such information will be sent to the applicant. If the requested information is not returned to the Medical Staff office within forty-five (45) days of the receipt of the request letter, this will be deemed a voluntary withdrawal of the application.

d. Upon receipt of a completed application as defined above, the applicant will be sent a letter of acknowledgment by the Medical Staff services office or CEO. Individuals seeking appointment and reappointment shall have the burden of producing any additional information deemed necessary by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and for resolving any doubts.

e. Any applicant not meeting the minimum objective requirements for membership to the Medical Staff, as outlined in Section 2 above, will

not have his or her application processed and will not be entitled to a fair hearing pursuant to Article IX.

f. Upon receipt of a completed application, the Medical Staff office will verify its contents from acceptable sources and collect additional information as follows:

1) Information from all prior and current liability insurance carriers concerning claims, suits, settlements, and judgments (if any) during the past ten (10) years

2) Documentation of the applicant's past clinical work experience

3) Licensure status in all current or past states where the applicant has held a license

4) Information from the AMA or AOA Physician Profile, Federation of State Medical Boards, CMS/OIG list of excluded individuals, Fraud and Abuse Control Information System, or other such data banks, and including a criminal background check

5) Verification of the completion of professional training programs, including residency and fellowship programs

6) Information from the National Practitioner Data Bank

7) Other information about adverse credentialing and privileging decisions

8) Three (3) peer recommendations from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, ethical character, and ability to work with others.

9) Additional information as may be requested to ensure applicant meets the criteria for Medical Staff membership and/or requested privileges

10) Government issued identification

11) If available, the results of any drug test and/or other health testing required by a healthcare institution or licensing board

12) Current Immunizations

4. Expedited credentials review

When a completed application and all related and requested material have been obtained, the file will then be reviewed by a designee of the MEC and by the Medical Staff office service professional (or designee), who will categorize the application as follows:

a. Category 1 Applications: A verified application that does not raise concerns as identified in the criteria for Category 2. Applicants in Category 1 will be granted Medical Staff membership and privileges following approval by: the officers of the MEC and a Member assigned by the President, and least two (2) members of the Medical Staff appointed by the Board.

b. Category 2 Applications: If one or more of the following criteria are identified in the course of the review of a completed file, the application will be treated as a Category 2. The full MEC and the Board review applications in Category 2. The MEC may request that an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is on the applicant to provide evidence that he or she meets the criteria for membership on the Medical Staff and for the granting of requested privileges. Criteria for Category 2 applications include, but are not necessarily limited to, the following:

1) The application is deemed to be incomplete

2) The final recommendation of the MEC is adverse or with limitation

3) The applicant is found to have experienced an involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization

4) The applicant is, or has been, under investigation by a state medical board or has had prior disciplinary actions or legal sanctions

5) The applicant has had one or more malpractice cases filed against him or her

6) The applicant's National practitioner Data Bank report is adverse

A "verified application" indicates that the primary source verification has been completed and all items listed under Article IX have been received and verified.

A "subject matter expert" is an individual chosen by the Medical Staff credentials committee or the MEC to assist and advise it in evaluating requests and recommendations for clinical privileges.

D. Application for Reappointment

1. The following information may be collected during the reappointment process:
   a. A summary of clinical activity at the Hospital for each appointee due for reappointment

   b. Performance and conduct in the Hospital and other hospitals (where available) in which a practitioner has provided substantial clinical care since the last reappointment, including, without limitation, patterns of care as demonstrated in findings of quality assessment/performance improvement activities, his or her clinical judgment and skills in the treatment of patients, and his or her behavior and cooperation with hospital personal, patients, and visitors

   c. Meet required continuing medical education credits as required by Texas Medical Board.

   d. Service on Medical Staff, Department, and hospital committees

   e. Timely and accurate completion of medical records

   f. Compliance with all applicable bylaws, policies, rules, regulations, and procedures of the Hospital and Medical Staff

   g. Any gaps in employment or practice since the previous appointment or reappointment

   h. A peer recommendation when insufficient peer review data are available to evaluate current competence, ethical character, and ability to work with others.

   i. Current malpractice certificate

2. Criteria for reappointment: It is the policy of the Hospital to approve for reappointment only those individuals who meet the criteria for initial appointment as identified in Article IV and who have been determined by the MEC to be providers of effective care that is consistent with the Hospital's standards of ongoing quality as determined by the MEC and the hospital performance improvement program.

3. Submission of Reappointment Application: Reappointment applications will be sent up to 6 months prior to reappointment, applications must be completed within sixty (60) days of receipt. Failure, without cause, to timely complete and submit such application, and all information required for assessment of current competence, qualifications, and eligibility for reappointment will constitute a resignation of the Member at the expiration of the Member's current term.

E. Clinical Privileges

1. Exercise of privileges: A practitioner providing clinical services at the Hospital may exercise only those Privileges granted to him or her by the Board.

2. Requests: Each application for appointment or reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. Specific requests also must be submitted for temporary privileges and for modifications of privileges in the interim between reappointments.

3. Basis for privileges determination:

a. Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence, as specified by the MEC and relevant committees, for clinical privileges.

b. Privileges for which no criteria have been established:

1) In the event a request for privileges is submitted for which no criteria have been established, the request will be tabled for a reasonable period of time, usually not to exceed sixty (60) days, during which the MEC will formulate the necessary criteria and recommend these to the Board. Once the Board has established objective criteria, the original request will be processed as described herein.

2) For the development of criteria, the Medical Staff service professional (or designee) will compile information relevant to the privileges requested, which may include, but need not be limited to, position and opinion papers from specialty organizations, commercial compilations of privileging criteria, position and opinion statements from interested individuals or groups, and documentation of criteria used by other hospitals in the region as appropriate.

3) Criteria to be established for the privilege(s) in question include education, training, experience, and evidence of current competence. Proctoring requirements, if any, will be determined, including which individuals may serve as proctors and how many proctored cases will be required. Hospital-related issues (e.g., the availability of adequate equipment and personnel) will be referred to the appropriate Committee.

c. Requests for clinical privileges will be evaluated on the basis of prior and continuing education, training, experience, utilization practice patterns, current ability to perform the procedures, etc., for which privileges are requested; as well as demonstrated current competence, ability, and judgment. Additional factors that may be used in determining privileges are patient-care needs and the Hospital's capability to support the type of privileges being requested and the availability of qualified coverage in the applicant's absence. The bases for privileges determination to be made in connection with periodic reappointment or a requested change in privileges must include documented clinical performance and the results of the Hospital's and Medical Staff's performance improvement activities. Privilege determinations will also be based on pertinent information from other sources, especially other institutions and healthcare settings where a practitioner exercises clinical privileges.

d. The procedure by which requests for clinical privileges are processed are outlined in Article X.C. ("Initial Appointment Procedure").

F. Temporary Privileges

Temporary privileges may be granted by the CEO acting on behalf of the Board, upon written concurrence of the Chair of the Department in which the privileges will be exercised, or by the President of the Medical Staff, provided that there is verification of the applicant's current licensure and current competence.

Temporary privileges may be granted in only two (2) circumstances: 1) to fulfill an important patient care need, and 2) when an initial applicant with a complete, clean application is awaiting review and approval of the MEC and the Board.

1. Important patient care need: Temporary privileges may be granted on a case-by-case basis when an important patient care need exists that mandates an immediate authorization to practice, for a limited period of time not to exceed thirty (30) days, while the full credentials information is verified and approved. For the purposes of granting temporary privileges, an important patient care need is defined as including the following:

    a. A circumstance in which one or more individual patients will experience care that does not adequately meet their clinical needs if the temporary privileges under consideration are not granted (e.g., a patient scheduled for urgent surgery would not be able to undergo the surgery in a timely manner); and

    b. A circumstance in which the Hospital will be placed at risk of not adequately meeting the needs of patients who seek care from the Hospital if the temporary privileges under consideration are not granted (e.g., the Hospital will not be able to provide adequate emergency room coverage in the practitioner's specialty, or the Board has granted privileges involving new technology to a physician on staff with the provision that the physician is precepted for a specific number of initial cases and that the precepting physician, who is not seeking Medical Staff membership, requires temporary privileges to serve as a preceptor); and

    c. A circumstance in which a group of patients in the community will be placed at risk of not receiving patient care that meets their clinical needs if the temporary privileges under consideration are not granted (e.g., urgent coverage for a physician who has a large practice in the community for which adequate coverage of hospital care for its patients cannot otherwise be arranged)

2. Clean application awaiting approval: Temporary privileges may be granted for up to one hundred twenty (120) days when the new applicant for Medical Staff membership or privileges is waiting for review and recommendation by the MEC and approval by the Board. Criteria for granting temporary privileges in these circumstances include the applicant providing evidence of the following information, which has been verified by the Hospital:

    a. Current licensure

    b. Education

c. Training and experience

d. Current competence, by one positive reference specific to the applicant's competence from an appropriate medical peer

e. Current DEA status (if applicable)

f. Current professional liability insurance in the amount $100,000 / $300,000

g. Malpractice history

h. Results from a query to the National Practitioner Data Bank

3. Special requirements: Special requirements of consultation and reporting may be imposed as part of the process of granting temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the bylaws, rules, regulations, and policies of the Medical Staff and the Hospital in all matters relating to his or her temporary privileges. Whether or not such written agreement is obtained, the Medical Staff bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.

4. Termination of temporary privileges: The CEO, acting on behalf of the Board and after consultation with the President of the Medical Staff, may terminate any or all of a practitioner's temporary privileges based on the discovery of any information or the occurrence of any event of a nature that raises questions about a practitioner's privileges. Where the life or well-being of a patient is determined to be endangered, any person entitled to impose summary suspension under the Bylaws may effect the termination. In the event of any such termination, the CEO or his or her designee will assign the practitioner's patients to another practitioner. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

5. Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded by the Investigation, Corrective Action, Hearing and Appeal Plan procedures outlined in the Bylaws if his or her request for temporary privileges is refused. However, he or she will be afforded these procedural rights if all or any part of his or her temporary privileges are terminated or suspended based on a determination of clinical incompetence or unprofessional conduct.

G. Disaster Privileges

1. If the institution's emergency management plan has been activated, the CEO and other designated individuals identified in the institution's emergency management plan may, on a case-by-case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected practitioners for the purpose of providing patient care, provided the practitioner can present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following items, or be personally identified and attested to by current Hospital or Medical Staff Members who can vouch for the practitioner's identity:

   a. A current hospital photo identification (ID) card

   b. A current medical license and photo identification (ID) card issued by a state, federal, or regulatory agency

   c. Identification indicating that the individual is a member of the Disaster Medical Assistance Team, Medical Reserve Corps, Emergency System for Advance Registration of Volunteer Health Professionals, or another recognized state or federal organization or group that addresses disasters

   d. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity)

2. Primary source verification of licensure should begin as soon as the immediate situation is under control, and when possible, should be completed within seventy-two (72) hours from the time the volunteer practitioner presents to the organization.

3. Once the immediate situation has passed and the determination that the disaster is over has been made consistent with the institution's disaster plan, the practitioner's disaster privileges will terminate immediately.

4. Any individual identified in the institution's disaster plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised at the sole discretion of the Hospital and will not give rise to a right to a fair hearing or an appeal pursuant to Article IX.

5. Oversight of these physicians will be provided by the President of the Medical Staff, Officers, and Active Medical Staff Members to assure appropriate medical care is provided to patients. The oversight of the

professional performance of volunteer practitioners who receive disaster privileges will consist of direct observation, monitoring, and clinical record review. Based on its oversight of each volunteer licensed independent practitioner, the hospital determines within 72 hours of the practitioner's arrival if granted disaster privileges should continue.

H. Leaves of Absence

1. Leave request: A Member may request a voluntary leave of absence from the Medical Staff without loss of membership by submitting written notice to the President of the Medical Staff. The notice must state the reasons for the leave and approximate period of time of the leave, which may not exceed one (1) year except for military service or express permission by the Board. A leave of absence is ordinarily granted for reasons of health, military service, or further education. Requests for leave of absence must be forwarded by the President of the Medical Staff to the MEC for a recommendation. Each request for a leave of absence will be evaluated on an individual basis by the MEC. The MEC must make a recommendation within thirty (30) days of its receipt of the request. The Board must affirm the MEC's recommendation. No decision of a leave of absence will be subject to a review or give rise to Fair Hearing rights.

   During the period of time of the leave of absence, the Member may not exercise Privileges or prerogatives (including the right to vote) and has no obligation to fulfill Medical Staff responsibilities.

2. Termination of leave: At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Member may request reinstatement of membership and Privileges by sending a written notice to the President of the Medical Staff for transmittal to the MEC. The Member must submit a written summary of relevant activities during the leave of absence if the MEC or Board so requests. In the event the leave of absence occurs during the time of the Member's scheduled reappointment, the Member will be required to submit an application for reappointment. The MEC shall make a recommendation to the Board concerning the reinstatement within thirty (30) days of its receipt of the written notice, and the Board may impose any conditions on reinstatement it deems appropriate for patient safety or effective operation of the Hospital. No decision on a leave of absence reinstatement will give rise to Fair Hearing rights.

3. Any Member who will be absent for a period longer than thirty (30) days must apply for a leave of absence.

4. Failure to make a timely and appropriate request for reinstatement, following a leave of absence, will result in termination of the Member's membership and Privileges without the right of review.

I. Voluntary Resignation:

Resignations from the Medical Staff and/or relinquishment of Privileges shall be submitted in writing to the President of the Medical Staff for transmittal to the MEC and will be effective on the date stated in the writing with no formal action required. The President of the Medical Staff will acknowledge receipt of the resignation, in writing, and the Member will be promptly notified of any medical records containing documentation deficiencies.

When a Member's resignation is accepted or Privileges are relinquished during the course of an investigation related to potential corrective action related to issues of clinical competency or professional conduct, a report will be submitted to the National practitioner Data Bank, as required by law.

J. Telemedicine Privileges

1) Initial Telemedicine Clinical Privileges - Each application for initial Telemedicine Clinical Privileges may be processed in one of the following manners:

a) The applicant may obtain Clinical Privileges at the Hospital in the manner detailed in Section IX of these Bylaws;

b) The Medical Executive Committee and Governing Body may rely solely upon information provided by any other Joint Commission-accredited hospital(s) at which the applicant is a member of the medical staff and has clinical privileges, or any Joint Commission-accredited telemedicine entity providing telemedicine services with which the applicant is affiliated, in accordance with a written agreement with such hospital or telemedicine entity that complies the applicable Joint Commission standards, in order to make a credentialing decision based upon this Hospital's standards; or

c) The Medical Executive Committee and Governing Body may rely fully on the credentialing and clinical privileging decisions made by any other hospital(s) in which the practitioner is a member of the medical staff and has clinical privileges, as long as such hospital(s) is/are Joint Commission-accredited, or any Joint Commission-accredited telemedicine entity providing telemedicine services with which the applicant is affiliated, in accordance with a written agreement with such hospital or telemedicine entity. This process may be used only: (1) if the written agreement complies with the requirements detailed in Title 42, C.F.R., Section 482.22(a)(3) or (a)(4) and Section 482.12(a)(8) or (a)(9), and Joint Commission standards, as applicable; and (2) to grant Telemedicine privileges that do not exceed in practice those granted by the distant-site hospital or distant-site entity. If the practitioner applies for privileges that exceed those Telemedicine privileges that he or she has at the distant-site hospital or the distant-site entity, the application for those

privileges must proceed through the standard privileging and credentialing process applicable to non-Telemedicine Staff applicants pursuant to Section IX of these Bylaws.

2) Recredentialing of Telemedicine Clinical Privileges - Each application for renewed Telemedicine Clinical Privileges shall be based upon the practitioner's performance at the Hospital, and upon information from any hospital(s) where the practitioner is a member of the medical staff and has clinical privileges, as well as from any telemedicine entity with which the practitioner is affiliated.

3) Termination of Telemedicine Staff Privileges and Clinical Privileges

a) Privileges and membership granted to Telemedicine Staff members may be revoked or limited in a manner consistent with these Bylaws, including those articles and sections that address corrective action and hearing and appeal rights. However, no hearing and appeal rights shall be granted to practitioners whose membership and privileges are terminated, revoked, suspended or limited for reasons detailed in subsections (b) or (c) below.

b) Telemedicine Staff membership and Clinical Privileges granted in full reliance on the credentialing and clinical privileging decisions of another Joint Commission-accredited hospital shall terminate automatically in the event that: (1) the practitioner's medical staff membership and/or clinical privileges at such hospital are revoked, suspended, limited or voluntarily relinquished; (2) the practitioner's license to practice medicine in this State is revoked, expired, suspended, or restricted; (3) such hospital no longer has a valid written agreement with the Hospital; or (4) such hospital no longer is Joint Commission-accredited. Practitioners whose Telemedicine Staff and Clinical Privileges are terminated, revoked, suspended or limited in this manner shall not be entitled to any hearing and appeal procedural rights under these Bylaws.

c) Telemedicine Staff membership and Clinical Privileges granted in full reliance on the credentialing and clinical privileging decisions of a Joint Commission-accredited telemedicine entity providing telemedicine services in accordance with a written agreement with the Hospital shall terminate automatically in the event that: (1) the practitioner's affiliation with and/or clinical privileges at the telemedicine entity are revoked, suspended, limited or voluntarily relinquished; (2) the practitioner's license to practice medicine in this State is revoked, expired, suspended, or restricted; (3) the telemedicine entity no longer has a valid written agreement with the Hospital; or (4) the telemedicine entity no longer is Joint Commission-accredited. Practitioners whose Telemedicine Staff membership and Clinical Privileges are terminated, revoked, suspended or limited in this manner shall not be entitled to any hearing and appeal procedural rights under these Bylaws.

4) Fees - Telemedicine Staff will be subject to application fees and dues in accordance with these Bylaws, unless Hospital's written agreement with the Joint Commission-accredited hospital or telemedicine entity, as applicable, provides otherwise.

K. Practitioners Providing Contracted Services

1. When the hospital contracts for patient care services with licensed independent practitioners (LIPs) who provide official readings of images, tracings, or specimens through a telemedicine mechanism, and these practitioner's services are under the control of a Joint Commission-accredited organization, one of the following mechanism(s) will be implemented:

   a. The Hospital will specify in a contract that the entity providing these services by contract (the contracting entity) will ensure that all services provided under this contract by individuals who are LIPs will be within the scope of those individual's privileges at the contracting entity; or

   b. The Hospital will verify that all individuals who are LIPs and providing services under the contract have privileges that include the services provided under the contract.

2. When the hospital contracts for care services with LIPs who provide official readings of images, tracings, or specimens through a telemedicine mechanism, and these practitioner's services are not under the control of a Joint Commission-accredited organization, all LIPs who will be providing services under this contract will be permitted to do so only after being granted privileges at the Hospital through the mechanisms established in this manual.

3. Exclusivity policy: Whenever certain hospital facilities or services are provided on an exclusive basis in accordance with contracts or letters of agreement between the Hospital and qualified practitioners for the hospital-based services of pathology, anesthesiology and emergency medicine, then other staff appointees must, except in an emergency or life-threatening situation, adhere to the exclusivity policy in arranging for or providing care. Application for initial appointment or for clinical privileges related to the Hospital's facilities or services covered by exclusive agreements will not be processed unless the applicant is employed by or under contract with the relevant exclusive provider(s). Members of the Medical Staff who have been granted privileges that are covered by an exclusive contract will not be able to exercise those privileges unless they become a party to the contract.

4. Qualifications: A practitioner who is or will be providing specified professional services pursuant to a contract or a letter of agreement with the Hospital must meet the same qualifications, must be processed in the same

manner, and must fulfill all the obligations of his or her appointment category as any other applicant or staff appointee. Such a contract or agreement may require the practitioner to meet additional criteria or qualifications beyond those required under the Bylaws.

5. Effect of disciplinary or corrective action recommended by the MEC: The terms of the Bylaws will govern disciplinary action taken or recommended by the MEC.

6. Effect of contract or employment expiration or termination: The effect of the expiration or other termination of a contract upon a practitioner's staff appointment and clinical privileges will be governed solely by the terms of the practitioner's contract or agreement with the Hospital. If the contract or the employment agreement is silent on the matter, then contract expiration or other termination alone will not affect the practitioner's staff appointment status or clinical privileges. Termination or expiration of a contract does not constitute disciplinary or corrective action under these Bylaws.

X. ALLIED HEALTH PROFESSIONALS

A. General:

1. The Board permits certain types of non-physician practitioners to be granted privileges without appointment to the Medical Staff. Such practitioners must be qualified by academic and clinical or other training to practice in a clinical or supportive role in providing services. All such individuals will provide services only under the supervision or delegation of a Member of the Medical Staff. The practitioner will provide only those clinical services that are consistent with the privileges granted.

2. All policies and procedures, as well as any applicable clinical protocols and guidelines governing the practice of individuals granted privileges without membership, must be reviewed and approved by the Chair of the Department in which the practitioner is granted privileges. For nurses practicing in an expanded role, the chief nursing officer must also review and approve such policies and procedures, clinical protocols, and guidelines. The expanded nursing role clinical protocols and guidelines must also be reviewed and approved by the MEC and the Board.

B. Practitioners: The following categories of practitioners are eligible to provide clinical services as allied health professionals ("AHPs"):

1. Nurse practitioner
2. Physician assistant

3. Certified registered nurse anesthetist
4. Psychologist
5. Licensed independent clinical social worker

C. Qualifications: To be eligible to provide clinical services, an AHP must:

1. be a graduate of a recognized and accredited school in his or her discipline

2. be legally qualified to practice in the given discipline in the State of Texas

3. have demonstrated clinical competence in his or her discipline consistent with the requested scope of services

4. meet the specific qualifications and requirements established by the Hospital

5. meet the same malpractice insurance coverage amounts and conditions as required for Medical Staff Members if not employed by the Hospital

6. agree to abide by the Hospital's rules, policies, and procedures

D. Application: AHP applications for Privileges will be processed in the same manner as applications for clinical privileges with Medical Staff membership, as described by the Bylaws, policies, and procedures. Terms of appointment will not exceed two (2) years. Application for reappointment will also be as described by the Bylaws for Medical Staff Members.

E. Practitioners Employed by Members of the Medical Staff: Practitioners employed by Members of the Medical Staff must submit a statement by their employer or cosigned by a Member of the Medical Staff concurring with the request for permission to provide services. The statement must confirm that the physician does contract with the practitioner and will, at all times, be responsible for the practice of the practitioner, and, if unavailable, will designate another Member of the Medical Staff to assume such responsibility. If the practitioner is employed by a group of physicians, at least one Member of the group must submit or cosign such a statement. If the appointment or privileges of the supervising physician are suspended or terminated, the practitioner's privileges will also be suspended or terminated.

F. Supervision: All AHPs must operate under the supervision or delegation of a licensed Member with Privileges on the Medical Staff. The care provided by all individuals granted clinical privileges will be supervised and evaluated through the Medical Staff quality monitoring and improvement processes.

G. Professional ethics: The professional conduct of each practitioner shall be governed both by the principles of professional ethics established by the

profession and by law, and in accordance with the mission and philosophy of the Hospital.

H. Suspension, modification, or termination of permission to provide services: Each practitioner is subject to discipline and corrective action. His or her permission to provide selected clinical services may be suspended, modified, or terminated consistent with hospital policies and procedures. If the practitioner is a Hospital employee, the Hospital's existing fair treatment policy will be applied. For all practitioners granted privileges without Medical Staff membership, in the event an action is taken that is adverse to the practitioner as defined in Section (9) below, the practitioner may request an appeal consistent with Section (9). Such practitioner will not have a right to the Fair Hearing and Appeals process pursuant to Article IX.

I. Appeal of an adverse action:

1. Triggering events: The following recommendations or actions shall, if deemed adverse under Section (9b) below, entitle the practitioner to an appeal under timely and proper request:

   a. Denial or restriction of requested clinical privileges
   b. Reduction of clinical privileges
   c. Suspension of clinical privileges
   d. Revocation of clinical privileges

2. When deemed adverse: A recommendation or action listed in Section (9a) above is adverse only when it has been

   a. Recommended by the MEC to the Board

   b. Taken by the Board under circumstances in which no prior right to request an appeal exists

3. Notice of adverse recommendation or action: The CEO shall promptly give the practitioner special notice of an adverse recommendation or action. The notice shall advise the practitioner of the recommendation or action and of his or her right to request an appeal pursuant to the provisions of this Section, specify that the practitioner has thirty (30) days after receiving the notice to submit a request for an appeal, indicate that the right to the appeal may be forfeited if the practitioner fails, without good cause, to appear at the scheduled appeal, state that as part of the appeal, the practitioner involved has the right to receive an explanation of the decision made and to submit any additional information the practitioner deems relevant to the review and appeal of this decision, state that, upon completion of the appeal, the practitioner involved has the right to receive a written decision from the hospital, including a statement of the basis of the decision

4. Request for appeal: The practitioner has thirty (30) days after receiving notice of an adverse action to file a request for an appeal. The request must be delivered to the CEO either in person or by certified or registered mail.

5. Waiver by failure to request an appeal. A practitioner who fails to request an appeal within the time specified waives his or her right to an appeal. Such a waiver applies only to the matters that were the basis for the adverse recommendation or action triggering the notice.

6. Appeal procedure: When a practitioner requests an appeal, the appeal shall consist of a single meeting attended by the practitioner, the CEO, and the President of the Medical Staff. During this meeting, the basis of the decision adverse to the practitioner which gave rise to the appeal will be reviewed with the practitioner, and the practitioner will have the opportunity to present any additional information the practitioner deems relevant to the review and appeal of the decision. Following this meeting, the CEO and president of the Medical Staff will make a recommendation to the Board that will then determine if the adverse decision will stand, be modified, or be reversed. The practitioner will receive a written decision from the Board stating the result of the appeal and the basis of the decision.

7. Sole remedy: This appeal process will be the sole remedy available to a practitioner who qualifies for this appeal who experiences an adverse action.

XI. MEDICAL STAFF OPERATIONAL ISSUES

A. Meeting Frequency and Notice:

1. Meeting: A meeting of the Medical Staff will be held at least ten (10) days before the end of the medical staff year (June). The purpose of the meeting shall be to report on the activities of the Medical Staff, to elect Officers, and to transact such other business as may be necessary and desirable.

2. Other routine meetings may be held 1-3 times per year, as called by the CEO and/ or President of the medical staff, to reflect on the activities of the medical staff or hospital and to transact business as might be necessary and desirable.

3. Notice: Written notice of the annual meeting will be mailed to Members at least seven (7) days prior to the meeting. Written or oral notice of special meetings and changes or cancellations of the regulator meeting will be made not less than three (3) nor more than thirty (30) days in advance.

B. Attendance requirements: Members of the Medical Staff are expected to attend at least fifty percent (50%) of the general medical staff meetings and meetings held by their assigned committees. Committee chairpersons and MEC members are expected to attend at least 75% of their committee meetings. Absences are submitted and approved through the MEC.

C. Required quorums: All medical staff meetings require a majority of members eligible to vote present to conduct business.

D. Manner of Action: The action of a majority of the voting Members present at a meeting at which a quorum is present will be the action of the Medical Staff or a committee, unless a greater vote is otherwise required by these Bylaws.

E. Robert's Rules of Order: Robert's Rules of Order will serve as a guideline at all meetings of the Medical Staff, MEC, and committees.

F. General language governing committees

1. The following committees shall be the standing committees of the Medical Staff:

Surgery Committee	Peer Review Committee
Medicine Committee	Nominating Committee
OB/Pediatrics Committee	Bylaws Committee
Emergency Services/Trauma Committee	

The President of the Medical Staff may appoint additional ad hoc committees for specific purposes. Ad hoc committees will cease upon the accomplishment of the purpose of the committee or upon a date set by the President of the Medical Staff when establishing the committee. Ad hoc or special committees will report to the MEC.

2. General provisions: The President of the Medical Staff and the CEO, or their designees, are ex-officio members of all standing and ad hoc committees.

3. Appointment of members and chairs: Except as otherwise provided, the President of the Medical Staff shall appoint, in consultation with the MEC, the members and chair of each standing and ad hoc committee of the Medical Staff. The President of the Medical Staff may also appoint Medical Staff members to hospital committees or to serve as Medical Staff physician advisors or liaisons to carry out specific functions.

4. Term of appointment, removal, and vacancies: Except as otherwise provided, the President of the Medical Staff shall appoint committee members for two (2) year terms that shall coincide with the office term of the President of the Medical Staff. Committee members may be removed from the committee by the President of the Medical Staff in consultation

with the MEC for failure to remain a Member of the Medical Staff in good standing or for failure to adequately participate in the activities of the committee. Any vacancy in any committee shall be filled for the remaining portion of the term in the same manner in which the original appointment was made.

G. Nominating Committee

1. Purpose: The purpose of the Nominating Committee is to nominate Officers.

2. Composition: The Nominating Committee will consist of the immediate Past President who serves as Chairperson, one Member of the MEC elected by the MEC, and one non-MEC member of the Active Staff appointed by the President.

3. Duties:

a. Nominate Medical Staff Officers.

b. Publish the names of candidates for each Officer at least thirty (30) days prior to the annual meeting. The Nominating Committee may substitute nominees at the annual meeting if any Members nominated either refuse or are otherwise unable to accept nomination.

4. Meeting: The Nominating Committee will meet every two (2) years.

H. Bylaws Committee

1. Purpose: The purpose of the Bylaws Committee is to conduct an ongoing review of the Bylaws, Rules, Regulations, Procedures, and other organizational documents pertaining to the Medical Staff to assure the appropriateness thereof and the existence of an organizational structure best designed to effectuate the purposes and functions of the Medical Staff as a component of the total Hospital.

2. Composition: The Bylaws Committee shall consist of at least five (5) members of the Active Medical Staff, of which one (1) Member will be the Past President, who will serve as the Bylaws Committee Chair.

3. Authority: The Bylaws Committee shall have authority to review copies of the organizational documents of the Medical Staff, to request and receive recommendations and reports from other units of the Medical Staff concerning the organization and operation of such units, and to make recommendations concerning the improvement thereof.

4. Duties: The duties of the Bylaws Committee shall be to:

   a. Conduct a periodic review of Bylaws, Rules, Regulations, and Procedures and of forms promulgated in connection therewith;

   b. Submit recommendations to the MEC concerning the improvement of such documents (in formulating its recommendations the Bylaws Committee shall specifically consider such matters as may be referred to it by the Board, committees of the Hospital, the committees of the Medical Staff, and the CEO);

   c. Meet at such times as may be appropriate for the discharge of its duties and keep minutes of all such meetings; and

   d. Maintain the Bylaws so as to reflect current practices.

5. Accountability: The Bylaws Committee shall be accountable to the MEC via its Chair.

   a. Submit annually to the MEC a report of its review activities; and

   b. Submit such additional reports as may be required by the MEC or the Board.

I. Peer Review Committee

1. Purpose

   a. To provide an avenue for confidential peer review activities to take place with Medical Staff Members most related to the review being undertaken;

   b. The Peer Review Committee in and of itself shall be responsible for the following:

      1) Develop and conduct a program of monitoring, review, and evaluation with respect to the clinical services performed, including documentation to reflect the condition and progress of the patient, by its Members within the Hospital and to the current clinical competence of those individuals.

      2) Study the indicators for surgical and other invasive procedures performed by Members of the Medical Staff. To study the agreement or disagreement of preoperative, postoperative and pathologic diagnoses to determine the

justification for and the acceptability of all surgical and other invasive procedures undertaken in the Hospital.

3) To review blood and blood product usage, actual and suspected transfusion reactions reported, and amount of blood wasted;

4) To review the appropriateness of empiric, diagnostic, and therapeutic use of drugs through analysis of individual or aggregate patterns of drug practice.

2. Composition: The members of the Peer Review Committee shall be elected during the Annual Medical Staff meeting. The membership of the Peer Review Committee shall be representative of the overall diversity of the Medical Staff. The Peer Review Committee shall be comprised of the chairperson and four (4) members elected by ballot from the Active Medical Staff. The chairperson of the committee will be the Vice President of the Medical Staff. Members of the MEC shall not be eligible to serve on the Peer Review Committee with the exception of the Vice President of the Medical Staff.

3. Authority: The Peer Review Committee shall have the authority to:

a. Receive and review all pre-operative, post-operative, and pathological diagnosis; to review the usage of blood in the Hospital; and to perform such information gathering and reporting functions as may be appropriate to discharge its duties.

b. Require attendance of any Member whose case(s) is(are) being reviewed or whose attendance is necessary to perform the duties of the Peer Review Committee.

4. Duties: The duties of the Peer Review Committees shall be to:

a. Study the indications for surgery and other invasive procedures where disagreement exists among pre-operative, post-operative, and pathological diagnoses to determine whether surgery and other invasive procedures were indicated and whether the procedures were acceptable and justified.

b. Refer cases where surgery and other invasive procedures were not indicated or where surgery and other invasive procedures were unacceptable.

c. Study the usage of blood in the Hospital at least quarterly using pre-established criteria for:

1) Appropriateness of all transfusions including the use of blood and blood components.

2) Adequacy of transfusion services to meet the needs of patients.

3) Confirmed transfusion reactions.

4) Ordering practices for blood and blood products.

d. Develop or approve policies and procedures relating to the distribution, handling, use and administration of blood and blood components.

e. Refer cases where established criteria are not followed or blood wastage seems excessive.

f. Monitor, review, and evaluate the clinical skills and competence of members of the medical staff and AHP, using a program including but not limited to the identification of important aspects of care with specific indicators used to monitor this care. This program should draw conclusion, formulate recommendations, initiate actions, evaluate those actions, and communicate with either the entire Medical Staff or MEC as appropriate.

g. Determine the extent to which the Hospital's facilities and services are appropriately used by the Members through the following activities:

1) Identify areas of inappropriate utilization;

2) Make recommendations to the MEC as to how such inappropriate utilization can be rectified;

3) Formulate, recommend, and maintain a written Utilization Review Plan appropriate for the Hospital which meets the requirements of Titles XVII and XIX of the Social Security Act of 1965 at all times;

4) Assure that such Utilization Review Plan is in effect, known to the Members of the Medical Staff, and functioning at all times;

5) Conduct studies of utilization patterns of any Member or group of Members of the Medical Staff as requested by the MEC or the CEO;

6) Perform concurrent review of those diagnoses, procedures, or Members, with identified or suspected utilization-related problems;

h. Act on such related matters as may be assigned to it by the MEC;

i. Assure that an annual evaluation of the Utilization Review Plan is conducted and the results are forwarded to the MEC;

j. Review and analyze PRO denial rates and determination;

k. Monitor the discharge-planning program to assure timely discharge planning activities are carried out.

l. Act on such related matters as may be assigned to it by the MEC or the President of the Medical Staff.

5. Accountability: The Peer Review Committees shall be accountable to the MEC via the Committee Chair and shall submit a timely report following each meeting which includes:

a. All invasive procedures which were not indicated;

b. All invasive procedures where those procedures were unacceptable for whatever reason;

c. All cases where blood usage did not meet established criteria or where blood wastage seemed excessive; and

d. The results of the focused monitoring, review, and evaluation program including all specific actions and recommendations made.

J. Emergency Services/Trauma Committee

1. Purpose: The purpose of the Emergency Services/Trauma Committee is to monitor, evaluate, and improve the care delivered in the Emergency Room.

2. Authority: The Emergency Services/Trauma Committee shall have the authority to:

a. Have access to any and all medical records, abstracts, and reports related to care of patients who received care in the emergency room;

b. Require any Member to appear at any Emergency Services/Trauma Committee meeting for the purpose of obtaining information or

suggestions with respect to carrying out the Emergency Services/Trauma Committee's duties; and

c. Recommend and monitor the establishment and implementation of policies and procedures for the Trauma Services.

3. Composition: The composition of the Emergency Services/Trauma Committee shall consist of at least three (3) members of the Active Medical Staff and shall have representation from multiple medical disciplines from within the Medical Staff. Such members will be appointed by the President of the Medical Staff. The Emergency Room Director or his/her designee shall also be a member of this committee. The Emergency Department Nurse Manager and Director will serve as an ex-officio member. The chairperson will be elected by the committee membership.

4. Duties: The duties of the Emergency Services/Trauma Committee shall be as follows:

a. To recommend standards of professional performances within the Emergency Room;

b. To recommend guidelines of performance and review activities in the areas of ethics, professional economics and socio-professional conduct within and concerning the Emergency Room physicians and attending Medical Staff physicians who have privileges in this service;

c. To evaluate the quality, safety, and appropriateness of emergency patient care and institute appropriate action based on the findings of the review activities which can be taken;

d. To recommend the methods of maintaining staff coverage in the emergency room of both primary care and specialty care;

e. To review suggestions and grievances related to the Emergency Room from all sources and recommend action to the MEC if it involves items of a professional-economic nature; or to the Administrator if it involves other matters;

f. To assure patients are appropriately transferred according to the Hospital's transfer protocol;

g. Act as coordinating body for the purpose of ensuring that the trauma care activities in the hospital are an integrated and comprehensive system;

h. To establish clinical indicator screening criteria for the trauma service and to aid the various Departments that interface with the trauma service in the development of clinically valid screening criteria necessary for problem identification and prioritization;

i. Act in such related matters as may be assigned to it by the MEC or the President; and

j. Meet at least four (4) times yearly and keep minutes of all such meetings.

5. Accountability: The Emergency Services/Trauma Committee shall be accountable to the MEC via its chairperson and shall submit a report at least quarterly of its findings and recommendations to the MEC.

K. Responsibilities for Medical Staff functions: The ultimate responsibility for Medical Staff functions lies with the MEC. The Medical Staff officers, Committee Chairs, and hospital are responsible for working collaboratively to develop a process for communicating Medical Staff function activities by providing periodic reports as appropriate to the committees and hospital departments. In addition, they are responsible for elevating issues of concern to the MEC as necessary to ensure compliance with regulatory/accreditation standards and appropriate standards of medical care. Medical Staff officers may appoint designated physician liaisons/advisers to help fulfill Medical Staff functions and identify other medical and administrative resources needed to adequately fulfill these functions.

XII. MEMBER RIGHTS AND DUE PROCESS

A. Investigations

1. Criteria for Initiation: Any person may provide information in good faith to any Member of the MEC about the conduct, performance, or competence of Medical Staff members. An investigation may be initiated when reliable information indicates a Member may have exhibited acts, demeanor, or conduct reasonably likely to be:

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

b. unethical;

c. contrary to the Medical Staff bylaws, associated manuals, rules and regulations, or Medical Staff or hospital policies; or

d. below applicable professional standards of behavior or clinical management.

2. Initiation: A request for an investigation or action against such Member may be initiated by the President of the Medical Staff, the Vice President of the Medical Staff, the CEO, the MEC, or the Board. A request for an investigation must be submitted by one of the above parties to the MEC through the President and supported by reference to the specific activities or conduct of concern. The MEC must begin acting on a request for an investigation within fourteen (14) days of its receipt. If the MEC initiates the request, it shall make an appropriate record of its reasons.

3. Investigation: If the MEC concludes an investigation is warranted, it shall direct an investigation to be undertaken. In the event the Board believes the MEC has incorrectly determined that an investigation is unnecessary, it may direct the MEC to proceed with an investigation. The MEC may conduct the investigation itself or may assign the task to an appropriate standing or ad hoc committee of the Medical Staff and/or the Board (the "Investigating Body").

4. Delegation to Committee: If the investigation is delegated to a committee other than the MEC, such committee shall proceed with the investigation in a prompt manner and shall forward a written report of its findings, conclusions, and recommendations to the MEC as soon as practicable, but in no event later than thirty (30) days following the start of the investigation. The Investigating Body shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems them necessary and such use is approved by the MEC and hospital CEO. The Investigating Body may also require the practitioner under review to undergo a physical and/or mental examination and may access the results of such exams to inform its deliberation.

5. Notification of practitioner: The practitioner of concern shall be notified that the investigation is being conducted within three (3) business days and shall be given an opportunity to provide information in a manner and upon such terms as the Investigating Body deems appropriate. This meeting (and meetings with any other individuals the Investigating Body chooses to interview) shall not constitute a Hearing" as that term is used in these Bylaws, nor shall the procedural rules with respect to hearings or appeals apply. The individual being investigated shall not have the right to be represented by legal counsel before the Investigating Body nor to compel the Medical Staff to engage external consultation.

6. Special Meeting Attendance: Whenever suspected deviation from standard clinical practice or professional conduct is identified, the Medical Staff president or the applicable Department Chair may require the Medical Staff Member to confer with him or her, or with a standing or ad hoc committee that is considering the matter. The Member will be given notice of the conference at least three (3) business days prior to the conference; will be provided with the date, time, and location of the conference and a statement of the issue involved; and will be informed that his or her appearance is mandatory. Failure of the Member to appear at any such conference after two notices, unless excused by the MEC upon showing good cause, will be considered a voluntary resignation from the Medical Staff. This relinquishment of membership and privileges will not give rise to a fair hearing, but the Member may withdraw this resignation by attending the requested meeting within thirty (30) days. Should the Member fail to attend the requested meeting within thirty (30) days, he or she must reapply for Medical Staff membership by completing an application and completing the credentialing procedures for a new applicant.

B. Precautionary or Summary Suspension

1. Criteria for Initiation: Whenever a Member's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s); or to reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person, then the CEO or designee and the Medical Staff President or designee, or the MEC, may immediately restrict or suspend the Medical Staff membership or Privileges of such Member as a precaution.

Unless otherwise stated, such summary suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the Member, the MEC, the CEO, and the Board. The summary suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein, but in no event longer than thirty (30) days. The summary suspension is not a complete professional review action in and of itself, and it shall not imply any final finding regarding the circumstances that caused the suspension. Unless otherwise indicated by the terms of the precautionary restriction or suspension, the Member's patients shall be promptly assigned to another Member by the President of the Medical Staff, considering, where feasible, the wishes of the affected Member and the patient in the choice of a substitute Member.

2. MEC Action: As soon as practicable and within fourteen (14) days after such summary suspension has been imposed, a meeting of the MEC shall be convened to review and consider the action and if necessary begin the investigation process as noted in Article IX. Upon request and at the

discretion of the MEC, the Member will be given the opportunity to address the MEC concerning the issues under investigation, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the Member, constitute a "hearing" within the meaning defined in Article IX, nor shall any procedural rules with respect to hearing and appeal apply. The MEC may modify, continue, or terminate the precautionary restriction or suspension within thirty (30) days, but in any event it shall furnish the Member with notice of its decision.

3. Procedural Rights: Unless the MEC promptly terminates the summary suspension prior to or immediately after reviewing the results of any investigation described in Article IX, the Member shall be entitled to the procedural rights afforded by the hearing and appeal plan once the suspension lasts more than fourteen (14) days.

C. Automatic Suspension

In the following instances, the Member's Privileges or membership will be considered automatically suspended, which action shall be final without a right to hearing pursuant to Article IX. Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand until the MEC determines it is not applicable. The MEC will make such a determination as soon as practicable but in any event within three (3) business days. In addition, further corrective action may be recommended in accordance with these Bylaws whenever any of the following actions occur:

1. Licensure

a. Revocation and suspension: Whenever a Member's license or other legal credential authorizing practice in this or any other state is revoked or suspended, Medical Staff membership and clinical privileges shall be automatically relinquished by the Member as of the date such action becomes effective and throughout the term of the revocation or suspension.

b. Restriction: Whenever a Member's license or other legal credential authorizing practice in this or any another state is limited or restricted by an applicable licensing or certifying authority, any clinical privileges that the Member has been granted at the Hospital that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

c. Probation: Whenever a Member is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the

same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

d. Medicare, Medicaid, or other federal programs: Whenever a Member is sanctioned or barred from Medicare, Medicaid, or other federal programs, Medical Staff membership and clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any practitioner listed on the United States Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals/Entities will be considered to have automatically relinquished his or her privileges. Such suspension shall remain in effect until the Member provides evidence acceptable to the Board which confirms he is no longer excluded from such federal health care programs.

2. Controlled substances

a. DEA certificate: Whenever a Member's United States Drug Enforcement Agency (DEA) certificate is revoked, limited, or suspended, the Member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

b. Probation: Whenever a Member's DEA certificate is subject to probation, the Member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

3. Medical record completion requirements: A Member of the Medical Staff will be considered to have voluntarily relinquished the privilege to admit new patients or schedule new procedures when he or she fails to complete medical records within time frames established by the MEC, as set forth in the Rules and Regulations. This relinquishment of privileges shall not apply to patients admitted or already scheduled at the time of relinquishment, to emergency patients, or to imminent deliveries. The relinquished privileges will be automatically restored upon completion of the records and compliance with medical records policies.

4. Professional liability insurance: Failure of a practitioner to maintain professional liability insurance in the amount required by state regulations and Medical Staff and Board policies and sufficient to cover the clinical privileges granted shall result in immediate automatic relinquishment of a Member's clinical privileges. If within sixty (60) days of the relinquishment the practitioner does not provide evidence of required professional liability insurance (including tail coverage for any period during which insurance was not maintained), the Member shall not be considered for reinstatement

and shall be considered to have voluntarily resigned from the Medical Staff. The Member must notify the Medical Staff office immediately of any change in professional liability insurance carrier or coverage. If the Member obtains the requisite coverage prior to sixty (60) days elapsing, then the Member's Privileges shall automatically be reinstated.

5. Felony indictment or conviction

   a. Felony/misdemeanor indictment or conviction: A Medical Staff Member who is indicted, convicted of, or pled "guilty" or "no contest" or its equivalent to a felony or to a misdemeanor involving a charge of moral turpitude in any jurisdiction shall be suspended automatically. Such suspension shall become effective immediately upon such indictment, conviction, or plea, regardless of whether an appeal is filed. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Board or through corrective action, if necessary.

   b. Failure to satisfy the special appearance requirement: A practitioner who fails without good cause to appear at a meeting where his or her special appearance is required in accordance with these Bylaws shall be considered to have automatically relinquished all clinical privileges with the exception of emergencies and imminent deliveries. These privileges will be restored upon compliance with the special appearance requirement. Failure to comply within thirty (30) days will be considered a voluntary resignation from the Medical Staff.

   c. Failure to participate in an evaluation: A practitioner who fails to participate in an evaluation of his or her qualifications for Medical Staff membership or privileges as required under these Bylaws (whether an evaluation of physical or mental health or of clinical management skills), shall be considered to have automatically relinquished all Privileges, or those specific Privileges which are the subject of the evaluation, as applicable. These privileges will be restored upon compliance and/or successful completion with the requirement for an evaluation. Failure to comply or at least beginning to comply within thirty (30) days will be considered a voluntary resignation from the Medical Staff.

6. Automatic suspension of sponsored AHP: A physician who has privileges at the Hospital may apply on behalf of AHPs for AHP privileges. Such AHP privileges shall be contingent upon the sponsoring physician's privileges. When a physician loses privileges or resigns, the AHPs whom he or she has sponsored automatically lose their privileges pending sponsorship by a different Member of the Active Medical Staff. They are not entitled to due process procedures enumerated in the Medical Staff bylaws, collective bargaining agreements, or elsewhere.

D. Procedure: The President of the Medical Staff shall notify Members in writing of any automatic suspension, and shall refer the matter to the MEC for corrective action recommendation.

E. Provision for coverage of existing hospitalized patients: An administrative time out will take effect after the practitioner has been given an opportunity to arrange for his or her patients currently at the hospital to be cared for by another qualified practitioner or to provide needed care prior to discharge. During this period, the practitioner will not be permitted to schedule any elective admissions, surgeries, or procedures. The president or the vice president of the Medical Staff will determine details of the extent to which the practitioner may continue to be involved with hospitalized patients prior to the effective date of the disciplinary suspension.

XIII. FAIR HEARINGS

A. Interviews: When the MEC receives or is considering initiating an adverse recommendation concerning a practitioner, the practitioner shall be afforded an interview. The interview shall not constitute a hearing, shall be preliminary in nature, and shall not be conducted according to the procedural rules provided with respect to hearings. The practitioner shall be informed of the general nature of the circumstances and may present information relevant thereto. A summary record of such interview shall be made.

B. Initiation of Hearing:

1. Recommendations or Actions. The following recommendation or corrective action shall, if deemed adverse, entitle the practitioner affected thereby to a hearing:

a. Denial of initial staff appointment;

b. Denial of reappointment;

c. Suspension of staff membership;

d. Revocation of staff membership;

e. Denial of requested appointment to or advancement in staff category;

f. Reduction in staff category;

g. Suspension, revocation or limitation of the privilege to admit patients or any other Medical Staff membership privilege directly related to the provision of patient care;

h. Denial, suspension or revocation of requested department/service/section affiliation;

i. Denial or restriction of requested clinical privileges, other than limited or emergency clinical privileges;

j. Reduction in clinical privileges;

k. Suspension of clinical privileges;

l. Revocation of clinical privileges;

m. Terms of probation;

n. Imposition of mandatory consultation requirement; and

o. Any recommendation which adversely affects the applicant or practitioner.

All hearings shall be held in accordance with the procedural safeguards set forth in this Article to assure that the affected practitioner is accorded all rights to which he is entitled

2. Adverse Recommendations. A recommendation or action listed in Article XIII.B.1. shall be deemed adverse only when it has been:

a. Recommended by the MEC; or

b. Taken by the Board contrary to a favorable recommendation by the MEC under circumstances where no right to hearing existed; or

c. Taken by the Board on its own initiative without benefit of a prior recommendation by the MEC.

3. Notice of Adverse Recommendation or Action. Notice of an adverse recommendation or action shall be sent to the practitioner by the President, shall be in writing, sent by certified mail or by messenger, return receipt requested and shall state the following:

a. That an adverse action has been proposed to be taken against the practitioner.

b. The reasons for the proposed action with specific reference to the practitioner's activities.

c. That the practitioner has a right to request a hearing on the proposed adverse action by making a written request to the President of the Medical Staff by certified mail, return receipt requested, postage prepaid and properly addressed.

d. That the request for a hearing shall be made within thirty (30) days of the notice.

e. That the failure to request a hearing within the specified time and manner herein provided shall be deemed a waiver of his right to such hearing and to any appellate review to which he might otherwise have been entitled on the matter.

f. A summary of the rights and conduct of the hearing.

4. Waiver by Failure to Request a Hearing. A practitioner who fails to request a hearing within the time and in the manner specified in Article X.B.3 waives any right to such hearing and to any appellate review to which he might otherwise have been entitled. Such waiver in connection with:

a. An adverse action by the Board shall constitute acceptance of that action, which shall thereupon become effective as the final decision of the Board.

b. An adverse recommendation by the MEC shall constitute acceptance of that recommendation which shall thereupon become and remain effective pending the final decision of the Board. The Board shall consider the committee's recommendation at its next regular meeting following waiver. In .its deliberations, the Board shall review all of the information and material considered by the committee and may consider all other relevant information received from any source in making its final decision.

c. The Administrator shall promptly send the practitioner special notice, forwarded by certified mail, return receipt requested, informing him of each action taken and shall notify the President of the Medical Staff of such action.

C. Hearing Prerequisites

1. Receipt of a Request for a Hearing. Upon receipt of a timely request for a hearing, the CEO shall deliver such request to the President of the Medical Staff or to the Board, depending on whose recommendation or action

prompted the request for hearing. The President of the Medical Staff or the Board, as applicable, shall promptly schedule and arrange such a hearing (provided, however, that a hearing for a practitioner who is under summary or automatic suspension of clinical privileges then in effect shall be held as soon as the arrangements for it may reasonably be made, but not later than fourteen (14) days from the date of receipt of the request for hearing).

2. Notice of Hearing. The President shall notify the practitioner in writing, delivered by certified mail, return receipt requested, the notice of hearing which shall state the following:

   a. The place, time, and date of the hearing, which date shall not be less than thirty (30) days after the date of the notice (except in instances of summary or automatic suspensions);

   b. A list of witnesses, if any, expected to testify at the hearing; and

   c. A concise statement of the practitioner's alleged acts or omissions, a list by number of the specific or representative charts or patient records being questioned and/or other reasons or subject matter forming the basis for adverse recommendation or action which is the subject of the hearing.

3. Appointment of Hearing Committee.

   a. By the Medical Staff. A hearing occasioned by an adverse MEC recommendation shall be conducted by a hearing committee appointed by the President of the Medical Staff and composed of three (3) members of the Medical Staff ("Hearing Committee"). The President of the Medical Staff shall designate one of the members as Chairman.

   b. By the Board. A hearing occasioned by an adverse action of the Board shall be conducted by a hearing committee appointed by the Chairman of the Board and composed of five (5) persons (also the "Hearing Committee"). At least one (1) Active Staff Member chosen with the advise of the President of the Medical Staff shall be included on the Hearing Committee. The Chairman of the Board shall appoint the Chairman of the Hearing Committee.

   c. Service on Hearing Committee. A Medical Staff or Board Member shall be disqualified from serving on a Hearing Committee if he has participated in initiating or investigating underlying matter at issue.

D. Hearing Procedure

1. Personal Presence. The personal presence of the practitioner who requested the hearing shall be required. A practitioner who fails without good cause

to appear and proceed at such a hearing shall be deemed to have waived his right to the hearing. The practitioner shall be further deemed to have accepted the adverse recommendation or decision involved and the same shall thereupon become and remain in effect.

2. Presiding Officer. Either the Hearing Officer, if one is appointed pursuant to Article X.I.1, or the Chairman of the Hearing Committee shall be the presiding officer (the "Presiding Officer"). The Presiding Officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence.

3. Representation. The practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by an attorney or other person of his choice. The MEC or the Board, depending on whose recommendation or action prompted the hearing, shall appoint an individual to present the facts in support of its adverse recommendation or action, and to examine witnesses.

4. Rights of Parties. During a hearing, each of the parties shall have the right to:

   a. Call and examine witnesses;

   b. Introduce exhibits;

   c. Cross-examine any witness on any matter relevant to the issues;

   d. Impeach any witness;

   e. Rebut any evidence;

   f. Present and introduce written and/or oral evidence;

   g. To present evidence determined to be relevant by the Hearing Officer, regardless of its admissibility in a court of law;

h. To submit a written statement at the close of the hearing;

i. To have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated with the preparation thereof;

j. The representative of the Hospital may introduce as evidence the record of other hospitals or health entities with whom practitioner has been associated.

k. If the practitioner who requested the hearing does not testify on his own behalf, he may be called and examined as if under cross-examination.

5. Procedure and Evidence. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in a civil or criminal action. Each party shall, prior to or during the hearing be entitled to submit memoranda concerning any issue of procedure or fact and such memoranda shall become part of the hearing record. The Presiding Officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by him and entitled to notarize documents in Texas.

6. Evidentiary Notice. A majority of the members of the Hearing Committee shall be present when the hearing and deliberations take place and no Member may vote by proxy. If a Member of the Hearing Committee is absent during any part of the proceedings he may not participate in the deliberation or the decision.

a. In reaching a decision, the Hearing Committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts in the State of Texas. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be noted in the hearing record. Any party shall be given opportunity, on timely request, to request that a matter be officially noticed and to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the Hearing Committee. The Hearing Committee shall also be entitled to consider all other information that can be considered, pursuant to these Bylaws, in connection with applications for appointment or reappointment to the Medical Staff and for clinical privileges.

7. Burden of Proof. When a hearing relates to a denial of Medical Staff appointment, the practitioner who requested the hearing shall have the burden of proving, by clear, convincing and preponderance of the evidence, that the adverse recommendation or action lacks any substantial factual basis or that such basis or the conclusions drawn therefrom are either arbitrary, unreasonable, or capricious. Otherwise, the body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support thereof; but the practitioner shall thereafter be responsible for supporting his challenge to the adverse recommendation or action by a preponderance of the evidence that the grounds therefore lack any substantial factual basis or that such basis or the conclusions drawn therefrom are either arbitrary, unreasonable, or capricious.

8. Presentation of Written Statement. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed and written statement shall be presented at that time. The Hearing Committee may thereupon, within a reasonable time which is convenient to its members, conduct its deliberations after all other individuals have been excluded. Upon completion of deliberation and reaching a decision, the hearing shall be finally adjourned.

9. Record of Hearing. A record of the hearing shall be kept that is of sufficient accuracy to permit an informed and valid judgment to be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The Hearing Committee may select the method to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceedings. However, the practitioner may request an alternative method of making a record of the hearing and shall bear the cost thereof.

10. Postponement. Request for postponement of a hearing shall be granted by the Hearing Committee, in its sole discretion, only upon a showing of good cause. Notice of postponement shall be furnished to the practitioner by written notice, certified mail, return receipt requested, or by messenger to the affected practitioner by the Chairman of the Hearing Committee.

11. Recess and Adjournment. The Hearing Committee may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of its deliberations, the hearing shall be declared finally adjourned.

E. Hearing Committee Report and Further Action

1. Hearing Committee Report. Within three (3) business days after final adjournment of the hearing, the Hearing Committee shall make a written report of its findings and recommendations in the matter and shall forward the same, together with the hearing record and all other documentation considered by it, to the body whose adverse recommendation or action occasioned the hearing, either the MEC or the Board. Any dissenting views must also be reduced to writing and transmitted to the body whose adverse recommendation or action occasioned the hearing.

2. Action on Hearing Committee Report. After receipt of the report of the Hearing Committee, the MEC or the Board as the case may be, shall consider the same and affirm, modify, or reverse its recommendation or action in the matter. It shall transmit the result, together with the hearing record, the report of the Hearing Committee and all other documentation considered, to the CEO.

3. Notice and Effect of Result.

a. Notice. The CEO shall promptly send a written decision to the practitioner by special notice, to the President of the Medical Staff, to the MEC and to the Board, including a statement of the basis of the decision.

b. Effect of Favorable Result

1) Adopted by the Board: If the Board's result is favorable to the practitioner, such result shall become the final decision of the Board and the matter shall be considered finally closed. If the Board's action is adverse, the practitioner shall be entitled to appellate review by the Board as provided in Article X.G.

2) Adopted by the MEC: If the MEC's result is favorable to the practitioner, the CEO shall promptly forward it, together with all supporting documentation, to the Board for its final action. The Board shall take action thereon by adopting or rejecting the MEC's result in whole or in part, or by referring the matter back to the MEC for further consideration. Any such referral back shall state the reasons therefor, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take final action. The CEO shall

promptly send the practitioner special notice informing him of each action taken. Favorable action shall become the final decision of the Board, and the matter shall be considered finally closed. If the Board's action is adverse, the special notice shall inform the practitioner of his rights to request an appellate review by the Board as provided in Article X.G.

c. Effect of Adverse Result. If the result of the MEC or of the Board continues to be adverse to the practitioner, the notice made to the practitioner shall inform the practitioner of his right to request an appellate review by the Board as provided in Article X.G.

F. Initiation and Prerequisites of Appellate Review

1. Request for Appellate Review. A practitioner shall have fourteen (14) days following his receipt of a notice to file a written request for an appellate review. Such request shall be delivered to the CEO, either in person or by certified mail, and may include a request for a copy of the report and record of the Hearing Committee and all other material, favorable or unfavorable, if not previously forwarded, that was considered in making the adverse action or result.

2. Waiver by Failure to Request Appellate Review. A practitioner who fails to request an appellate review within the requisite time frame waives any right to such review.

3. Notice of Time and Place for Appellate Review. Upon receipt of a timely request for appellate review, the CEO shall deliver such request to the Board. As soon as practicable, the Board shall schedule and arrange for an appellate review which shall not be less than fourteen (14) days from the date of receipt of the appellate review request; provided, however, that an appellate review for a practitioner who is under a suspension then in effect shall be held as soon as the arrangements for it may be reasonably made, but not later than seven (7) days from the receipt of the request for review. At least seven (7) days prior to the appellate review, the CEO shall send the practitioner special notice of the time, place, and date of the review. The time for the appellate review may be extended by the appellate review body for good cause.

4. Appellate Review Body. The Board shall determine whether the appellate review shall be conducted by the Board as a whole or by an appellate review committee of five (5) members of the Board appointed by the Chairman of the Board (the "Appellate Review Body"). If a committee is appointed, the Chairman of the Board shall designate one of the committee members as chairman.

G. Appellate Review Procedure

1. Nature of Proceedings. The proceedings by the Appellate Review Body shall be in the nature of an appellate review based upon the record of the hearing before the Hearing Committee, the Hearing Committee's report, and all subsequent results and action thereon. The Appellate Review Body shall also consider the written statements, if any, and such other material as may be presented and accepted.

2. Written Statements. The practitioner seeking the review may submit a written statement detailing the findings of fact, conclusions and procedural matters with which he disagrees, and his reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the Appellate Review Body through the CEO at least seven (7) days prior to the scheduled date of appellate review, except if such a time limit is waived by the Appellate Review Body. A written statement in reply may be submitted by the MEC or by the Board, and if submitted, the CEO shall provide a copy thereof to the practitioner at least four (4) days prior to the scheduled date of the appellate review.

3. Presiding Officer. The Chairman of the Appellate Review Body shall be presiding officer. He shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

4. Oral Statement. The Appellate Review Body, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions of him by any member of the Appellate Review Body.

5. Consideration of New or Additional Matters. New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review only under unusual circumstances. The Appellate Review Body, in its discretion, shall determine whether such matters or evidence shall be considered or accepted. The Appellate Review Body, may, within its sole discretion, allow an explanation by the party requesting the consideration of such matter setting out the reason why it was not presented earlier.

6. Powers. The Appellate Review Body shall have all powers granted to the Hearing Committee, and such additional powers as are reasonably appropriate to the discharge of its responsibilities.

7. Presence of Members and Vote. A majority of the Appellate Review Body must be present throughout the appellate review and deliberation. If a

member of the Appellate Review Body is absent from any part of the proceedings, he shall not be permitted to participate in the deliberations or the decision.

8. Recesses and Adjournment. The Appellate Review Body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence of consultation. Upon the conclusion of oral statements, if allowed, the appellate review shall be closed. The Appellate Review Body shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusions of those deliberations, the appellate review shall be declared finally adjourned.

9. Action Taken. The Appellate Review Body may recommend that the Board affirm, modify, or reverse the adverse result or action taken by the MEC or by the Board, or in its discretion, may refer the matter back to the Hearing Committee for further review and recommendation to be returned to it within fourteen (14) days and in accordance with its instructions. Within seven (7) days after receipt of such recommendations after referral, the Appellate Review Body shall make its recommendations to the Board as provided in this Section.

10. Conclusion. The appellate review shall not be deemed to be concluded until all of the procedural steps provided herein have been completed or waived.

H. Final Decision of the Board

1. Board Action. At the next regularly scheduled meeting after the conclusion of an appellate review, the Board shall render its final decision in the matter in writing and shall send notice thereof to the practitioner by special notice, the President of the Medical Staff, and to the MEC. If this decision is in accord with the MEC's last recommendation in the matter, if any, it shall be immediately effective and final. If the Board's action has the effect of changing the MEC's last recommendation, if any, the Board shall refer the matter to a joint conference as provided in Article X.H.2. below. The Board's action on the matter following receipt of the joint conference recommendation shall be immediately effective and final.

2. Joint Conference Review. Within fourteen (14) days of its receipt of a matter referred to it by the Board pursuant to the provisions in this Article a joint conference of equal numbers of Medical Staff and Board members shall convene to consider the matter and shall submit its recommendation to the Board.

I. General Provisions

1. Hearing Officer Appointment and Duties. The use of a hearing officer to preside at an evidentiary hearing is optional. The use and appointment of such officer shall be determined by the Board after consultation with the President of the Medical Staff. A hearing officer may or may not be an attorney at law, but must be experienced in conducting hearings. If a hearing officer is appointed, he shall act as the presiding officer of the hearing.

2. Attorney. If the affected practitioner desires to be represented by an attorney at any hearing or at any appellate review appearance the practitioner's request for such hearing or appellate review must so state. In such event the practitioner shall be entitled to be accompanied by and or represented at the hearing by an attorney or by the person of the practitioner's choice. In any event the practitioner, the MEC or the Board may use legal counsel in connection with preparation for a hearing or an appellate review.

3. Number of Hearings and Reviews. Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to an adverse recommendation or action.

4. Waiver. If at any time after receipt of special notice of an adverse recommendation, action, or result, a practitioner fails to make a required request or appearance or otherwise fails to comply with this Article or to proceed with the matter, he shall be deemed to have consented to such adverse recommendation, action, or result and to have voluntarily waived all rights to which he might otherwise have been entitled under this Article with respect to the matter involved.

XIV. CONFIDENTIALITY, IMMUNITY, AND RELEASES

A. Confidentiality of information: To the fullest extent permitted by law, the following shall be kept confidential: information submitted, collected, or prepared by any representative of this or any other healthcare facility or organization or Medical Staff for the purposes of assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of healthcare provided; evaluations of current clinical competence and qualifications for staff appointment/affiliation clinical privileges or specified services; contributions to teaching or clinical research; or determinations that healthcare services were indicated or performed in compliance with an applicable standard of care. This information will not be disseminated to anyone other than a representative of the hospital or to other healthcare facilities or organizations of health professionals engaged in official, authorized activities for which the information is needed.

Such confidentiality shall also extend to information provided by third parties. Each practitioner expressly acknowledges that violations of confidentiality provided here are grounds for immediate and permanent revocation of staff appointment and/or clinical privileges or specified services.

B. Immunity from liability: No representative of the Hospital shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of his or her duties as an official representative of the Hospital or Medical Staff or for providing information, opinion, counsel, or services to a representative or to any healthcare facility or organization of health professionals concerning said practitioner. The immunity protections afforded in these Bylaws are in addition to those prescribed by applicable state and federal law.

C. Covered activities: The confidentiality and immunity provided by this Article apply to all information or disclosures performed or made in connection with this or any other healthcare facility's or organization's activities concerning, but not limited to:

1. applications for appointment/affiliation, clinical privileges, or specified services

2. periodic reappraisals for renewed appointments/affiliations, clinical privileges, or specified services

3. corrective or disciplinary actions hearings and appellate reviews

4. quality assessment and performance improvement/peer review activities

5. utilization review and improvement activities

6. claims reviews

7. risk management and liability prevention activities other hospital, committee, department, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

D. Releases: Each practitioner shall, upon request of the hospital, execute general and specific releases when requested by the president of the Medical Staff or chair of the credentials or quality committees or their respective designees. Failure to execute such releases shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn, and it shall not be further processed.

XV. AMENDMENTS TO BYLAWS

A. Adoption and Amendment of Bylaws: Amendments of these Bylaws may be proposed by any Member of the Medical Staff, the CEO, or the Board. Such proposed amendments shall be presented to the Bylaws Committee for consideration. The Bylaws Committee shall present the proposed amendments to the Medical Staff at any regular or special meeting of the Medical Staff. Notice of proposed amendments shall be sent to all members of the Medical Staff at least fourteen (14) days prior to such meeting. Such notice shall include the exact wording of the existing Bylaw language. Approval by a two-thirds (2/3) supermajority of the Members of the Active Medical Staff present and voting at a meeting at which a quorum is present shall be required for adoption. Amendments so made shall be effective when approved by the Board. Neither the Medical Staff nor Board may unilaterally amend the Bylaws.

B. Rules and Regulations (Policies) of the Medical Staff:

1. The MEC will make recommendations to the Board related to the Rules and Regulations. All substantive proposed changes to the Rules and Regulations will be distributed to the Medical Staff thirty (30) days in advance of the MEC's anticipated action. Any amendments to the Rules and Regulations will be approved by the MEC and the Board.

2. Prior to amending the Rules and Regulations, the MEC must first communicate the proposed amendment to the Active Medical Staff for review and comment. This review and comment opportunity shall be accomplished by circulating the proposed amendment to all Active Medical Staff Members at least thirty (30) days prior to the scheduled MEC meeting, together with instructions on how interested Members may communicate their comments to the MEC. A comment period of at least fifteen (15) days shall be afforded, and all comments shall be summarized and provided to the MEC prior to the MEC's action on the proposed changes.

3. As an alternative to the MEC proposing an amendment to the Rules and Regulations, the Active Medical Staff Members may petition to MEC by at least 25% of active Members. The MEC shall act on such amendment at its next scheduled meeting.

4. The MEC's approval is required on all amendments to the Rules and Regulations, unless the petition described in Section 3 above was generated by at least two-thirds (2/3) of the Members of the Active Medical Staff, in which case, if the MEC does not approve the proposed amendment, the MEC shall give the Medical Staff notice within ten (10) days of its

decision, and the Active Medical Staff Members may choose to present the proposed amendment to the Rules and Regulations directly to the Board for approval. If the proposed amendment was not generated by a petition of at least two-thirds (2/3) of the Members of the Active Medical Staff and the MEC fails to approve the proposed amendment, the proposed amendment shall be submitted to the Active Medical Staff Members for a formal vote, and if approved by two-thirds (2/3) of the Members of the Active Medical Staff, shall be forwarded to the Board for approval and implementation.

5. Following approval by the MEC, the presentation of an amendment to the Rules and Regulations by petition of at least two-thirds (2/3) of the Active Medical Staff Members, or the approval of an amendment to the Rules and Regulations proposed through a petition as described in Section 3, the proposed amendments shall be forwarded to the Board for approval. The amendment to the Rules and Regulations shall become effective immediately following approval by the Board, unless otherwise indicated, or automatically within sixty (60) days if no action is taken by the Board.

6. Urgent Amendment to the Rules: In cases of a documented need for an urgent amendment to the Rules and Regulations, in order to comply with a law or regulation, the MEC may provisionally adopt such an amendment and forward it to the Board for provisional approval without prior notification of the Medical Staff. The Medical Staff will then be immediately notified by the MEC of the provisionally adopted and provisionally approved Rule and Regulation, for immediate implementation. The Medical Staff shall then have the opportunity for retrospective review of and comment on the provisional amendment. The Medical Staff may, by a petition signed by at least two-thirds (2/3) of the Active Medical Staff Members require that the Rule and Regulation be reconsidered; provided, however, the approved Rule and Regulation shall remain effective until such time as a superseding Rule and Regulation meeting the requirements of the law or regulation has been approved.

XVI. HISTORY AND PHYSICAL EXAMINATION

A. A history and physical examination must be dictated or documented in the patient’s medical record by the patient's attending physician or a member of the house medical staff, a credentialed Advanced Registered Nurse practitioner (ARNP) or a Physician Assistant (PA), all under the attending physician's supervision. The history and physical must be available in the patient’s medical record within twenty-four (24) hours after inpatient admission and prior to surgery or a procedure requiring anesthesia services. The history and physical examination shall be countersigned by the attending physician.

B. The history and physical examination completed before admission is valid for thirty (30) days only, and must be updated with any changes (or state that based on physical examination, no changes have occurred) within twenty-four (24) hours after admission, and prior to a surgery or a procedure requiring anesthesia services. A history or physical examination greater than thirty (30) days old cannot be updated, or referred to, in a current history and physical examination.

Approved by the Covenant Hospital Plainview Medical Executive Committee on May 21, 2018.

Approved and adopted by the Covenant Hospital Plainview Medical Staff on June 18, 2018.

Approved by the Covenant Hospital Plainview Governing Board on June 28, 2018.