BYLAWS of THE MEDICAL STAFF of COVENANT HOSPITAL LEVELLAND

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BYLAWS

of

THE MEDICAL STAFF

of

COVENANT HOSPITAL LEVELLAND

PREAMBLE

Covenant Hospital Levelland (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.

Condition of Participation or **CoPs** means Centers for Medicare/Medicaid Services Conditions of Participation for Hospitals.

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

Hospital means Covenant Hospital Levelland, 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 of AHP, as described in these Bylaws to render specific patient services.

I. NAME

The name of this organization is Covenant Hospital Levelland.

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. Assist the Hospital in fulfilling its responsibilities for providing charitable care;

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, including providing call coverage requirements;

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.

9. Shall be well organized and accountable to the governing body for the quality of medical care provided to patients to comply with the CoP Standard §482.22

C. Non-Discrimination

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

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, 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

      2) A history of consistently acting in a professional, appropriate, and collegial manner with others in clinical and professional settings; refraining from disruptive conduct

   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. An unrestricted 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 recent clinical performance and competence within the last twelve (12) months with an active clinical practice in the area in which clinical privileges are sought, for the purposes of ascertaining current clinical competence.

   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. Documented evidence of professional liability insurance of at least $200,000 per occurrence and $600,000 aggregate.

   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.

   i. A physician applicant (MD or DO) must have successfully completed an allopathic or osteopathic residency program of at least three (3) years, approved by the Accreditation Council for Graduate Medical

Education or the AOA, appropriate for the area of medicine they intend to practice.

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.

o. When the Medical Executive Committee or board has reason to question the physical and/or mental health status of a Practitioner the Practitioner shall be required to submit an evaluation of his physical and/or mental health status by a physician acceptable to the Medical Executive Committee and/or the Board, as a prerequisite to further consideration of his application for appointment or reappointment, to the exercise of previously granted privileges or to maintain his staff appointment.

E. Duration of Appointment

Appointment to the Medical Staff will be for no more than two (2) year intervals. Initial appointment to the Medical Staff shall be limited to one (1) year.

V. CATEGORIES OF THE MEDICAL STAFF

A. Categories

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

B. 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

C. Courtesy Staff

1. Qualifications: In addition to the qualifications described in Article IV, the Courtesy Staff is reserved for Medical Staff Members who meet the basic eligibility requirements for the Active Medical Staff and may occasionally admit Patients to the Hospital and who shall not have more than twelve (12) Patient Contacts per year at the Hospital. When a Member on the Courtesy Staff has more than twelve (12) Patient Contacts in a year at the Hospital, the Member will automatically be changed to the 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 Department meetings to which they are appointed, as well as attend any staff or hospital education programs. Members of the Courtesy Staff may not vote, hold office, or serve on Medical Staff committees.

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

D. Referring Staff

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

2. Prerogatives: The Referring Staff status is awarded to a physician whose practice and Privileges are entirely outpatient in scope. 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 Referring Staff may attend meetings of the Medical Staff but are not entitled to vote, hold office, or serve on Medical Staff Committees.

E. Honorary Category

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 or be eligible to vote.

F. **Postgraduate Medical Trainees**

Postgraduate medical trainees shall not be members of the Medical Staff and be entitled to the procedural rights provided by the Bylaws. All matters concerning postgraduate medical trainees and their practice in the Hospital shall be governed exclusively by the affiliation agreement (if one exits) between the Hospital and the Texas Tech University School of Medicine or the perceptive agreements.

VI. OFFICERS OF THE MEDICAL STAFF

A. The Officers of the Medical Staff shall consist of:

1. President/Chief of the Medical Staff

2. Vice President/Vice Chief 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 year at the annual meeting of the Medical Staff.

2. Nominations by Nominating Committee

Prior to the first day of the month of December in each 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 Nominating Committee will consist of the immediate past President of the Medical Staff who serves as Chairperson and one Member of the MEC elected by the MEC.

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. 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 one (1) year. Officers will take office on the first day of month of January, 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 and the Quality Improvement 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 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 three (3) members of the Active Medical Staff: the chairs of the Medicine Committee, the OB/Pediatric Committee, and the Surgery Committee. 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 Department 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. Review 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 MEC 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 Medical Staff may delegate the MEC to act on the Medical Staff's behalf on certain matters by 50% vote of the Members of the Active Medical Staff. The Members of the Active Medical Staff may also remove the MEC's delegated authority upon 50% vote.

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 or the OB/Pediatric 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 monthly and maintain a permanent record of its proceedings and actions.

G. The Medical Executive Committee will recognize Section Committees as needed for the Organization.

1. Surgery Section

VIII. MEDICAL STAFF ORGANIZATION

Organization: The Medical Staff shall be organized into the following Committee: Quality Improvement Committee, which will appoint sub-committees as needed.

A. Assignment: Each person appointed to the Medical Staff shall be assigned to the Committee appropriate to their medical specialty and Privileges they have been granted.

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

C. 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 Hospital's inpatient and outpatient clinical activities. Committee Chairs report to the MEC. To qualify as a Committee Chair a physician must be certified by a specialty board relevant to his or her respective Committee. Committee Chairs will serve for a one (1)year term.

D. Appointment of a Committee Chair: Committee Chairs will be nominated by the Medical Staff. 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 Medical Staff.

E. 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. Recommend Privileges for each Member of the Committee.

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. Recommend a sufficient number of qualified and competent persons to provide care, treatment and services for the Committee.

14. 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.

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

16. Determine the qualifications and competence of the Committee personnel who are not licensed independent practitioners and who provide patient care, treatment and services.

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

F. 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 Departments, 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.

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 will provide the potential applicant with an application package. 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 application 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. Application Content: The application package provided to Inquirers will include the following:

   a. A blank application form with a cover letter outlining membership eligibility criteria;

   b. A list of required supporting information;

   c. A list of performance expectations for individuals granted Medical Staff membership and/or privileges (if such a list of expectations has been formally adopted by the Medical Staff);

d. A description of responsibilities for Medical Staff members;

e. An overview of the delineation of Privileges;

f. A privilege request form(s), including criteria for Privileges; and

g. A detailed list of requirements for completion of the application.

2. The applicant must sign the application 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, 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 MEC

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. 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.

c. 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 CVO. 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.

d. 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.

e. 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

5) Boards, CMS/OIG list of excluded individuals, Fraud and Abuse Control Information System, or other such data banks, and including a criminal background check

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

7) Information from the National practitioner Data Bank

8) Other information about adverse credentialing and privileging decisions

9) One or more 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.

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

11) Recent photograph of the applicant to verify identity if not previously made available

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

13) Information from a criminal background check

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 X 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. Evidence of the required hours, if any, of category 1 continuing medical education activities

   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. Malpractice history for the past two (2) years from a primary source verified by the malpractice carrier(s).

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: A least ninety (90) days prior to the end of the Member's appointment period, the Member will submit a written application to the Medical Staff Office specifically requesting reappointment to a Medical Staff category. 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. Although all Privileges will terminate upon such resignation, if the Member submits a complete application for reappointment within ninety (90) days of such resignation, the complete application for reappointment will be processed as a reappointment application in accordance with these Bylaws. Any Member requesting privileges more than ninety (90) days following resignation will be required to complete the initial appointment process.

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 Hospital in its Board-approved criteria 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, upon recommendation from the Credentials Committee and appropriate or subject matter experts (as determined by the Credentials Committee), 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, Board status or certification (if applicable), 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 Department director.

4) If the privileges requested overlap two or more specialty disciplines, the Chair of the Credentials Committee will appoint an ad hoc committee to recommend criteria for the privilege(s) in question. This committee will consist of at least one (1), but not more than two (2), members from each involved discipline. The chair of the ad hoc committee will be a member of the Credentials Committee who has no vested interest in the issue.

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 procedures 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

    e. Current DEA status (if applicable)

    f. Current professional liability insurance in the amount $200,000 per claim/$600,000 annual aggregate

    g. Malpractice history

    h. One positive reference specific to the applicant's competence from an appropriate medical peer

    i. The ability to perform the privileges requested

    j. 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. 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.

2. 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 at the Hospital.

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 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 direction 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. Annual Meeting: An annual meeting of the Medical Staff will be held at least ten (10) days before the end of the medical staff year (Dec). The purpose of the annual 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. Special Meeting: A special meeting of the Medical Staff may be called at any time by the President of the Medical Staff, and will be called at the request of the Board or the MEC, or upon written requested signed by at least ten percent (10%) of the Active Medical Staff. At any special meeting, no business will be transacted except that stated in the notice calling the meeting.

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 encouraged to attend meetings of the Medical Staff. Members of the MEC and Peer Review Committee are expected to attend at least sixty percent (60%) of the meetings held.

C. Required quorums for various committees:

1. Medical Staff meetings: those Members present and eligible to vote

2. MEC and Peer Review Committee: a majority of the Members eligible to vote

3. Medical Staff committees other than those listed in number 2 above: those Members present and eligible to vote

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. Designation: The following committees shall be the standing committees of the Medical Staff: Emergency Services/Trauma Committee, Peer Review, Nominating and Bylaws Committees. 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 one (1) 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 as needed.

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 two (2) 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 Peer Review Committee. 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 one (1) other appointed by the Chief of 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 individuals on the committee 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 ongoing monitoring, review, and evaluation program including all specific actions and recommendations made.

6.

J. Medical Staff physician liaisons/advisers: The president of the Medical Staff may appoint a Member of the staff to represent the Medical Staff on the following hospital committees. The representatives of these committees will report to the MEC on the activities of these various committees and on any issues of concern to the Medical Staff.

K. Responsibilities for Medical Staff functions: The ultimate responsibility for Medical Staff functions lies with the MEC. The Medical Staff officers, Department Chairs, and hospital and Medical Staff committee chairs are responsible for working collaboratively to develop a process for communicating Medical Staff function activities by providing periodic reports as appropriate to the Departments and committees. 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. For each function listed below, the accountable parties are listed in parentheses.

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. 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) 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) 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) 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 X.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 Administrator 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 Administrator 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 Administrator 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. The Chairman and members of the Hearing Committee shall not be in direct economic competition with the applicant for a hearing.

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 when the issues concern professional competence or performance. The Chairman of the Board shall appoint the Chairman of the Hearing Committee. The Medical Staff Member appointed to the Hearing Committee shall not be in direct economic competition with the applicant for a hearing.

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) 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 Administrator.

3. Notice and Effect of Result.

a. Notice. The Administrator 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 Administrator 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 Administrator 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 Administrator, 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 Administrator 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 Administrator 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 Administrator 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 Administrator 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 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. The Rules and Regulations may be amended by the MEC. 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 propose an amendment to the Rules and Regulations by a petition signed by at least forty percent (40%) of the Members of the Active Medical Staff. Such petition shall first be submitted to the MEC for its consideration and approval. The MEC shall act on such petition 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 approval and immediate implementation without prior notification of the Medical Staff. The Medical Staff will then be immediately notified by the MEC of the provisionally adopted and approved Rule and Regulation. 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.

C. Policies of the Medical Staff

1. The MEC may adopt or amend any other policies or procedures of the Medical Staff as it sees fit (collectively, "Policies").

2. As an alternative to the MEC amending the Policies through its delegated authority, the Members of the Active Medical Staff may propose an amendment to the Policies by a petition signed by at least forty percent (40%) of the Members of the Active Medical Staff submitted to the MEC for its consideration and approval.

3. The MEC's approval is required on all amendments to the Policies, unless the petition described in Section 2 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 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 amendments to the Policies directly to the Board for approval. If the proposed amendment was not generated by 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.

4. Following approval by the MEC, the presentation of an amendment to the Policies by petition of at least two-thirds (2/3) of the Active Medical Staff Members, or the approval of an amendment to the Policies proposed through a petition as described in Section 2, the proposed amendments shall be forwarded to the Board for approval. The amendment to the Policies 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.

5. The Medical Staff shall be notified immediately of all Policies approved by the MEC and the Board.

XVI. MEDICAL RECORDS

1. Entries in the medical record may be made only by individuals authorized to do so as specified in administrative policies. Entries will be made during the regular course of business by those authorized individuals. Per CMS 482.24(c)(1), all medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person

responsible for providing or evaluating the service provided, consistent with hospital policies and procedures as well as the following:

a. A medical record will be initiated and maintained for every individual assessed or treated. The medical record will incorporate information from subsequent contacts between the patient and the organization.

b. The medical record will contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results accurately, and facilitate continuity of care among health care providers. Each medical record will contain at least the following:

i) The patient's name, address, date of birth, and the name of any legally authorized representatives;

ii) The patient's legal status for patients receiving mental health services;

iii) Emergency care provided to the patient prior to arrival, if any;

iv) The record and findings of the Practitioner's assessment of the patient;

v) A statement of the conclusions or impressions drawn from the medical history and physical examination;

vi) The diagnosis or diagnostic impression;

vii) The reason(s) for admission or treatment;

viii) Evidence of informed consent for procedures and treatments for which informed consent is required by organizational policy, CoPs, and applicable state law;

ix) Diagnostic and therapeutic orders, if any;

xi) All diagnostic and therapeutic procedures and tests performed and the results;

xii) Test results relevant to the management of the patient's condition;

xiii) All operative and other invasive procedures performed using acceptable disease and operative terminology that includes etiology, as appropriate;

xv) Progress notes made by the Medical Staff, physicians in training, physician assistants, and nurse practitioners;

xvi) All reassessments, when necessary;

xvii) Clinical observations;

xviii) The patient's response to the care provided;

ixx) Consultation reports;

xx) Every medication ordered or prescribed;

xxi) Every dose of medication administered and any adverse drug reaction;

xxii) Each medication dispensed to or prescribed for patient on discharge;

xxiii) All relevant diagnoses established during the course of care; and

ivxx) Any referrals/communications made to external or internal care providers and to community agencies.

xxv) Conclusions at termination of hospitalization;

xxvi) Discharge instructions to the patient and family; and

xxvii) Clinical resumes and discharge summaries, or a final progress note or transfer summary.

2. A history and physical examination must be dictated or documented in the patient's medical record by the patient's attending physician, a member of the house 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 in the patient medical record on all patients within twenty-four (24) hours of admission and on all patients prior to surgery or procedure. The history and physical examination must be countersigned by the attending physician when dictated by any of the aforementioned members. Per CMS 482.22(c)(5),

   i) 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 procedure. A history or physical examination greater than thirty (30) days old cannot be updated, or referred to, in a current history and physical examination.

a) A History and Physical must include the following:

3. The medical record of any patient undergoing operative or other invasive procedures and/or anesthesia will include the following:

a) Except in life threatening emergencies, the history, physical examination, and preoperative diagnosis must be recorded in the patient's record prior to any surgical procedure. If not recorded, the operation will be postponed until all data are available.

b) Any indicated laboratory and x-ray examinations should be completed and recorded in the medical record or a summary of pertinent findings may be documented in the medical record.

c) A preoperative diagnosis prior to surgery, and the attending physician's and/or surgeon's documented plan for the operative or invasive procedure;

d) Documentation by the anesthesiologist of a pre-anesthesia evaluation to determine the proper anesthetic to be given;

e) Handwritten or electronically recorded documentation of the patient's physiological status during the procedure;

f) Proper surgical consent shall be obtained prior to the operative procedure except in emergent situations. Risk, benefit, alternative options, and potential complications associated with the procedure shall be discussed with the patient and/or appropriate family members prior to signature of consent. Alternatives to blood transfusion, when blood or blood components are needed, shall be considered. Patients shall be allowed to participate in care decisions and shall provide informed consent.

g) Plans of care shall be developed and documented and should include a post-procedure plan and an initial assessment of the patient's physical, mental, and neurological status and needs.

h) The operative report, which will be written in the medical record immediately after operative or any other procedure, will describe the name of the procedure, pre and postoperative diagnoses, the technical procedure used, the name of the

surgeon, assistants, and the anesthesiologist if in attendance, blood loss, specimens removed, and patient conditions and complications, if any;

i) Postoperative documentation of the patient's vital signs and level of consciousness; medications (including intravenous fluids), blood, and blood components; any unusual events or postoperative complications, including blood transfusion reactions, and management of such events;

j)Postoperative documentation of the patient's discharge from the post-anesthesia care area by the responsible licensed independent practitioner or according to discharge criteria.

4. The medical record of any patient receiving an epidural catheter placement will include the following:

a) Informed consent for the epidural catheter placement, obtained in the same manner and form as consent for other procedures.

b) Documentation of adequate monitoring of the patient's status with regard to the epidural catheter.

c) Daily progress notes by the anesthesiologist who placed the epidural catheter as long as the epidural catheter remains in place.

5. Physician responsibilities for moderate sedation (conscious sedation/analgesia) will be As follows:

Pre-procedure:

1. A history and physical must be in the record prior to the procedure on all patients receiving moderate or deep sedation.

2. A pre-sedation assessment should be in the record prior to the procedure on all patients to include documentation of:

a. Pertinent medical and surgical history

b. Personal history of sedation/anesthesia complications

c. Physical exam of airway, heart and lung, level of consciousness

d. Clinical impression or pre-op diagnosis

e. Operative and other invasive procedure plan

f. Pertinent lab or test results

g. Current medications and dosages (inclusive of over the counter medications and herbal supplements, allergies and all past medication reactions)

h. Sedation risk assessment (e.g., ASA score)

i. Plan for moderate sedation (e.g., IV sedation with monitoring)

3. Obtains and documents appropriate informed consent for procedure and sedation

4. Communicates the moderate sedation plan to involved care providers

5. Reassesses the patient prior to administration of sedation and documents that they remain a candidate for the procedure and sedation

Post procedure:

a) Document a post procedure / anesthesia note, including pre and post procedure diagnoses, procedure findings, complications, blood loss or specimen removed (if any) and plan of care.

6. A consultation will show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report will be made a part of the patient's record. A limited statement, such as "I concur," will not constitute an acceptable report of consultation. When an attending physician desires another physician to perform a formal consultation, he should document such by an order in the medical record. When the attending physician requests that another physician perform a limited procedure without formal consultation, he should specify such request on the order. When a physician intends mere notification to another physician of the patient's admission, he should specify this intention in the orders.

7. The medical record for a patient receiving continuing ambulatory care services will include known significant diagnoses, conditions, procedures, drug allergies,, and medications.

8. Any chart will be delinquent when:

a) The history and physical are not present within twenty-four (24) hours of admission.

b) Any portion of the chart is incomplete fifteen (15) days after the date of discharge.

9. A delinquent record that lacks a history and physical will be handled separately from all other records. The Director of Medical Records, or his designee, will notify the physician of his suspension from the Hospital. A written notification from the Chief of Staff will follow. The Director of Medical Records will notify the appropriate departments.

10. Any Practitioner with a delinquent chart will be notified by letter from the Quality Review Committee liaison physician. If those records are not completed within seven (7) days, a letter will be faxed from the Chief of Staff notifying the Practitioner of automatic suspension of all Hospital privileges, except for the care of patients presently hospitalized under his care at the time of the suspension and the responsibilities for emergency call as assigned on the call schedule.

11. In extenuating circumstances, as determined by the Chief of Staff, suspension may be deferred until the next meeting of the Medical Executive Committee, at which time a decision as to the disposition of the suspension will be made.

12. Each practitioner will be prompted to review and complete their patient's medical records in an electronic format Horizon Patient Folder. All Charts that require completion, correction, or a final electronic signature will be 'flagged' automatically upon 'log in'. If the Medical Records HPF staff cannot make a record available to a Practitioner, a new available date will be entered into the computer for that record, giving the Practitioner an additional seven (7) days to complete the record.

13. When Medical Records determines that the record has not been satisfactorily completed, the physician will have (7) days to complete the records. If the physician fails to complete the records within the (7) day period, the physician's name will automatically be re-posted to the suspension list.

14. When a Practitioner has been on the suspension list for thirty (30) consecutive days, he will receive a one-month reminder letter from the Chief of Staff.

15. After forty-five days of continuous suspension, the Chief of Staff will notify the suspended Practitioner that failure to complete the delinquent records within sixty (60) days of continuous suspension will result in referral of the matter to the MEC.

16. If a physician does not complete all delinquent medical records within sixty (60) days of continuous suspension, his Medical Staff membership and clinical privileges will be terminated, unless he can provide evidence that extenuating circumstances have prevented completion of the record(s). Such

termination will entitle the Member to his procedural rights under the Fair Hearing Plan of these Rules and Regulations.

17. A medical record will not be permanently filed until it is completed by the responsible Practitioner or is ordered filed by the Medical Executive Committee.

18. A Practitioner's routine pre-printed orders, when applicable to a given patient and ordered by the Practitioner, shall be reproduced in detail on the order sheet of the patient's record, dated, and signed by the Practitioner.
19. All orders for treatment shall be in writing. Verbal orders are discouraged and should only be given in the event of a dire patient emergency. Telephone orders by staff physicians will be accepted and transcribed when given to a qualified, designated ward personnel (i.e., a charge nurse or floor nurse - R.N. or L.V.N., nursing supervisor, licensed, registered or certified ancillary personnel pertaining to therapy they are providing, social service personnel pertaining to continuity of care, or a pharmacist). Verbal or telephone orders are to be dated and identify the names of the individuals who gave, received, and implemented the order. Any order transmitted by phone will be signed by the designated personnel to whom the order as been given and followed with the physician's authenticated signature. All verbal and telephone orders must be dated, timed, and authenticated within 48 hours by the prescriber or another practitioner who is responsible for the care of the patient. Any orders given by the Ordering Practitioner while detained in the operating room or otherwise indisposed should only be received by qualified personnel (as described above) and should adhere to verbal or telephone order guidelines. Orders, critical values, or results of a critical test received by phone should immediately be written and then read back to the staff physician for verification purposes. To maintain a culture of patient safety, all ordering Practitioners should request that their telephonic or emergency verbal orders be immediately read back to them.

ADOPTED by the Covenant Hospital Levelland Medical Staff on December 20, 2012.

President of the Medical Staff

APPROVED by the Covenant Hospital Levelland Board of Directors on Dec 20, 2012.

Chairperson of the Board of Directors

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RULES AND REGULATIONS

METHODIST HOSPITAL LEVELLAND

(dba)

COVENANT HOSPITAL LEVELLAND

MEDICAL/DENTAL STAFF RULES AND REGULATIONS

A. ADMISSION AND DISCHARGE

1. Only practitioners granted Medical/Dental Staff membership and clinical privileges may admit patients to this hospital except as provided in the Medical/Dental Staff Bylaws and Rules and Regulations. Only practitioners granted clinical privileges may treat patients at this Hospital. All practitioners with authority to admit patients shall be governed by the official admitting policy of this Hospital. Dentists with authority to admit patients to the Hospital must obtain a physician member of the Medical/Dental Staff to perform an admitting history and physical for the patient being admitted.

2. The Hospital shall accept patients for care and treatment except as follows:

   (a) Patients who are known to be suffering from drug abuse, alcoholism, or mental illness and who, in the physician's opinion, may cause harm to himself or others, shall not be admitted unless proper safety precautions can be taken to safeguard the patients, and employees. It shall be the physician's responsibility to arrange for appropriate referral.

   (b) The rule described in Section A.2-(a) shall also apply to patients who become emotionally ill while in the Hospital.

3. A physician member of the Medical/Dental Staff shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions and for transmitting reports of the conditions of the patient, if appropriate, to the referring practitioner. Whenever these responsibilities are transferred to another practitioner, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record. A progress note summarizing the patient's condition and treatment shall be made and the practitioner transferring his responsibility shall personally notify the other practitioner to ensure the acceptance of that responsibility is clearly understood.

The patient shall be assigned to the service concerned in the treatment of the disease which necessitated admission. In the case of a patient requiring admission who has no practitioner, the patient may select any appropriate practitioner to attend him. When no such selection is made, the patient shall be assigned to the practitioner on-call.

4. Except in the case of emergency admission, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible. A copy of the emergency service record shall accompany the patient to the nursing unit.

5. Physicians shall be able to justify emergency admissions based on criteria developed by the Medical/Dental Staff. The history and physical must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's medical record as soon as possible after admission. Violators of this rule shall be referred to the MEC for appropriate actions.

6. A patient to be admitted on an emergency basis shall be given the opportunity to select a member of the Medical Staff to be responsible for the patient while in the Hospital. Where no such selection is made or where the selected staff physicians does not assume responsibility for care of the patient for some reason, the on-call physician shall assume responsibility for the patient.

7. Each member of the Medical/Dental Staff shall name another member of the Staff as an alternate to be called to attend this patients in an emergency when the attending physicians not available or until the attending physician can be present. In case the alternate is not available, the Administrator or the Chief of Staff shall have the authority to call the on-call physician or any other member of the Staff to attend the patient. Failure of a member of the staff to meet these requirements may result in disciplinary action.

8. Patients shall be discharged from the Hospital only on the written order of the patient's attending practitioner. If a patient leaves the Hospital against the advice of the attending practitioner, or without proper discharge, a notation shall be made in the patient's medical record.

9. Patients shall be admitted to the Hospital on the basis of the following order of priorities when there is a shortage of available beds;

(a) Emergency

(b) Urgent

(c) Pre-operative

(d) Routine

The committee responsible for the Utilization Review functions shall review admissions that do not meet the established criteria for the above categories if there is a need to do so. Unjustified variations and recommended actions shall be reported to the MEC for appropriate action.

10. Admissions and discharges to special care units shall be in accordance with established criteria. Exceptions shall be approved by the unit or service medical director.

11. Practitioners shall abide by the Hospital's Utilization Review Plan to include:

(a) The appropriateness and medical necessity of admissions;

(b) Continued stay;

(c) Supportive services;

(d) Discharge planning.

12. In the event of a Hospital death, the deceased shall be pronounced dead by the attending practitioner or designated staff physician within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased, by a member of the Medical Staff. Policies with respect to release of dead bodies shall conform to local law.

13. It shall be the duty of all staff members to secure meaningful autopsies whenever possible. An autopsy may be performed only with a written consent, signed in accordance with state law. All autopsies shall be performed by the Hospital pathologist, or by a practitioner delegated this

responsibility. Provisional anatomic diagnosis shall be recorded on the medical record within five days and the complete protocol should be made a part of the record within three months. The cost to perform the autopsy will be borne by the family requesting the autopsy.

B. EMERGENCY SERVICES

1. Members of the Medical/Dental Staff shall accept responsibility for emergency service care in accordance with emergency service policies and procedures.
2. Clinical privileges shall be delineated for all practitioners rendering emergency care in accordance with Medical Staff and Hospital procedures.
3. The Medical Executive Committee of emergency services shall have the overall responsibility for emergency medical care.
4. A physician shall be available for rendering emergency patient care 24 (twenty four) hours per day, 7 (seven) days per week.
5. When appropriate, as determined by the emergency service physician on duty, the patient's private physician shall be called in accordance with the emergency service policies and procedures.
6. Emergency service policies and procedures shall be approved by the Medical Executive Committee and the Board.
7. If a patient needs to be admitted to the Hospital as an inpatient, in the judgment of the emergency physician, either for observation or for further treatment, the patient shall be admitted in the name of the patient's physician or the physician on-call. If in the judgment of the emergency physician the patient's condition requires continuing physician attendance the emergency physician shall continue to accept responsibility for the patient until the assigned physician assumes responsibility for the patient by physically coming to the Hospital and caring for the patient.
8. Except in cases where transfer to surgery is contradicted in the judgment of the emergency physician, surgery shall not be performed in the emergency treatment area.
9. In cases where the x-ray interpretation of the radiologist is different from that initially made by the emergency physician, copies of the radiologist's report shall be made available and brought to the attention of the emergency physician and the patient's private physician.
10. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's Hospital record, if such exists. The record shall include:
    (a) Adequate patient identification;

(b) Information concerning the time of patient's arrival and by whom transported;
(c) Pertinent history of injury or illness including details relative to first aid or emergency care given to patient prior to his arrival at the Hospital and history of allergies;
(d) Description of significant clinical, laboratory and x-ray findings;
(e) Diagnosis including condition of patient;
(f) Treatment given and plans for management;
(g) Condition of patient on discharge or transfer; and
(h) Final disposition, including instruction given to the patient and/or his family, relative to necessary follow-up care.

11. Each patient's emergency medical record shall be signed by the practitioner in attendance that is responsible for its clinical accuracy.
12. The Medical Director of emergency services shall coordinate the review of emergency service records with the Medical/Dental Staff medical records committee.
13. The Medical Director of emergency services shall be responsible for monthly patient care evaluation studies concerning the quality and appropriateness of patient care.
14. The emergency service medical record shall accompany patient being admitted as an inpatient.
15. Patients with conditions whose definitive care is beyond the capabilities of this Hospital shall be referred to the appropriate facility, when in the judgment of the attending physician; the patient's condition permits such a transfer. The Hospital's procedures for patient transfers to other facilities shall be followed.
16. The Medical Director of emergency services shall make certain that emergency service procedures are properly coordinated with the Hospital's disaster plan, especially as they pertain to the care of mass casualties.
17. Outpatient follow-up care will be arranged elsewhere if at all possible.

C. MEDICAL RECORDS

1. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current for each patient. This record shall include identification date; complaint; personal history; allergic history; family history; history of present illness; physical examination; special reports such as consultations, clinical laboratory and radiology services and consultations, clinical laboratory and radiology services and others;

Provisional diagnoses; medical and surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; summary or discharge note; and autopsy report when performed.

2. A complete admission history and physical examination shall be recorded within twenty four (24) hours of admission. If a complete physical examination has been performed within a week prior to admission, such as in the office of a physician staff member or, when appropriate, the office of a qualified oral surgeon staff member. A durable, legible copy of this report may be used in the patient's hospital medical record, provided there have been no changes subsequent to the original examination or the changes have been recorded at the time of admission.
3. *Copies of an acute stay admission history and physical examination and acute stay summary may be used in lieu of the admission history and physical examination for a Skilled Nursing Facility (SNF) stay when accompanied by a documented physician's statement that the data has been reviewed and is valid. Such statement must be signed and dated within 24 hours of admission to SNF. Rehabilitation history and physical examinations must be visit specific and include a plan of care.* ***(adopted/Medical Staff 12/22/2006).***
4. When a patient is readmitted within 30 days a new History and Physical must be completed. ***(adopted/Medical Staff 12/22/2006).***
5. When a history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be cancelled, unless the attending practitioner states in writing that such delay would be detrimental to the patient.
6. Progress notes will be recorded daily for acute care patients. Progress notes for long term patients will be recorded weekly. A rehabilitation patient shall have a pertinent progress note entered for each day patient receives therapy.
   (adopted/Medical Staff 12/22/2006.
7. The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

8. All clinical entries in the patient's medical record shall be accurately dated and authenticated.

9. Consultations shall be held, except in extreme emergencies, under the following conditions;

   (a) Where there is doubt as to the choice of therapeutic measures to be utilized.

   (b) In unusually complicated situations where specific skills of other practitioners may be needed.

   (c) Psychiatric consultation and treatment should be recommended to all patients who have attempted suicide or have taken a chemical overdose. Those services were at least recommended and must be documented in the patient's medical record.

   (d) When requested by the patient or his family.

   (e) When required by the policy of a special care unit.

   Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

   Any qualified physician with clinical privileges in this Hospital can be called for consultation.

10. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible practitioner at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order.

11. A discharge summary (clinical resume) shall be written or dictated on all medical records of patients hospitalized over forty eight (48) hours except for normal obstetrical deliveries and normal newborn infants. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible practitioner.

12. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

13. In case of readmission of a patient, all previous records shall be available for use by the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another.

14. A practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated, and signed by the practitioner.

15. Symbols and abbreviations may be used only when they have been approved by the Medical/Dental Staff.

16. Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statue. All records are the property of the Hospital and shall not otherwise be taken away without permission of the Administrator. Unauthorized removal of charts from the Hospital is grounds for suspension of the practitioner for a period to be determined by the Medical Staff Executive committee.

17. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Medical Staff before records can be studied. Subject to the Medical Staff they shall be permitted free access to information from medical records of their patients covering all periods during which they attended such patients in the Hospital.

18. Practitioners shall be responsible for obtaining the patient's informed consent prior to treatment. The patient shall be informed of the nature and risks of the procedure and of the possible alternatives. Both the patient and practitioner shall sign the consent form affirming that the practitioner has personally informed the patient and the practitioner has documented what was explained to the patient and that the patient understood and agreed to the proposed treatment.

19. *The patient's medical record shall be complete at time of discharge, including progress notes, final diagnosis and discharge summary.* **(effective 12/19/94)** Where this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the patient's chart will be available in the Medical Records Department. If a record is incomplete, except for lab reports, by the fourteenth (14^{th}) day after discharge, the physician shall be informed that he has delinquent charts. The physician will have a 16 day grace period in which to complete all delinquent charts. If at the end of the grace period the physician still has delinquent charts, the Administrator and/or Medical Executive Committee shall act in accordance with Article VIII, Section 8.6 of these Medical/Dental Staff Bylaws.

D. GENERAL CONDUCT OF CARE

1. All orders for treatment shall be in writing. A verbal order shall be

considered to be in writing if dictated to a L.V.N., R.N., or head of department actively involved in patient care, functioning practitioner. All orders dictated over the telephone shall be dictated by the practitioner and shall be signed by the appropriately authorized person who dictated with the name of the practitioner per his or her own name. The responsible practitioner shall authenticate such orders at the next visit, preferably shall authenticate such orders at the next visit, preferable within twenty four hours, and failure to do so shall be brought to the attention of the Executive Committee for appropriate action.

2. A general consent form, signed by or on behalf of every patient admitted to the Hospital must be obtained at the time of admission. The admitting office should notify the attending practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situation, be the practitioner's obligation to obtain proper consent before the patient is treated in the Hospital.
3. The practitioner's orders must be written clearly, legible and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.
4. All previous orders are cancelled when patients go to surgery or to a special care unit.
5. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, ASHP Drug Information, AMA Drug Evaluations, or Facts and Comparisons. Drugs of bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principle involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.
6. There will be an automatic "stop order" for the following drug categories:

*	Antibiotics	5 days
*	Anticoagulants	5 days/injectable 5 days/oral
*	Antineoplastics	per order
*	Atropine	5 days
*	Codeine Cough Syrups	5 days
*	Cortisone Products	5 days/injectable 5 days/oral
*	Donnagel PG, Lomotil, Etc.	5 days
*	Hypnotics, Sedatives, Tranquilizers	5 days
*	Narcotics	5 days
*	Oxytocics Post Partum	5 days

Long Term Patients – All medications reviewed by physician every 5 days.

Surgery – All medications are automatically discontinued.

Physicians are given written notices before any medication is discontinued. An automatic stop order may be overridden by ordering specific number of doses or days. If medication is not renewed within 24 hours, it is assumed physician does not want to continue it and it is automatically discontinued.

Narcotics	5 days
Oxytocics Post Partum	5 days

Long Term Patients - All medications reviewed by physician every 5 days.

Surgery - All medications are automatically discontinued.

Physicians are given written notices before any medication is discontinued. An automatic stop order may be overridden by ordering specific number of doses or days. If medication is not renewed within 24 hours, it is assumed physician does not want to continue it and it is automatically discontinued.

7. Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within his area of expertise.

8. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He will provide written authorization to permit another attending practitioner to attend or examine his patient, except in an emergency.

9. Blood which has been cross-matched and is being held for a patient will be held for forty-eight (48) hours at which time the order for the blood will be canceled unless reordered for another forty-eight (48) hours. Blood will not be released without notifying the appropriate physician.

10. Oxygen and respiratory therapy will be administered according to the attending physician's orders. In those cases where duration of treatment is indefinite or unspecified, the physician of record will be notified on the third day of treatment for new orders by the fourth day.

The physician will write new orders as soon after notification on the third day as possible, not to exceed the fourth day. If new orders are not given, the nurse will contact the physician for orders regarding continuing or discontinuing the respiratory therapy.

The respiratory therapy program notes should include:

(a) Type of therapy;
(b) Dates and times of administration;
(c) specifications of the prescriptions;
(d) Effects of therapy, including any adverse reactions;

(e) Physician entry describing the timely, pertinent clinical evaluation of the therapy.

11. Consultation request forms for radiology and pathology shall be filled out completely. The attending physician is responsible for providing necessary clinical data. the necessary data may be taken from the order sheet or progress notes by a nurse.

12. If a nurse has any reason to doubt or question the care provided to any patient or believers that appropriate consultation is needed and has not been obtained, she shall call this to the attention of her superior who in-turn may refer the matter to the Director of Nursing Service. If warranted, the Director of Nursing may bring the matter to the attention of the attending physicians, the Chief Executive Officer, or the Chief of Staff as appropriate. Where circumstances are such as to justify such action, the Chief of Staff may himself request a consultation.

13. Standing orders and/or instruction sheets shall be instituted only after approval of the Executive Committee of the Medical/Dental Staff. Such standing orders and/or instruction sheets shall be reviewed at least annually and revised as necessary. All standing orders and/or instruction sheets must be signed and dated by the responsible practitioner when utilized, as required for all orders for treatment.

14. All requests for radiology and nuclear medicine service must include information from the requesting practitioner justifying the need for examination(s) requested.

15. Prior to the performance of radiology exams on women of childbearing age, the patient shall be asked if she is pregnant. If there is any doubt as to whether pregnancy is possible, additional questions will be asked and/or a pregnancy test will be done.

16. All current physicians orders shall be rewritten if and when a patient has been hospitalized for fourteen (14) consecutive days and for each subsequent fourteen (14) days stay.

17. All patients that are restrained must have a physician's time limited written or verbal order not to exceed 7 days. Documentation must include type of restraint used, why patient is being restrained, and address periodic observation of patient. Restrains must be checked at least every 2 (two) hours. It is a policy of this facility to attend to all patient's needs, (Bathing, meals, toilet). effective

E. SURGICAL CARE

1. Except in emergencies, a history and physical examination, the preoperative diagnosis, appropriate consents, required laboratory and radiology reports, and consultations when requested, must be recorded on the patient's medical record prior to any surgical procedure. In the case of emergency, the physician will write the note but not necessary prior to surgery. The operating surgeon shall state in writing that a delay would be detrimental to the patient and shall make a comprehensive note in the medical records indicating the patient's condition prior to induction of anesthesia and the start of surgery. In all other cases, the responsible

nurse shall notify the operating surgeon, preferable no later than the night before surgery is scheduled, and preparation for surgery including premedication shall not be performed until proper entries are recorded in the patient's medical record. If this delay causes a change to be made in the surgery schedule, the operation shall be rescheduled to the next available time.

2. Surgeons shall be in the operating room and ready to commence surgery at the time scheduled. If a surgeon is repeatedly or flagrantly late, he may have his privilege to schedule 8:00 a.m. surgery suspended or may be referred to the executive committee for action.

3. The anesthetist is responsible for writing a pre-anesthetic note in the medical record prior to the patient's transfer to the operating area and before pre-operative medication has been administered. This note shall indicate a choice of anesthesia and the surgical or obstetrical procedure anticipated.

4. The anesthetist is responsible for writing a postanesthetic note after the patient has completed post-anesthesia recovery care to include at least a description of the presence or absence of anesthesia related complications.

5. If, in the opinion of the operating surgery and/or the Chief of Surgery, there is any surgical procedure an unusual hazard to life, there shall be present and scrubbed, as first assistant, a qualified surgeon.

6. A provisional staff member who is classified in a preceptorship or supervisory status for specified surgery privileges must have present his preceptor or qualified assistant for these specified surgery procedures.

7. A patient admitted for dental care is dual responsibility involving the dentist and physician member of the Medical/Dental Staff.

   (a) Dentist's responsibilities:

      (1) A detailed dental history justifying hospital admission.

      (2) A detailed description of the examination of the oral cavity and a pre-operative diagnosis.

      (3) A complete operative report, describing the findings and techniques.

      (4) The dentist is totally responsible for the oral or dental care.

      (5) Progress notes as are pertinent to the oral condition.

(6) Discharge summary.

(b) Physician's responsibilities:

(1) Medical history pertinent to patient's general health.

(2) A physical examination to determine the patient's condition prior to anesthesia and surgery.

(3) Supervision of the patient's general health status while hospitalized.

(4) Physician is not responsible for any dental care or consequences thereof.

8. A patient admitted for podiatry care is a dual responsibility involving the podiatrist and physician member of the Medical/Dental Staff.

(a) Podiatrist's responsibilities:

(1) A detailed history justifying hospital admission.

(2) A detailed description of examination of the feet and pre-operative diagnosis.

(3) A complete operative report, describing the findings and techniques. All tissue removed shall be sent to the hospital pathologist for examination.

(4) Progress notes.

(5) The podiatrist is solely responsible for the care of the feet.

(6) Discharge summary (or summary statement).

(b) Physician's responsibilities:

(1) Medical history pertinent to patient's general health.

(2) A physical examination to determine the patient's condition prior to anesthesia and surgery.

(3) Supervision of patient's general health status while hospitalized.

(4) Physicians are not responsible for any podiatric care or treatment of feet or consequences thereof.

(c) The discharge of the patient shall be on order of the attending physician.

9. Written, signed, informed, surgical consent (see C-19, above for details) shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits.

10. Outpatient surgical procedures may be done in the operating room or minor surgery/cast room.

    Records necessary for these procedures will include pertinent history, physician findings, diagnosis and description of the procedure. These records are the responsibility of the operating surgeon and should be completed within forty-eight (48) hours of the procedure.

11. The anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthesia evaluation and post-anesthesia follow-up of the patient's condition.

12. All tissues with the exception of dental extractions, prepuce from circumcisions and placentas, removed at the operation shall be sent to the hospital pathologist who shall make such examination as he may consider necessary to arrive at a tissue diagnosis. His authenticated report shall be made a part of the patient's medical record.

13. The rules for the scheduling of elective or non-emergency surgery will be as follows:

    (a) The schedule is available for posting of cases at all times.

    (b) The following information is required in order to post a case:

        (1) Patient's full name
        (2) age
        (3) sex
        (4) surgery procedure
        (5) type of anesthesia
        (6) operating surgeon
        (7) time and name of person posting the case
        (8) assistant surgeon

    (c) After the 8:00 a.m. slots are filled the order of the cases will be based on the time of the cases posted, availability of assistant surgeon, available operating room personnel, room cleaning, etc., as determined by the operating room supervisor.

(d) If cleared in advance with the operating room supervisor, cases may be posted at a specified time for justifiable reason, or if they do not interfere with the normal operating room schedule.

These cases will be scheduled in accordance with rule (c) and will be done as near to that time as a room is available in the order the case is posted.

The time may be changed if it does not interrupt the normal schedule as determined by the Chief of Surgery.

14. When the operating/anesthesia team consists entirely of nonphysicians (i.e., dentist with nurse anesthetist, dentist with dentist anesthetist, podiatrist with nurse or dentist anesthetist, etc.), there shall be a previously designated physician immediately available in case of emergency such as cardiac standstill or cardiac arrhythmia.

15. Any patient of any age who gives a history suggestive of pulmonary or cardiac disease shall have appropriate studies just prior to surgery.

16. Except in an emergency, consultations with another member of the Medical Staff shall be required on all major surgical cases in which the patient is not a good risk, on all critically ill patients, and on patients in which the diagnosis is obscure, or the preferred method of treatment is in question. A satisfactory consultation includes examination of the patient and the record. Consultations shall be recorded prior to the operation.

17. Patients who are admitted to the Hospital more than seven (7) days prior to major surgery shall have a new physical examination to include at least the heart + lungs, and other vital signs by the attending practitioner, the operating surgeon, or the anesthesiologist. Proper notes shall be made in the progress notes as to the findings. It shall be the responsibility of the operating surgeon to see that such physical examinations have been completed prior to surgery.

18. Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the Chief of Surgery.

F. OBSTETRICAL CARE

1. The current obstetrical records shall include a complete prenatal record. The prenatal record may be a legible copy of the attending physician's office records up to and including the 36th week of gestation transferred to the Hospital and shall be updated to include findings from the last visit prior to delivery.

2. Sterilization for the sole purpose of sterilization for either male or female patients may be done at the discretion of the attending physician and the fully informed consent of the patient being sterilized.

3. All patients shall have CBC, UA on admission and should have type and RH and postpartum hemoglobin or hematocrit on the chart prior to discharge.

4. A discharge summary shall be written or dictated on all medical records of patients hospitalized over forty-eight (48) hours except normal obstetrical deliveries.

5. All obstetrical medical records shall have complete prenatal histories, physical examinations and discharge summary (a discharge progress note or brief summary).

6. Oxytocic drugs shall be used in the following manner:

   (a) Oxytocic drugs for induction or augmentation of labor shall only be given by intravenous pump. Buccal pitocin is contradicted.

   (b) No more than two elective inductions shall be scheduled at one time. Oxytocin Challenge tests will be considered as one of the elective inductions. Elective inductions may be scheduled by calling the labor and delivery nurse.

   (c) The reason for induction of labor shall be stated in the history or progress notes.

7. Patients having Cesarean sections or postpartum tubal ligations shall have an updated history and physical examination. A progress note on important or new physical findings since her last physical examination on the pregnancy record shall suffice.

8. Patients in L&D may have their Consent to Deliver signed at the doctor's office at any time prior to delivery. The physician can explain and the nurse may witness. The permit will then be sent to L&D and will be kept on file until delivery. (*adopted 9/2006)*

9. All previous orders are cancelled after Cesarean Section or postpartum tubal ligation.

10. All patients who are going to undergo caudal, spinal, saddle block or epidural anesthesia should have an IV started prior to administration of the anesthesia.

11. A second physician will be in attendance at cesarean section for the immediate needs of the newborn baby. (*adopted 9/98)* ***(REMOVED FROM BYLAWS 7/08)***

G. NEWBORN CARE

1. All newborn orders must be itemized, including orders for formula and care of the newborn, and signed by the physician.

2. All physical examination shall be recorded in the medical record of all newborns.

3. PKU tests shall be done on all newborns prior to discharge, if the newborn has been on milk for twenty-four hours and not later than 7 days old. If this is not the case, the mother is given instructions as to where and when this procedure is to be done and a second PKU is done at 1-2 weeks of age.

H. DISASTER PLAN

1. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. The plan shall be reviewed and approved by the Medical Staff.

2. The Disaster Plan should make provisions within the Hospital for:
   (a) Availability of adequate basic utilities and supplies, including water, food and essential medical and supportive materials.

   (b) An efficient system of notifying and assigning personnel:

   (c) Unified medical command under the direction of Chief of Staff or his designated substitute;

   (d) Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care.

   (e) Prompt transfer, when necessary, and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definitive care;

   (f) A special disaster medical record, such as an appropriately designated tab, that accompanies the casualty as he is moved;

   (g) Procedures for prompt discharge or transfer of patients in the Hospital who can be moved without jeopardy;

   (h) Maintaining security in order to keep relatives and curious persons out of the triage area; and

   (i) Pre-establishment of a public information center and assignment of public relations liaison duties to a qualified individual.

3. All physicians may be assigned to posts, and it is their responsibility to report to their assigned stations. The Chief of Staff in the Hospital and Administrator will work as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the Hospital to another or evacuation from Hospital premises, the Chief of Staff during the disaster will authorize the movement of patients. All policies

concerning direct patient care will be a joint responsibility of the Chief of Staff and the Administrator of the Hospital. In their absence, the Vice Chief of Staff and alternate in administration are next in line of authority respectively.

4. The disaster plan shall be rehearsed at least twice a year, preferably as part of a coordinated drill in which other community emergency service agencies participate. The drills, which should be realistic, must involve the Medical Staff, as well as administrative, nursing, and other Hospital personnel. Actual evacuation of patients during drills shall be made.

I. RADIOLOGY

1. All x-ray reports are to be included in the patient's medical record within twenty four (24) hours after being dictated by the radiologist and all reports are to be signed before the record is filed.

2. Appropriate protection aprons are to be worn by all x-ray personnel within an x-ray room in which x-rays are exposed.

3. When none physicians are permitted to administer diagnostic agents intravenously for radiology evaluations, a physician shall be immediately available.

J. TRANSFER POLICY

1. The Medical Staff shall adhere to all patient transfer policies between the Hospital, other Hospitals, and/or Nursing facilities.

K. MISCELLANEOUS

1. The Infection Control committee, through its Chairman or practitioner members, has the authority to institute any appropriate control measures or studies when it is reasonably felt that danger to patients, visitors, or personnel exists.

2. The Utilization Review and Quality Assurance Plans of this Hospital as approved by the Executive Committee of the Medical Staff and the Board of Trustees of the Hospital shall be adhered to by all attending practitioners.

3. Policies and Procedures governing the use of various facilities of the Hospital, preparation of medical records, specialized and published by the

Authorized committees or the appropriate departments of the Medical Staff and approved by its Executive Committee and the Hospital's Board of Trustees, shall be adhered to by all attending practitioner's and said practitioners are responsible for remaining abreast of all current directives.

4. Policies and Procedures referred to above and elsewhere in these Rules and Regulations, are to be found in the Policy and Procedure Manual of the Hospital.

5. Institutional Review Board: ***(adopted 06/2009)***
Composition: The Institutional Review Board will be composed of the members of the quality Improvement Committee.

Physician members will be appointed by the Chief of Staff

Duties:
1. Review all investigational studies to be undertaken at the Hospital.
2. Monitor investigational studies at intervals appropriate to the degree of risk (but in no event exceeding one year)
3. Review all ongoing studies for continuing need, relevance and feasibility.

Any adverse or negative decisions made by the Institutional Review Board will not be subject to review or modification by the Medical Executive committee or the Board of Directors.

Meeting: The Institutional Review Board will meet as an Ad-Hoc and will meet as needed.

ADOPTED BY THE Medical/Dental Staff on 12/15/1998.

ADOPTED by resolution of the Board after considering the M.E.C.'s recommendation and in accordance with and subject to the Hospital corporate Bylaws. On 12/16/1988.