

**Pampa Regional Medical Center
Medical Staff Bylaws**

DEFINITIONS

1. "Board of Directors" or "Board" means the Board of Directors of Corporate as described in item 2 below, the sole member and the governing authority of the Corporation. Whenever the word Board is used in these Bylaws, it shall mean the Board of Directors.
2. "Corporation" means Signature Hospital, LLC, the sole general partner of Signature Pampa Hospital, LP, a limited partner, d.b.a. Pampa Regional Medical Center, in the state of Texas.
3. "Board of Trustees", "BOT", or "Trustees" means the local advisory board of Pampa Regional Medical Center.
4. "Chief Executive Officer" or "CEO" means the individual appointed by the Board of Trustees (Governing Authority) to act on its behalf in the overall management of the Medical Center. Whenever the word Administrator is used in these Bylaws, it shall mean the CEO.
5. "Medical Staff" or "Staff" means all duly licensed physicians, dentists, podiatrists and other licensed professionals designated by the Trustees who have been appointed to the medical staff and granted clinical privileges by the Trustees to attend patients in the Medical Center.
6. "Medical Executive Committee" or "MEC" means the Executive Committee of the Staff.
7. "Physician" means an individual who is properly licensed to practice medicine in the state of Texas and who manages and coordinates care, services, and treatment.
8. "Practitioner" or "Provider" means, unless otherwise limited, any physician, dentist, podiatrist, nurse practitioner or other licensed professional applying for or exercising clinical privileges in Pampa Regional Medical Center.
9. "Allied Health Professional" or "AHP" means an individual, other than a licensed physician, dentist or other licensed professional designated by the Trustees, whose patient care activities require services be processed through the usual Staff channels delineating his or her qualifications, status, clinical duties and responsibilities.
10. "Clinical privileges" or "Privileges" means the permission granted to a practitioner by the Trustees to render specific professional, diagnostic, therapeutic, medical, dental, investigational, or surgical services.
11. "Prerogative" means a participatory right granted, by virtue of Staff category or otherwise, to a Staff appointee or Allied Health Professional and exercisable subject to the conditions imposed in these Bylaws and in other Medical Center and Staff policies.
12. "Staff Year" means the period from January 1 through December 31.
13. "Ex Officio" means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.
14. "Special Notice" means written notification sent by certified or registered mail, return receipt requested or other traceable mail.

PREAMBLE

WHEREAS, Signature Pampa Hospital, L.P. d.b.a. Pampa Regional Medical Center is a limited partnership organized under the laws of the State of Delaware and authorized to conduct business in
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Texas (not an agency or instrumentality of any state, county or federal government); and

WHEREAS, it is recognized that no practitioner shall be entitled to staff appointment and privileges at this Medical Center solely by reason of education or licensure, or appointment to the staff of another hospital; and

WHEREAS, its purpose is to serve as an acute-care general Medical Center providing patient care and education; and

WHEREAS, it is recognized that one of the aims and goals of the Staff is to strive for a high standard of quality of patient care in the Medical Center, that the Staff must cooperate with and is subject to the ultimate authority of the Board of Directors and that the cooperative efforts of the Staff, Management, and the Trustees are necessary to fulfill the Medical Center's aims and goals;

THEREFORE, the following bylaws have been established and approved by the Board to facilitate the aims, goals and purposes listed above.

ARTICLE I NAME

The practitioners granted privileges to practice in the Medical Center shall be collectively known as the Medical Staff or Staff of Pampa Regional Medical Center, Pampa, Texas.

ARTICLE II PURPOSES AND RESPONSIBILITIES

2.1 PURPOSES

The purposes of the Medical Staff are:

- 2.1-1 To strive to provide optimal achievable patient care to Medical Center patients;
- 2.1-2 To ensure an optimal level of professional performance of practitioners authorized to practice in the Medical Center;
- 2.1-3 To serve as a means of accountability and the reporting of results to the Trustees of patient care evaluation, and other performance improvement activities in accordance with the Medical Center's performance improvement plan;
- 2.1-4 To assist in continuous professional advancement, knowledge and skill for the Medical Staff, Medical Center employees and the community;
- 2.1-5 To develop, maintain, and enforce rules and regulations for the proper functioning of the Staff; and
- 2.1-6 To provide a means whereby the Medical Staff with the Administrator may discuss issues concerning the Medical Staff and Medical Center.
- 2.1-7 To structure organized medical staff using designated members of the organized medical staff who have independent privileges to provide oversight of care, treatment, and services provided by practitioners with privileges;
- 2.1-8 To provide a uniform standard of quality patient care, treatment, and services;
- 2.1-9 To be accountable to the Board of Trustees.

2.2 RESPONSIBILITIES

The responsibilities of the Staff are:

- 2.2-1 To account for the quality and appropriateness of patient care rendered by

practitioners authorized to practice in the Medical Center through the following measures:

- a. Medical Staff membership;
- b. The credentialing process and recommended action to the BOT;
- c. A continuing education program;
- d. Utilization review program;
- e. Quality Assurance program;
- f. Performance Improvement process; and
- g. Patient Safety.

2.2-2 To exercise the authority granted by these Bylaws as necessary to adequately fulfill the foregoing responsibilities.

ARTICLE III STAFF APPOINTMENT

3.1 NATURE OF APPOINTMENT

- a. Staff appointment is a privilege extended by the Medical Center, and is not a right of any practitioner. Continued exercise of such privilege is contingent upon compliance with these Bylaws, Rules and Regulations, and Policies and Procedures. Membership on the Medical Staff or temporary privileges shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws, Rules and Regulations. No practitioner shall admit or provide services to patients in the Medical Center unless he is a member of the Medical Staff.
- b. The Board of Trustees (BOT) appoints and reappoints to the medical staff and grants initial, renewed, or revised clinical privileges, based on medical staff recommendations, in accordance with the bylaws, rules and regulations, and policies of the medical staff and of the Medical Center.
- c. Appointment or reappointment to the medical staff and the granting, renewal, or revision of clinical privileges are made for a period of no more than two years.

3.2 BASIC QUALIFICATIONS FOR MEMBERSHIP

3.2-1 Basic Qualifications

Only practitioners legally licensed to practice in the State of Texas, who

- a. Document their experience, background, training, ability, physical health status, and mental health status with sufficient adequacy to demonstrate to the Staff and the Trustees that any patient treated by them will receive care of the generally recognized professional level established by the Medical Center;
- b. Are determined, on the basis of documented references, to adhere strictly to the legally enforceable ethics of their respective professions, to work cooperatively with others, and to be willing to participate in the discharge of staff responsibilities;
- c. Are oriented to these bylaws, rules and regulations, and policies and agrees in writing that his or her activities as a medical staff member will be bound by them; and

d. Shall be qualified for appointment to the Staff.

3.2-2 Effect of Other Affiliations

No practitioner shall be automatically entitled to appointment to the Medical Staff or to the exercise of particular clinical privileges merely because he/she is licensed to practice in this or in any other state, or because he/she is a member of any professional organization, or because he/she is certified by any clinical board, or because he/she had, or presently has, staff appointment at this Medical Center or at another health care facility or in another practice setting.

3.2-3 Nondiscrimination

No aspect of Staff appointment or particular clinical privileges shall be denied on the basis of sex, race, creed, color, or national origin or on the basis of any other criterion unrelated to the delivery of optimal achievable quality patient care in the Medical Center.

3.2-4 Ethics

The burden shall be on the applicant to establish that he or she is professionally competent, worthy in character, professional ethics, and conduct. Acceptance of appointment to the Staff shall constitute the appointee's certification that he or she has in the past, and agrees that he or she will in the future, strictly abide by the ethical codes and principles of his/her profession.

3.3 BASIC RESPONSIBILITIES OF STAFF APPOINTMENT

Each appointee of the Staff shall:

- a. Provide his/her patients with care at the generally recognized professional level of quality and efficiency;
- b. Abide by the current Staff Bylaws and by all other lawful standards, current policies and rules of the Medical Center;
- c. Discharge such Staff, Department, Committee and Medical Center functions for which he/she is responsible by appointment, election or otherwise;
- d. Prepare and complete in timely fashion the medical and other required records for all patients he admits or in any way provides care to in the Medical Center;
- e. Must respond to emergent situations within 30 minutes;
- f. Provide quality care to patients at the Medical Center in an economical and efficient manner without adversely affecting the financial viability of the Medical Center; provided, however, that:
 1. Prudent and appropriate care of patients shall have priority over the financial viability of the Medical Center;
 2. The source of the Medical Center's revenue or reimbursement for patients shall not be a factor in determining whether or not this qualification is satisfied; and
 3. Determinations of failure to satisfy this qualification shall be based primarily (but not exclusively) on appropriate comparisons of the practitioner's practice patterns with accepted practitioner practice patterns.

- g. Maintain professional liability insurance with minimum limits of coverage of \$100,000/\$300,000. Each appointee to the staff shall furnish to the Medical Center at least annually a Certificate of Insurance or a copy of the policy evidencing compliance with this requirement, and shall notify the Medical Center no less than thirty days prior to the effective date of any cancellation, termination, or other lapse of coverage;
 - 1. Any termination or cancellation or other lapse of coverage shall be covered by Tail Coverage effective for three years after termination of coverage. All coverage provided shall be with a carrier recognized as a reputable and viable company by the industry;
 - 2. Honorary staffs are exempt from this requirement;
 - 3. Any physician who cannot meet the minimum insurance requirement by his primary policy has the right to petition the Board of Trustees for a possible exclusion to this requirement.
- h. Be subject to review as part of the Medical Centers Performance Improvement activities.

3.4 DURATION OF APPOINTMENT

3.4-1 Duration and Renewal of Initial Appointments

Initial appointments shall be for a period of up to one year. Renewals of provisional appointments (initial appointments) may be extended for a period of up to twelve (12) months.

3.4-2 Reappointment

Reappointment to any category of the Medical Staff shall be for a period of up to two years.

3.4-3 Modification in Staff Category and Clinical Procedures

The MEC may recommend to the Trustees that a change in staff category of a current staff appointee or the granting of additional privileges to a current staff appointee be made provisional in accordance with procedures similar for initial appointments.

3.4-4 Renewals

Associate status may be continued for an additional year beyond the initial year for continued review. If the associate appointee fails within the provisional year or renewal thereof to meet the burden of proof of clinical competency, then the Medical Executive Committee may make a recommendation for membership termination. An appointee who has not participated in any patient care activity at the Medical Center during a year of associate status, will be deemed as having not met the requirements and not satisfying the burden of proof of clinical competency. Upon this basis the Medical Executive Committee may make a recommendation to terminate staff privileges. Any appointee so affected by the above stated action shall be given special notice of such termination and shall be entitled to procedural rights afforded in Interview, Hearings, and Appellant Review.

3.5 LEAVE OF ABSENCE

3.5-1 Leave of Absence

A Staff appointee may obtain a voluntary leave of absence from the Staff by submitting written notice to the MEC and Administrator stating the exact period of time of the leave, which may not exceed two years. During the period of leave, the

staff member's privileges and prerogatives shall be suspended.

3.5-2 Termination of Leave

At least 30 days prior to the termination of the leave, or at any earlier time, the staff appointee may request reinstatement of privileges and prerogatives by submitting a written notice to that effect to the Administrator for transmittal to the MEC. The staff appointee shall submit a written summary of his or her relevant activities during the leave, if the MEC so requests. The MEC shall make a recommendation to the Trustees concerning the reinstatement of the appointee's privileges and prerogatives. Failure to request reinstatement or to provide a requested summary of activities as above provided shall result in automatic voluntary termination of staff appointment, privileges and prerogatives without right of hearing or appellate review. A request for staff appointment subsequently received from a staff appointee so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

If an appointee requests leave of absence status for the purpose of obtaining further medical training in his/her own or another field of medical practice, reinstatement will become automatic upon request. However, any new privileges requested will be acted upon and monitored in similar fashion as if the appointee were a new applicant.

Reinstatement will be automatic if leave of absence is for serving armed services commitment. If leave of absence occurs with no medical activity for 12 or more months, the MEC and/or department involved may require proof of competency by further education, i.e., a refresher course, and/or appropriate monitoring for a period of time to insure continuing competence.

3.6 CHANGE OF STATUS

At reappointment for active staff if minimum number of contacts has not been met, status will automatically be changed to courtesy. Medical Staff member may request a change of status at any time once the minimum number of admissions has been met or for other reasons as appropriate.

For Courtesy staff, once the maximum number of contacts in one calendar year has been reached, the provider's status will automatically be changed to Active.

3.7 RESIGNATION FROM STAFF

A staff member may resign from membership on the Medical Staff for any reason at any time. The resignation shall be in writing to the Chief of Staff and does not require acceptance to be in effect.

If a previous staff member wishes to apply for staff membership within two (2) years after resignation from the Medical Staff, he/she shall only be required to update his/her previous application by describing his activities during that period instead of submission of entire application. Show proof of current licensures and malpractice liability insurance. If a member in good standing upon resignation, a reapplying practitioner may have the provisional period (Associate Staff) waived by the MEC and with the concurrence by the Board of Trustees.

If the reappointment is not completed prior to the end of the current appointment, the appointee will be considered to have voluntarily resigned from staff.

If it has been more than two (2) years since staff membership, a practitioner will be required to apply for staff privileges as if it were an initial appointment.

ARTICLE IV

CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The staff shall include Associate, Active, Emeritus, Courtesy, Hospital Based, Alternative, Referring, Disaster, Allied Health, and Medical Assistant categories.

4.2 ASSOCIATE STAFF

4.2-1 Qualifications

The Associate Staff shall consist of practitioners serving in a provisional status, each of whom:

- a. Is eligible for advancement to Active or Courtesy Staff appointment and will, in the ordinary course of events and unless he/she requests otherwise, be advanced to Active or Courtesy Staff status after serving no less than one year or more than two (2) years on the Associate Staff; and
- b. Meets the qualifications for members of the Active or Courtesy Staff as specified in these Bylaws.

4.2-2 Prerogatives

The prerogatives of an Associate Staff member shall be to:

- a. Admit patients to the Medical Center under the same conditions as Active Staff appointees or for Courtesy Staff appointees;
- b. Exercise such clinical privileges as are granted to him or her;
- c. Vote on matters presented at meetings of the department and committees to which he/she is appointed; and
- d. Associate Staff appointees shall not be eligible to vote or to hold office in this Medical Staff organization other than (c) above.

4.2-3 Responsibilities

Each appointee of the Associate Staff applying for Active privileges shall be required to discharge the same responsibilities as Active Staff. Each appointee of the Associate Staff applying for Courtesy privileges shall be required to discharge the same responsibilities as those specified for Courtesy Staff. Failure to fulfill those responsibilities shall be grounds for termination of privileges or denial of reappointment.

4.3 ACTIVE STAFF

4.3-1 Qualifications

The Active Staff shall consist of practitioners:

- a. Who meet the basic qualifications;
- b. Medical Staff must be able to arrive at the Medical Center within 30 minutes when he/she has responsibilities of patients in the Medical Center; and
- c. Who regularly admits at least 24 patients in a 24-month period, or is otherwise regularly involved in the care of patients in the Medical Center. At reappointment if minimum number of admissions is not met, status will automatically be changed to Courtesy. Medical Staff member may request a

change of status at any time once the minimum number of admissions is met.

- d. Hospital based physicians who have active staff status will not be granted admitting privileges.

4.3-2 Prerogatives

The prerogatives of an Active Staff member shall be to:

- a. A physician member may admit patients without limitation, unless otherwise provided in the Medical Staff Bylaws, Rules and Regulations, or policies;
- b. A dentist or podiatrist member may admit provided it is demonstrated, at the time of admission, that a physician member of the Medical Staff will assume responsibility for the basic medical appraisal of the patient and for the care of any medical problem that may be present or may arise during hospitalization. It shall be the responsibility of the dentist or podiatrist to obtain a physician as a co-admitter;
- c. Exercise such clinical privileges as are granted to him or her;
- d. Vote on matters presented at general and special meetings of the staff and of the department and committees of which he/she is a member; and
- e. Hold office in the Staff organization and in the department and committees of which he or she is a member.

4.3-3 Responsibilities

Each appointee of the Active Staff shall:

- a. Meet the basic responsibilities;
- b. Retain responsibility within his or her area of professional competence for the continuous care and supervision of each patient in the Medical Center for whom he/she is providing services, or arrange a suitable alternative for such care and supervision and notify the Medical Center of change;
- c. Actively participate in the quality assurance, performance improvement and peer review activities required of the Staff, in supervising associate appointees where appropriate and except for hospital based physicians participating, in the emergency service coverage, and in discharging such other Staff functions as may be required from time to time;
- d. Satisfy the requirement for attendance at meetings of the Staff and of the department and committees to which he/she is appointed; and
- e. Except for hospitals based physicians, participate in the Emergency Department Call Schedule and provide coverage within his area of professional competence. On call physicians must respond and report within thirty (30) minutes to the Medical Center if necessary as determined by the requestor. Medical Staff must also notify the House Supervisor of changes in the call schedule under emergent situations.
- f. Hospital based physicians may not serve as Chairpersons of any clinical committee.

4.4 EMERITUS STAFF

With a written request after reaching the age of 65, Active staff members may apply for relief in participation in the Emergency Room call rotation and leadership roles.

4.5 COURTESY STAFF

4.5-1 Qualifications

The Courtesy Staff shall consist of practitioners each of whom:

- a. Meets the basic qualifications;
- b. Whose office and residence are located within 30 minutes to the Medical Center, or otherwise arranges, to provide continuous care to his/her patients; and
- c. Who only occasionally admits patients to the Medical Center and shall not have more than twelve (12) contacts (including Admissions, Consults, and Out-Patient Surgeries) per year to the Medical Center. When a provider with Courtesy provider has more than 12 contacts, the provider will automatically be changed to Active Status.

4.5-2 Prerogatives

The prerogatives of a Courtesy Staff appointee shall be to:

- a. Admit patients to the Medical Center within the limitations and under the same conditions as specified for Active Staff appointee;
- b. Exercise such clinical privileges as are granted to him or her; and
- c. Attend meetings of the Staff and the department of which he/she is an appointee and any Staff or Medical Center education programs. Courtesy Staff appointees shall not be eligible to vote or to hold office.

4.5-3 Responsibilities

Each appointee of the Courtesy Staff shall be required to discharge the basic responsibilities and, further, shall retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Medical Center for whom he/she is providing services, or arrange a suitable alternative for such care and supervision. Appointment to the Courtesy Staff shall be made only after the practitioner serves at least one (1) year as a member of the Associate Staff or the practitioner has served as an Active Staff member at another facility and has completed the credentialing process.

4.6 HOSPITAL BASED STAFF

4.6.1 Qualifications

These physicians have a contract with the Medical Center and will act in accordance with their contract with the Medical Center, such as Anesthesiologists, Radiologists, Pathologists, and Emergency Physicians.

- A. Hospital Based Practitioners shall meet the basic qualifications as specified in the Bylaws.
- B. Hospital Based Practitioners shall not have admitting privileges.
- C. Hospital Based Physicians shall serve at least one (1) year as a member of the Associate Staff.

4.6.2 Prerogatives

The prerogatives of a Hospital Based Staff member shall be to:

- A. Exercise clinical privileges as are granted to him/her;
- B. May attend General Medical Staff and Department meetings but are not entitled to vote or hold office or serve on Medical Staff Committees.

4.6.3 Responsibilities

- A. Each appointee applying for Hospital Based Staff privileges shall be required to discharge responsibilities as per privileges granted. Failure to fulfill those responsibilities shall be grounds for termination of privileges or denial of reappointment.
- B. Actively participate in the quality assurance, performance improvement and peer review activities required of the Staff as defined in their privileges, in supervising associate appointees where appropriate and in discharging other staff functions as may be required from time to time.

4.7 HOSPITALIST STAFF

4.7.1 Qualifications

The Hospitalist Staff shall consist of practitioners:

- a. Who meet the basic qualifications;
- b. Who do not have an active private clinic practice in the community;
- c. Must be able to arrive at the Medical Center within 30 minutes when he/she has responsibilities of patients in the Medical Center;
- d. Who are regularly involved in the care of patients in the Medical Center.
- e. Hospitalists shall serve at least one (1) year as a member of the Associate Staff.

4.7.2 Prerogatives

The prerogatives of a Hospitalist Staff member shall be to:

- a. Admit patients without limitation, unless otherwise provided in the Medical Staff Bylaws, Rules and Regulation, or policies;
- b. Exercise clinical privileges as are granted to him/her;
- c. May attend General Medical Staff and Department meetings but are not entitled to vote or hold office or serve on Medical Staff Committees.
- d. May serve as Medical Directors within the hospital.

4.7.3 Responsibilities

Each appointee to the Hospitalist staff shall:

- a. Meet the basic responsibilities
- b. Retain responsibility within his or her area of professional competence for the continuous care and supervision of each patient in the Medical Center for whom he/she is providing services, or arrange a suitable alternative for such care and supervision and notify the Medical Center of change;

- c. Actively participate in the quality assurance, performance improvement and peer review activities required of the Staff as defined in their privileges.
- d. Participate in the Hospitalist Call Schedule and provide coverage within his area of professional competence. On call physicians must respond and report within thirty (30) minutes to the Medical Center if necessary as determined by the requestor.

4.8 ALTERNATIVE STATUS

4.8-1 Alternative Status

Upon the written concurrence of the Chairperson of the Department where the privileges will be exercised, or of the Chief of Staff, the Administrator may grant alternative status in the following circumstances:

4.8-1a *Locum Tenens*

Upon receipt of a written request, an appropriately licensed practitioner who is serving as locum tenens for a member of the Medical Staff may, without applying for membership on the Staff be granted Alternative privileges for an initial period of ninety (90) days.

4.8-1b Temporary

Pending completion of the credentialing process, Temporary status may be granted for a specified period, not to exceed one hundred twenty (120) days, to an applicant for medical staff membership whose services are required to maintain or enhance the quality of care of the Medical Center as necessary.

4.8-1c Care of Specific Patients

Upon receipt of a written request, an appropriately licensed practitioner who is not an applicant for membership may be granted temporary status for the care of one or more specific patients. Such status shall be restricted to the treatment of not more than two (2) patients in any one year by any practitioner, after which such practitioner shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients. The time limit for this type of Alternative Privileges will be the length of stay for that particular patient.

4.8-2 Conditions

Alternative status shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges granted. Special requirements of consultation and reporting may be imposed by the Chairman of the Department responsible for supervision of a practitioner granted temporary privileges. Verification of current license, DEA, and competence will be required.

Before Alternative status is granted:

- a. The practitioner must acknowledge in writing that he/she has received and read the Medical Staff Bylaws, Rules and Regulations and that he/she agrees to be bound by the terms thereof in all matters relating to his or her alternative status.
- b. The practitioner must complete the application and provide the requested information including but not limited to a current license, current DEA, DPS, current malpractice coverage, and current competence. Medical Staff Services will verify as much as possible of the application prior to submitting the application for the approval process.

4.8-3 Termination

On the discovery of any information or the occurrence of any event of a professionally questionable nature about a practitioner's qualifications or ability to exercise any or all of the privileges granted, the Administrator may, after consultation with the Department Chairperson responsible for supervision or the Chairperson of the MEC, terminate any or all of such practitioner's Alternative status provided that where the life or well-being of a patient is determined to be endangered by continued treatment by the practitioner, the termination may be effected by any person entitled to impose summary suspensions under Article VII. In the event of any such termination, the Department Chairperson responsible for supervision shall assign the practitioners patients then in the Medical Center to another practitioner. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

4.8-4 Rights of the Practitioner

A practitioner shall not be entitled to the procedural rights because of his/her inability to obtain termination or suspension of alternative status.

4.9 REFERRING STAFF

4.9-1 Qualifications

Meets the basic qualifications of appropriate licensure and are not sanctioned by GSA or OIG.

4.9-2 Prerogatives

This status is awarded to a physician whose practice and privileges are entirely outpatient in scope. Such members shall have no admitting privileges, no operating room privileges, and are not required to attend Emergency Service patients.

4.9-3 Responsibilities

Each appointee of the Referring Medical Staff may attend Medical Staff meetings but are not entitled to vote or hold office or serve on Medical Staff Committees.

4.10 DISASTER STAFF

Practitioners under the following circumstances may exercise disaster Staff Status:

In the case of a medical emergency any medical staff appointee is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the appointee's license, but regardless of department affiliation, staff category, or level of privileges. A practitioner exercising privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

If the institution's Emergency Management Plan has been activated, the CEO, Chief of Staff, or their designees may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster status to provide patient care to selected practitioners provided at least one of the following requirements has been met by the practitioner:

- a. Presentation of a current hospital photo identification (ID) card;
- b. Presentation of a current medical license with photo identification (ID) card; issued by a state, federal or regulatory agency;
- c. Presentation of a photo identification (ID) card that certifies the practitioner is a licensed Independent Practitioner (LIP) indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT);

- d. Presentation of an (ID) card that certifies the practitioner is an LIP who has been granted authority by federal, state, or municipal entity to administer patient care, treatment, and services in disaster circumstances; and
- e. Presentation by a current hospital or medical staff member(s) who can vouch for the practitioner's identity.

As soon as feasible while a practitioner is practicing under Disaster Status, the hospital will seek to verify the practitioner's current licensure and current competency in the same manner as for individuals granted temporary privileges.

The practitioner's Disaster Status will terminate immediately, once the immediate situation has passed.

CEO, Chief of Staff, or designees shall also have the authority to terminate Disaster Status. 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.

4.11 LIMITATION OF PREROGATIVES

The prerogatives set forth under each staff category are general in nature and may be subject to limitation by special conditions attached to a practitioner's staff membership, by other sections of these Bylaws and by other policies or agreements of the Medical Center.

ARTICLE V ALLIED HEALTH PROFESSIONALS AND MEDICAL ASSISTANTS

5.1 ALLIED HEALTH PROFESSIONALS

5.1-1 Qualifications

Qualified individuals in allied health professional (AHP) categories approved by the Board of Trustees, following recommendation from the Medical Staff Executive Committee, may be granted clinical privileges in accordance with and subject to the procedures and requirements set forth in the Medical Staff Bylaws Rules and Regulations.

5.1-1a. AHP's must document their qualifications, licensures or certification if required status, clinical duties, and training, demonstrated ability, physical and mental health status with sufficient adequacy to demonstrate that they can exercise independent judgment within their areas of competence.

5.1-1b. AHP shall hold a license, certificate, other legal credentials or be sponsored by a member of the Medical Staff.

5.1-1c. AHP's shall be individually assigned to an appropriate clinical department/service policies and procedures and in conformity with these Bylaws, Rules and Regulations.

5.1-2 Conditions of Appointment

5.1-2a. AHPs shall be entitled to the rights, privileges, and responsibilities of appointment to the Staff and may only engage in acts within the scope of practice specifically approved for them by the Trustees.

5.1-2b. Appointments as AHPs are at the discretion of the Trustees, The applicant for appointment as an AHP shall have the right to appear personally before the MEC to appeal and discuss the scope of activities recommended by that Committee.

5.1-3 Prerogatives

The prerogatives of an AHP shall be to:

- 5.1-2a. Participate directly in the management of patients under the supervision or direction of an appointee of the staff;
- 5.1-2b. Within the limits established by the staff and consistent with State Practice Acts, they may write orders, record reports, and progress notes in the patient's medical records;
- 5.1-2c. Serve on Staff, department, and Medical Center committees without a vote; and
- 5.1-2d. Exercise such other prerogatives as shall, by resolution or written policy duly adopted by the Staff or by any of its departments or committees and approved by the MEC and the Trustees, be accorded to AHPs as a group or to any specific category of AHPs, such as the right to vote on specified matters, to hold defined offices, or other prerogatives for which medical education, training, and experience beyond that which an AHP can demonstrate, is not a prerequisite.

5.1-4 Responsibilities

Each AHP shall:

- 5.1-1a. Retain appropriate responsibility within his or her area of professional competence for the care and supervision of each patient in the Medical Center for whom he/she is providing services, or arrange a suitable alternative for such care and supervision;
- 5.1-1b. Participate as appropriate in the quality assurance activities required of the staff, and in discharging such other staff functions as may be required from time to time; and
- 5.1-1c. Satisfy the requirements set forth in Article XIII for attendance at meetings of the department and committees of which he/she is a member.

5.2 MEDICAL ASSISTANTS

5.2-1 Qualifications

- 5.2-1a. The Medical Center shall examine, pass upon, limit and delineate the scope of activities within the Medical Center of Medical Assistants who are licensed or certified and who provide medical services as employees of physicians who are presently appointed to the Medical Staff. The Administration of the Medical Center shall be responsible for this task.
- 5.2-1b. No such individual shall provide patient services in the Medical Center as an employee of a physician appointed to the Staff until and unless Administration has received, on a form provided by the Medical Center, sufficient information about the qualifications of that individual to permit the Medical Executive Committee to determine the scope of activities the individual will be permitted to undertake in the Medical Center in compliance with applicable state and federal law. The form shall be prepared by the individual's physician employer and signed by both the employer and the individual with the employing Medical Staff member assuming full responsibility for all errors and omissions of such Medical Assistant. Each Medical Assistant shall be insured in amounts determined appropriate by the Administrator.
- 5.2-1c. It shall be clearly understood that any activities permitted by Medical Center's Administration to be done in the Medical Center by Medical Assistants shall be

under the direct and immediate supervision of the physician employer, but that "direct and immediate supervision" shall not require the physical presence of the employer medical staff appointee. However, should any licensed or certified Medical Center employee have any question regarding the competence or authority of the Medical Assistant either to act or to issue instructions outside the physical presence of the physician employer, such Medical Center employee has a duty to require that the individual's employer validate, either at the time or later, the order of the Medical Assistant. Any act or instruction of the Medical Assistant shall be delayed until such time as the Medical Center employee can be certain that the act is clearly within the scope of the Medical Assistant's activities as permitted by the Medical Center's Administration.

5.2-1d. The number of Medical Assistants acting as employees of one physician as well as the acts they may undertake shall be consistent with the applicable state statutes and regulations.

5.2-1e. Medical Assistants are not eligible for the fair hearing process.

5.2-2 Prerogatives

The prerogatives of a Medical Assistant shall be to:

5.2-2a. Participate directly in the management of patients under the supervision or direction of an appointee of the staff;

5.2-2b. Within the limits established by the staff and consistent with State Practice Acts, they may document in the patient's medical records;

5.2-3 Responsibilities

Each Medical Assistant shall:

5.2-3a. Retain appropriate responsibility within his or her area of professional competence for the care and supervision of each patient in the Medical Center for whom he/she is providing services, or arrange a suitable alternative for such care and supervision;

5.2-3b. Participate as appropriate in the quality assurance activities required of the staff, and in discharging such other staff functions as may be required from time to time; and

ARTICLE VI PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

6.1 GENERAL PROCEDURE

The Medical Staff through its designated departments, services, committees and officers shall investigate and consider each application for appointment or reappointment to the staff and each request for modification of Staff appointment status and shall adopt and transmit recommendations thereon to the Trustees which shall be the final authority on appointment, reappointment, extension, termination or reduction of Staff privileges.

6.2 APPLICATION FOR INITIAL APPOINTMENT

6.2-1 Issuance of Application

Any applicant who wishes to apply for appointment to the Staff of the Medical Center shall submit a letter requesting an application. Upon request of an applicant, Medical Staff Services shall provide the application and information explaining the application process.

6.2-2 Application Content

Professional criteria are designed to assure the medical staff and governing body that patients will receive quality care, treatment, and services from qualified providers. The professional criteria at least pertain to evidence of current licensure, relevant training or experience, current competence, and ability to perform the privileges requested. The application form will be the Texas Standardized Credentialing form and addendum and as a minimum shall include:

- a. Acknowledgment and Agreement: A statement that the applicant has received and read the current Bylaws, Rules & Regulations of the Staff, and current Medical Center Bylaws and Policies and that he/she agrees: (i) to be bound by the terms thereof if he/she is granted appointment and/or clinical privileges, and (ii) to be bound by the terms thereof in all matters relating to consideration of his/her application without regard to whether or not he/she is granted appointment and/or clinical privileges;
- b. Qualifications: Detailed information concerning the applicant's qualifications including information in satisfaction of the basic qualifications and any additional qualifications specified in these Bylaws for the particular staff category to which the applicant requests appointment;
- c. Requests: Specific requests stating the staff status; department and specific clinical privileges for which the applicant wishes to be considered;
- d. Current competence: The names of at least three (3) practitioners who have worked with the applicant and personally observed his/her professional performance and who will provide truthful references as to the applicant's education, experience and clinical ability, ethical character, competence, and ability to work with others;
- e. Professional Sanctions: Information as to whether the applicant's appointment status and/or clinical privileges have ever been voluntarily/involuntarily revoked, suspended, reduced, previously successful or currently pending challenges, or not renewed at any other Medical Center or health care institution, and as to whether any of the following have ever been voluntarily/involuntarily suspended, revoked or denied:
 1. Membership/fellowship in local, state or national professional organizations;
 2. Specialty board certifications;
 3. License to practice any profession in any jurisdiction;
 4. Department of public Safety (DPS) or Drug Enforcement Agency (DEA) number;
 5. National Practitioner Data Bank (NPDB) under the provisions of Title IV of Public Law 99-60, the Healthcare Quality Improvement Act of 1986. If any such actions were ever taken, the particulars thereof shall be included.
- f. Professional Liability Insurance: Information regarding professional liability insurance shall be required;
- g. Malpractice Claims: Details about malpractice claims, suits, and settlements. Involvement in a professional liability action under circumstances specified in the medical staff bylaws, rules and regulations, and policies, and at a minimum, final judgments or settlements involving the individual are reported;

- h. Notification of Release and Immunity Provisions: Statements notifying the applicant of the scope and extent of authorization, confidentiality, immunity and release provisions; and
- i. Administrative Remedies: A statement whereby the practitioner agrees that, when an adverse ruling is made with respect to his/her staff appointment, staff status, and/or clinical privileges, he/she will exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action; and
- j. A current photo or copy of driver's license.

6.3 EFFECT OF APPLICATION

By applying for appointment to the Medical Staff, the applicant:

- a. Consents to the inspection of records and documents pertinent to his or her licensure, specific training, experience, current competence, and ability to perform the privileges requested, and if requested, appears for an interview;
- b. Pledges to provide for continuous care for his or her patients;
- c. Authorizes Medical Center representatives to consult with others who have been associated with him or her and/or who may have information bearing on his competence and qualifications;
- d. Consents to the inspection by Medical Center representatives of all records and documents that may be material to an evaluation of his professional qualifications and ability to carry out the clinical privileges he/she requests as well as his/her professional ethical qualifications for staff membership;
- e. Release from any liability all Medical Center representatives for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials;
- f. Release from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Medical Center representatives in good faith and without malice concerning the applicant's ability, professional ethics, character, physical and mental health, emotional stability and other relevant qualifications for Staff appointment and clinical privileges;
- g. Authorizes and consents to Medical Center representatives providing other hospitals, medical associations, licensing boards and other organizations concerned with provider performance and the quality and efficiency of patient care with any information the Medical Center may have concerning him or her, and releases Medical Center representatives from liability for so doing; provided that such furnishing of information is done in good faith and without malice.

For purpose of this Section, the term "Medical Center representative" includes the Board of Trustees, Board of Directors and the Medical Center's employees or shareholders, Committees, the Administrators, all Staff members, departments and committees which have responsibility for collecting or evaluating the applicant's credentials or acting upon his application, and any authorized representative of any of the foregoing.

6.4 PROCESSING THE APPLICATION

6.4-1 Applicant's Burden

The applicant shall signify his/her willingness to appear for interviews in regard to his/her application and have the burden of producing adequate information for a proper evaluation of his/her experience, background, training, demonstrated ability,

previous performance, physical health status, and, upon request of the MEC or the Trustees, mental health status, and of resolving any doubts about these or any of the other basic qualifications.

6.4-2 Statement of Release and Immunity from Liability

The following are expressed conditions applicable to any applicant and to any person appointed to the Staff and to anyone having or seeking privileges to practice his or her profession in the Medical Center during his or her term of appointment or reappointment. In addition, by applying for appointment, reappointment or clinical privileges, the applicant expressly accepts these conditions during the processing and consideration of his or her application, regardless of whether or not he or she is granted appointment or clinical privileges. They shall also apply during his or her appointment and reappointment.

- a. To the fullest extent permitted by law, the applicant or appointee extends absolute immunity to and releases from liability, this Medical Center and its representatives and any third party with respect to any and all civil liability which might arise from any acts, communications, reports, recommendations, or disclosures involving an applicant or appointee, performed, made, requested or received by this Medical Center and its representatives, to, from, or by any third party, including other appointees to the Staff, concerning activities relating to, but not limited to:
 1. Applications for appointment or clinical privileges;
 2. Periodic reappraisals undertaken for reappointment or for increase or decrease in clinical privileges;
 3. Proceedings for reduction or suspension of clinical privileges or revocation of medical staff appointment, or any other disciplinary sanction;
 4. Summary suspension;
 5. Hearings and appellate reviews;
 6. Patients care evaluations;
 7. Utilization reviews;
 8. Other medical center and medical staff, departmental, service or committee activities relating to the quality of patient care or the professional conduct of an appointee to the Staff or any individual granted privileges to practice in the Medical Center;
 9. And concerning statements, investigations, materials provided, or inquiries, oral or written, relating to an applicant's or appointee's professional qualifications, credentials, clinical competence, previous competence, previous performance, character, mental or emotional stability, physical condition, ethics, behavior, as well as the inspection of all records and documents that may be material to such questions or any other matter that might directly or indirectly have an effect on the individual's competence, or on patient care, or on the orderly operations of this Medical Center or any other hospital or health care facility including otherwise privileged or confidential information provided such information is provided in good faith and without malice.
- b. Any act, communication, report, recommendation or disclosure, with respect to any such applicant or appointee, made in good faith and at the request of

an authorized representative of this Medical Center or any other hospital or health care facility, anywhere at any time, for the purposes set forth in (a) above, shall be privileged to the fullest extent permitted by law. Such privilege shall extend to employees of the Medical Center, its authorized representative, and to any third parties that either supply or are supplied information and to any of the foregoing authorized to receive, release or act upon the same.

- c. The Medical Center and its authorized representatives are specifically authorized to consult with the appointees to the medical staffs of other hospitals or Health care facilities or the management of such hospitals or facilities with which the applicant or appointee is or has been associated, and with others who may have information bearing on the applicant's or appointee's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter, as well as to inspect all records and documents that may be material to such questions. The applicant or appointee grants immunity to any and all hospitals, health care facilities, individuals, institutions, organizations and their representatives who in good faith supply oral or written information, records or documents to the Medical Center in response to an inquiry emanating from the Medical Center or its authorized representatives.
- d. The applicant or appointee specifically releases from liability all representatives of the Medical Center, including all appointees to its Medical Staff, for investigations requested, statements made, materials provided or acts performed in good faith in evaluating the applicant or appointee for any of the purposes or reasons set forth in this section.
- e. As used in this section, the term "Medical Center and its representatives" means this Medical Center, its shareholders, the members of its Board of Trustees, Board of Directors and Their appointed representatives, Medical Center shareholders or employees, the Chief Administrative Officer and his subordinates or designees, consultants to the Medical Center, the Medical Center's attorney and his partners, assistants or designees, and all appointees to the Medical Staff who have any responsibility for obtaining or evaluating an applicant's or appointee's credentials and/or acting upon his application or conduct in the Medical Center and any authorized representative of any of the foregoing.
- f. As used in this section, the term "third parties" means all individuals or government agencies, organizations, associations, partnerships and corporations, whether hospitals, health care facilities or not, from whom information has been requested by the Medical Center or its authorized representatives or who have requested such information from the Medical Center and its authorized representatives.

6.4-3 Verification of Information

- a. The applicant shall deliver a completed application to Medical Staff Services, who on behalf of the Medical Executive Committee in timely fashion seek to collect or verify at least 2 preferably 3 references, licensure and other qualification evidence submitted;
- b. For an applicant for initial appointment to the medical staff and for initial granting of clinical privileges, the Medical Center verifies information about the applicant's licensure, specific training, experience, and current competence provided by the applicant with information from the primary source(s) whenever feasible;
- c. Medical Staff Services shall promptly notify the applicant of any problems in obtaining the information required and it shall then be the applicant's

obligation to obtain the required information;

- d. Action on an individual's application for appointment or initial clinical privileges is withheld until the information is available and verified;
- e. The Medical Center will consider additional information concerning the applicant from other sources, including the National Practitioner Data Bank. These databases and other sources may provide the medical center with information that is new or that may flag an inconsistency when compared with the individual's application;
- f. When collection and verification is accomplished, Medical Staff Services shall transmit the application and all supporting materials to the Chairperson of each department in which the applicant seeks privileges. A separate record is maintained for each individual requesting medical staff membership or clinical privileges. Complete applications are acted on within a reasonable period of time, usually within 90 days. Decision on appointments or on granting of clinical privileges must consider criteria that are directly related to the quality of care.

6.4-4 Description of Initial Clinical Privileges

Clinical privileges are authorized by the BOT after recommendation from MEC to a practitioner to provide specific care services in the medical center within well-defined limits, based on the following factors as applicable: licensure, education, training, experience, competence, health status, and judgment. Individuals who are permitted by law and by the Medical Center to provide patient care services independently in the Medical Center have delineated clinical privileges, whether or not they are medical staff members.

- a. Staff appointment or reappointment shall not confer any clinical privileges or right to practice in the Medical Center;
- b. Each practitioner who has been given an appointment to the Staff of the Medical Center shall be entitled to exercise only those clinical privileges specifically granted by the Trustees, except as stated in policies adopted by the Trustees. The delineation of an individual's clinical privileges includes the limitations, if any, on an individual's privileges to admit and treat patients or direct the course of treatment for the conditions for which the patients were admitted;
- c. The clinical privileges recommended to the Trustees shall be based upon the applicant's education, training experience, past performance, demonstrated competence and judgment, references and other relevant information, including an appraisal by the clinical department in which such privileges are sought;
- d. The applicant shall have the burden of establishing his/her qualifications for competence to exercise the clinical privileges he or she requests;
- e. When physicians or other individuals eligible for delineated clinical privileges are engaged by the medical center to provide patient care services pursuant to a contract, their clinical privileges to admit or treat patients are defined through medical staff mechanisms;
- f. Recommendations of the clinical department in which privileges are sought shall be forwarded to the Medical Executive Committee, and thereafter processed as a part of the initial application for staff appointment.

6.4-5 Medical Executive Committee Action

Upon receipt, members of the Medical Executive Committee shall review the application, the supporting documentation, each department chairperson's report and recommendations, and such other information available to it that may be relevant to consideration of the applicant's qualifications for the staff category and clinical privileges requested. The medical staff executive committee requests evaluations of providers privileged through the medical staff process in instances where there is doubt about an applicant's ability to perform the privileges requested. The MEC shall then forward to the Administrator for transmittal to the Trustees a written report and recommendations as to staff appointment and, if appointment is recommended, as to staff category, department, and clinical privileges to be granted and any special conditions to be attached to the appointment. The Committee may also defer action on the application. The reasons for each recommendation shall be stated and supported by reference to the completed application and other documentation considered by the Committee.

6.4-6 Effect of Medical Executive Committee Action

- a. Deferral: Action by the MEC to defer the application for further consideration must be followed up within 30 days (or the next regular meeting) with a recommendation for either provisional appointment with specified clinical privileges or for rejection for staff appointment;
- b. Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the Administrator shall promptly forward it, together with supporting documentation, to the Trustees. For the purposes of this Section, "and supporting documentation" includes the application form and its accompanying information and the reports and recommendations of the Department Chairperson;
- c. Adverse Recommendation: When the recommendation of the MEC is adverse to the applicant, the Administrator shall immediately so inform the practitioner by special notice, and he/she shall be entitled to the procedural rights in the Fair Hearing Plan appended hereto. The applicant shall exercise his or her procedural rights prior to submission of the adverse recommendation to the Trustees. For the purposes of this Section, an "adverse recommendation" by the MEC is defined in the Fair Hearing Plan.

6.4-7 Trustee Action

- a. On Favorable MEC Recommendation: The Trustees shall in whole or in part, adopt or reject the favorable recommendation of MEC, or refer the recommendation back to MEC for further consideration stating the reasons for such referral and setting a time limit within which a subsequent recommendation shall be made. If the Board's action is adverse to the applicant as defined in the Fair Hearing Plan, the Administrator shall promptly so inform the applicant by special notice, and he shall be entitled to the procedural rights as provided in the Fair Hearing Plan;
- b. Without Benefit of MEC Recommendation: If the Trustees do not receive a MEC recommendation within the time period specified, it may take action on its own initiative as provided in Bylaws. If such action is favorable, it shall become effective as the final decision of the Trustees. If such action is adverse, as defined in the Fair Hearing Plan, the Administrator shall promptly so inform the applicant by special notice, and he/she shall be entitled to the procedural rights as provided in the Fair Hearing Plan;
- c. Physician Trustee Member Participation: If a physician Trustee member has participated in the earlier Medical Staff recommendation process, he/she may be excused from the Trustee discussions and vote on the applicant he/she has previously reviewed;

- d. After Procedural Rights: In the case of an adverse MEC recommendation or an adverse Trustee decision, the Trustee shall take final action in the matter only after the applicant has exhausted or has waived his/her procedural rights as provided in the Fair Hearing Plan. Action thus taken shall be the conclusive decision of the Trustees, except that the Trustees may defer final determination by referring the matter back for further reconsideration. Any such referral shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Trustees shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the Trustees shall make a final decision whether to appoint the applicant to the staff or to reject him/her for staff membership.

6.4-8 Denial for Medical Center's Inability to Accommodate Applicant

A recommendation by the MEC, or a decision by the Board, to deny staff appointment, a department or staff category assignment or particular clinical privileges, either:

- a. On the basis of the Medical Center's present inability as supported by documented evidence to provide adequate facilities or supportive services for the applicant and his patients; or
- b. On the basis of inconsistency with the Medical Center's Management Plan including the mix of patient care services to be provided, as currently being implemented; or
- c. On the basis of professional contracts the Medical Center has entered into for the rendition of services within various departments shall be considered adverse in nature and shall entitle the applicant to the procedural rights as provided in the Fair Hearing Plan. If the Trustee's final decision remains adverse, the notice of final decision shall state that upon written request by the applicant to the Administrator, the application will be kept in a pending status for the next succeeding two years. If during this period, the Medical Center finds it possible to accept staff applications for which the applicant is eligible, and the Medical Center has no obligation to applicants with prior pending status, the Administrator shall promptly so inform him/her by special notice.

Within 30 days of receipt of such notice, the applicant shall provide, in writing on the prescribed form, such supplemental information as is required to update all elements of his/her original application. Thereafter, the procedure provided for initial appointments shall apply.

6.4-9 Conflict Resolution

Whenever the Trustees' decision will be contrary to the MEC's recommendation, the Board may submit the matter to a joint conference of equal numbers of Medical Staff and Board members for a review and recommendation as provided in the Fair Hearing Plan before making its final decision and giving the notice of final decision .

6.4-10 Notice of Final Decision

- a. Notice of the Trustees' final decision shall be given, through the Administrator, to the Chairperson of the MEC, to the chairperson of each department concerned, to the appropriate Medical Center staff, and to the applicant.
- b. A decision and notice to appoint shall include:
 - 1. The staff category to which the applicant is appointed;

2. The department to which he/she is assigned;
3. The clinical privileges he/she may exercise; and
4. Any special conditions attached to the appointment.

6.4-11 Reapplication after Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment shall not be considered for application to the Medical Staff for a period of one year after notice of such decision is sent. Any such reapplication shall be processed as an initial application and the applicant shall submit such additional information as the Staff or the Trustees may require in demonstration that the basis for the earlier adverse action no longer exists.

6.4-12 Time Periods for Processing

Applications for Staff appointments shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and except for good cause, shall be processed within the time periods specified in this section. Medical Staff Services shall transmit an application to the Medical Staff upon completing his/her information collection and verification tasks, but in any event within 120 days after receiving the application. The Department Chairperson shall act on an application within a reasonable time after receiving it from the Medical Staff Office. The MEC shall review the application and make its recommendation to the Trustees within a reasonable time after receiving the Department Chairperson's report. The Trustees shall review the application and shall then take final action on the application at their next meeting. Otherwise, the Trustee action shall take place within six months from the receipt of a fully completed application.

6.5 REAPPOINTMENT PROCESS

6.5-1 Information Form for Reappointment

Medical Staff Services shall, at least ninety (90) days prior to the expiration date of the present staff appointment of each Staff appointee, provide such Staff appointee with reappointment information for use in considering reappointment. Each Staff appointee who desires reappointment shall, at least sixty (60) days prior to such expiration date send his/her reappointment information to Medical Staff Services. Failure to return the form may result in automatic termination of appointment at the expiration of the appointee's current term except for extenuating circumstances to be determined by the MEC.

6.5-2 Content of Reappointment Information

The Reappointment Information shall be a prescribed form and shall contain information necessary to maintain a current file on the Staff appointee's healthcare activities. This reappointment information shall include, without limitation, information about:

- a. Continuing training, education, judgment, professional performance including clinical and technical skills and experience that qualifies the Staff appointee for the privileges sought on reappointment;
- b. Current physical and, upon specific request by the MEC or the Trustees, mental health status, and ability to perform privileges requested;
- c. The name and address of any other health care organization or practice

setting where the Staff appointee provided clinical services during the preceding period;

- d. Membership, awards, or other recognition conferred or granted by any professional health care societies, institutions or organizations;
- e. Sanctions of any kind imposed by any other health care institutions, professional health care organization, or licensing authority; including voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another facility, organization, or licensing authority;
- f. Details about malpractice claims, suits, and settlements including involvement in a professional liability action under circumstances specified in the bylaws, rules and regulations, and policies, and at a minimum, final judgments or settlements involving the individual;
- g. Such other specific information about the Staff appointee's professional ethics, qualifications and ability that may bear on his/her ability to provide quality patient care and competence in the Medical Center;
- h. Information obtained from Quality Assurance and Performance Improvement activities on adverse clinical outcome and appropriateness of care;
- i. National Practitioner Data Bank Report (NPDB);
- j. Names and addresses of at least three (3) peers willing to provide peer references to the individual;
- k. A current photo or copy of drivers license.

6.5-3 Verification of Information

Medical Staff Services shall, in timely fashion, seek to collect or verify the additional information made available on each Reappointment application and to collect any other materials or information deemed pertinent, including information regarding the Staff appointee's professional activities, performance and conduct in this Medical Center. When collection and verification is accomplished, Medical Staff Services shall transmit the information form and supporting materials to the Chairperson of each department in which the Staff appointee requests privileges. The verification process will be completed within a reasonable period of time and prior to the individual's current appointment expiration date but no more than ninety (90) days after receiving the completed information from the individual. A separate record will be maintained for each individual.

6.5-4 Meeting with Affected Individual

If, during the processing of a particular individual's reappointment, it becomes apparent to the Medical Executive Committee or its Chairperson that consideration is being given to a recommendation that would deny reappointment, deny a requested change in staff category or clinical privileges, or reduce clinical privileges, the Chairperson of the Medical Executive Committee shall notify the individual of the general tenor of the possible recommendation and ask him/her if he/she desires to meet with the Committee prior to any final recommendation.

At such meeting, the affected individual shall be informed of the general nature of the evidence supporting the action contemplated and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply nor shall minutes of the discussion in the meeting be kept. However, the Committee shall indicate as part of its report whether such a meeting occurred.

6.5-5 Medical Executive Committee Action

The Medical Executive Committee shall review each information form and all other relevant information available to it and shall, on the prescribed form forward to the Administrator for transmittal to the Trustees its report and recommendation that appointment be either renewed, renewed with modified staff category and/or clinical privileges, or terminated. The committee may also defer action. Each such report shall satisfy the requirements regarding Basis of Information, see below.

6.5-6 Final Processing and Board Action

Thereafter, the procedure provided in Section 6 shall be followed. For purposes of reappointment, the terms "applicant" and "appointment" as used in those Sections shall be read, respectively, as "staff appointee" and "reappointment," except as indicated otherwise by the Fair Hearing Plan.

6.5-7 Basis for Recommendations

Each recommendation concerning the reappointment of Staff appointee and clinical privileges to be granted upon reappointment shall be based upon such appointee's professional performance, ability and clinical judgment in the treatment of patients, clinical or technical skills, his/her professional ethics, his/her discharge of staff obligations, his/her compliance with the Medical Staff Bylaws, Rules and Regulations, his/her cooperation with other practitioners and with patients, and other matters bearing on his/her ability and willingness to contribute to the maintenance of quality patient care practices in the Medical Center. Such decisions are subject to the fair hearing and appeal process.

6.5-8 Time Periods for Processing

Transmittal of the reappointment packet to a Staff appointee and his/her return of it shall be carried out as stated above. Thereafter and except for good cause, each person, department and committee required by these Bylaws to act thereon shall complete such action in timely fashion such that all reports and recommendations concerning the reappointment of a Staff appointment shall have been transmitted to the Medical Executive Committee for its consideration and action and to the Trustees for its action, all prior to the expiration date of the Staff appointment of the appointee being considered for reappointment, if possible or within one-hundred-twenty (120) days of the completed application.

If the reappointment is not completed prior to the end of the current appointment, the appointee will be considered to have voluntarily resigned from staff.

**ARTICLE VII
DETERMINATION OF CLINICAL PRIVILEGES**

7.1 EXERCISE OF PRIVILEGES

Every practitioner or other professional providing direct clinical services at this Medical Center by virtue of his/her Staff appointment or otherwise, shall, in connection with such practice and except as provided otherwise in these Bylaws, Rules and Regulations or policies and procedures, be entitled to exercise only those clinical privileges or specified services specifically granted to him/her by the Board of Trustees. Classification or categorization of privileges are defined and approved by MEC and BOT.

7.2 DELINEATION OF PRIVILEGES IN GENERAL

7.2-1 Requests

Each application for appointment and reappointment to the Staff must contain a

request for the specific clinical privileges desired by the applicant. A request by a Staff appointee for a modification of privileges must be supported by documentation of training and experience supportive of the request.

7.2-2 Basis for Privileges Determination

Requests for clinical privileges shall be evaluated on the basis of the practitioner's education, training, performance, demonstrated ability and judgment. Board certification and/or eligibility is considered when delineating clinical privileges. When privilege delineation is based primarily on experience, the individual's credentials record reflects the specific experience and successful results that form the basis for the granting of privileges. The basis for privilege determinations to be made in connection with periodic reappointment or otherwise shall include documentation of observed clinical performance, treatment results, and the documented results of quality assurance activities and other performance improvement activities required by these Bylaws and the BOT Bylaws. Clinical privileges granted or modified on initial appointment, reappointment or otherwise shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a practitioner exercises clinical privileges. This information shall be added to and maintained in the Medical Staff file established for a Staff appointee.

7.2-3 Procedure

Requests for clinical privileges shall be evaluated and granted, modified or denied pursuant to, and as a part of, the procedures outlined in these Bylaws, Rules and Regulations or policies and procedures.

7.3 SPECIAL CONDITIONS FOR DENTAL OR PODIATRIC PRIVILEGES

Requests for clinical privileges from dentists or podiatrists shall be processed, evaluated and granted in the same manner specified as listed above. Surgical procedures performed by podiatrists/dentists shall be under the overall supervision of the Chief of Surgery. All dental/podiatry patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A practitioner member of the Staff shall be responsible for medical evaluation, history and physical of the patient. A practitioner member of the Staff shall be responsible for the care of any medical problems that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

7.4 SPECIAL CONDITIONS FOR ORAL AND MAXILLOFACIAL SURGERY PRIVILEGES

Requests for clinical privileges for oral and maxillofacial Surgeons shall be processed, evaluated, and granted in the manner specified in the above sections. Surgical procedures performed by Oral and Maxillofacial Surgeons shall be under the overall supervision of the Chief of Surgery. Patients admitted for Oral and Maxillofacial Surgery care shall receive the same basic medical appraisal as patients admitted for other services, whether the appraisals are performed by a practitioner member of the Medical Staff or by an Oral and Maxillofacial Surgeon qualified and privileged to write histories, perform physical examinations, and assess the risks of oral surgery procedures they plan to perform for their patients without medical problems. A practitioner member of the Medical Staff shall be responsible for the care of medical problems that may be present at the time of admission or that may arise during hospitalization of the Oral Surgery patient.

7.5 TELEMEDICINE SERVICES

Practitioners who diagnose or treat patients via telemedicine link are subject to the credentialing and privileging processes of the organization that receives the telemedicine service. MEC and BOT recommends the clinical services to be provided by telemedicine, if

any.

7.6 MODIFICATION IN CLINICAL PRIVILEGES

A practitioner may request a change or modification in clinical privileges by providing a request and supporting documentation to support training and experience. The Medical Executive Committee will review the request and supporting documentation and make a recommendation to the Board of Trustees. New privileges may be monitored, proctored, and or reviewed as determined by the committees.

ARTICLE VIII CORRECTIVE ACTION

8.1 ROUTINE CORRECTIVE ACTION

8.1-1 Criteria for Initiation

Whenever the activities or professional conduct of any practitioner with clinical privileges are detrimental to patient safety or to the delivery of quality patient care, or are disruptive to Medical Center operations, corrective action against such practitioner may be initiated by any officer of the Medical Staff, by the Chairperson of any standing committee of the Medical Staff, by the Administrator, or by the Trustees.

8.1-2 Requests and Notices

Requests for corrective action shall be in writing, submitted to the MEC, and supported by reference to the specific activities or conduct, which constitute the grounds for the request. The Chairperson of MEC shall promptly notify the Administrator in writing of requests for corrective action received by the Committee and shall continue to keep the Administrator fully informed of action taken in conjunction therewith.

8.1-3 Investigation by a Department

The MEC shall forward the request for corrective action to the Chairperson of the department in which the questioned activities or conduct occurred. The Chairperson of such department shall immediately investigate the matter or appoint an ad hoc committee to investigate it. Within thirty (30) days if appropriate after the receipt of the request, the Department Chairperson or the ad hoc committee shall forward a written report of the investigation to the MEC.

8.1-4 Medical Executive Committee Action

Within thirty (30) days if appropriate, following receipt of the department report, the MEC shall take action upon the request. Such shall be reported in writing to the department and action may include, without limitation:

- a. Rejecting the request for corrective action;
- b. Issuing a warning, a letter of admonition, or a letter of reprimand;
- c. Recommending terms of probation or requirements of consultation;
- d. Recommending reduction, suspension or revocation of clinical privileges;
- e. Recommending reduction of Staff category or limitation of any Staff prerogatives directly related to patient care;
- f. Recommending suspension or revocation of Staff appointments.

8.1-5 Procedural Rights

Any action by MEC pursuant to Section 8.1-4 (c), (d), (e), or (f), or any combination of such actions shall entitle the practitioner to the procedural rights as provided in Article IX and the matter shall be processed in accordance with the provisions of the Fair Hearing Plan appended hereto.

8.1-6 Other Action

If the MEC's recommended action is provided as in Section 8.1-4 (a) or (b), such recommendation, together with supporting documentation, shall be transmitted to the Trustees.

8.2 SUMMARY SUSPENSION

8.2-1 Criteria and Initiation

Whenever a practitioner willfully disregards these Bylaws or other Medical Center policies, or whenever his/her conduct may require that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other person present in the Medical Center, the Chairperson of the MEC, the CEO, or the Executive Committee of the Medical Staff, shall have the authority to summarily suspend the Staff appointment status of all or any portion of the clinical privileges of such practitioner. Such summary suspension shall become effective immediately upon imposition, and subsequently the Administrator shall promptly give special notice of the suspension to the practitioner.

8.2-2 Medical Executive Committee Action

As soon as possible after such summary suspension, a meeting of the MEC shall be convened to review and consider the action taken. The MEC may recommend notification, continuation, or termination of the terms of the summary suspension.

8.2-3 Procedural Rights

On MEC recommendation, the practitioner shall be entitled to the procedural rights provided in Article IX and the Fair Hearing Plan. The terms of the summary suspension shall remain in effect pending a final decision by the Trustees.

If a practitioner is summarily suspended during the time when the practitioner is seeking rehabilitation pursuant to a Committee on Physician Health recommendation, the practitioner may waive, in writing, the immediate application of the fair hearing process and such practitioner shall then be granted all rights pursuant to the fair hearing process upon subsequent denial of such practitioner's request to resume practice at the Medical Center. If the suspension continues more than fifteen (15) days, it shall be reported as required by law.

8.3 AUTOMATIC SUSPENSION AND/OR TERMINATION OF PRIVILEGES

8.3-1 License

A staff appointee or affiliate whose license, certificate or other legal credential authorizing him/her to practice in this state is revoked, suspended or modified, shall immediately and automatically be suspended from practicing in the Medical Center. If the Staff member's license, certificate or other legal credential is revoked, his privileges shall be automatically terminated.

8.3-2 Department of Public Safety (DPS) and/or Drug Enforcement Agency (DEA) Numbers

A practitioner whose DPS or DEA number is revoked or suspended shall immediately and automatically be divested by the CEO of his/her right to prescribe medications covered by such number. As soon as possible after such automatic suspension, the

MEC shall convene to review and consider the facts under which the DPS or DEA number was revoked or suspended. The MEC may then recommend such further corrective action as is appropriate to the facts disclosed in its investigation.

8.3-3 Medical Records

An automatic suspension of a practitioner's admitting and/or medical center privileges shall, after warning of delinquency, be imposed for failure to complete medical records in a timely fashion. Such suspension shall continue until such records are completed. The Chief of Staff may waive the suspension in cases of prolonged illness or unusual circumstances if requested by the practitioner.

ARTICLE IX INTERVIEWS, HEARINGS, AND APPELLANT REVIEW

9.1 INTERVIEWS

When MEC or the Board receives or is considering initiating an adverse recommendation concerning a practitioner, the practitioner may 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.

9.2 HEARINGS AND APPELLANT REVIEW

9.2-1 Adverse Medical Executive Committee Recommendation

When any practitioner receives special notices of an adverse recommendation of the MEC, he/she shall be entitled upon request, to a hearing before an ad hoc hearing committee of the Medical Staff. If the recommendation of the MEC following such hearing is still adverse to the practitioner he shall then be entitled, upon request, to an appellant review by the Board before a final decision is rendered.

9.2-2 Adverse Board Decision

When any practitioner receives special notice of an adverse decision by the Board that is taken either contrary to a favorable recommendation of the MEC under circumstances where no right to a hearing existed, or on the Board's own initiative without benefit of a prior recommendation by the MEC, such practitioner shall be entitled, upon request, to a hearing by an ad hoc hearing committee appointed by the Board. If such hearing does not result in a favorable recommendation, he/she shall then be entitled, upon request, to an appellant review by the Board before a final decision is rendered.

9.2-3 Fair Hearing

Hearings and appellant reviews shall be in accordance with the procedures and safeguards set forth in the Fair Hearing Plan appended to these Bylaws.

9.2-4 Exceptions

Neither the issuance of a warning, a request to appear before a committee, a letter of admonition, or a letter of reprimand, nor the denial, termination or reduction of temporary privileges, or any other actions except these specified in the Fair Hearing Plan shall give rise to any right to a hearing or appellant review.

ARTICLE X STAFF CLINICAL DEPARTMENTS

10.1 ORGANIZATION OF STAFF DEPARTMENTS

Each department shall be organized as a separate part of the Medical Staff and shall have a Chairperson (Chief) who shall be elected by the members of his/her department and has the authority, duties, and responsibilities as specified in these Bylaws, Rules and Regulations or policies and procedures.

10.2 DESIGNATION

10.2-1 Current Departments

The current departments are Medicine and Surgery.

10.2-2 Future Departments

When deemed appropriate, the Medical Executive Committee may create a new, eliminate, subdivide, further subdivide or combine departments subject to Trustees approval.

10.3 ASSIGNMENT TO DEPARTMENTS

Each appointee of the Staff shall be assigned to at least one department, but may be granted clinical privileges in one or more of the other departments. The exercise of clinical privileges within any department shall be subject to the Rules and Regulations of that department and the authority of the Department Chairperson. The Department Chairperson for each of the departments will appraise for granting or renewal or revision of clinical privileges and make recommendations to the Medical Executive Committee.

10.4 FUNCTIONS OF DEPARTMENTS

The primary function of each department is to implement specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the department. To carry out this responsibility, each department shall:

- a. Require retrospective patient care evaluation to be performed for the purpose of analyzing, reviewing, and evaluating the quality of care within the department. Each department shall review clinical work performed under its jurisdiction. Family Practitioners shall be subject to review by each department in which they exercise clinical privileges;
- b. Establish guidelines for the granting of clinical privileges within the department and submit the recommendations required under these Bylaws, Rules and Regulations or policies and procedures regarding the specific privileges each staff appointee or applicant may request;
- c. Conduct and participate in, and make recommendations regarding the need for continuing medical education programs pertinent to changes in state-of-the-art and to findings of review and evaluation activities;
- d. Monitor, on a continuing and concurrent basis, adherence to: (1) Staff and Medical Center policies and procedures; (2) requirements for alternate coverage and for consultations; (3) sound principles of clinical practice; and (4) fire and other regulations designed to promote patient safety;
- e. Coordinate the patient care provided by the department's members with nursing and other non-physician patient care services and with administrative support services;
- f. Foster an atmosphere of professional decorum within the department appropriate to the healing arts;
- g. Submit written reports or minutes of department meetings to the MEC on a regularly

scheduled basis concerning:

1. Findings of the department's review and evaluation activities, actions taken thereon, and the results of such action;
 2. Recommendations for maintaining and improving the quality of care provided in the department and the Medical Center; and
 3. Such other matters as may be requested from time to time by the MEC;
- h. Meet as deemed necessary for the purposes indicated above and receiving reports on other departments and staff functions;
- i. Establish such committees or other mechanisms as are necessary and desirable to properly perform the functions assigned to it.

ARTICLE XI OFFICERS

11.1 OFFICERS OF THE STAFF

11.1-1 Identification

- a. Chief of Staff
- b. Vice-Chief of Staff
- c. Immediate Past Chief of Staff
- d. Secretary-Treasurer

11.1-2 Qualifications

Officers must be appointees of the Active Staff, at the time of nomination and election and must remain appointees in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. The Chief of Staff and Vice-Chief of Staff must be practitioners with demonstrated qualifications on the basis of experience and ability.

11.1-3 Nominations (See Policy on Committees)

- a. By Nominating Committee: The Nominating Committee shall convene not less than 45 days prior to the annual meeting and shall submit to the Secretary of Staff at least two (2) qualified nominees for each office. The names of such nominees shall be reported to the staff at least thirty (30) days prior to the annual meeting.
- b. Open Nominations: any active staff member may also make Nominations from the floor at the time of the annual meeting. Nominees must be members of the Active Staff in good standing at the time of nomination, and must indicate their willingness to serve if elected.
- c. By Other Means: If, before the election, all individuals nominated for an office pursuant to Section 11.1-3 (a) and (b) shall refuse, be disqualified from or otherwise unable to accept nomination, then the Nominating Committee shall submit one or more substitute nominees at the annual meeting, and nominations shall be accepted from the floor.

11.1-4 Election

Officers shall be elected at the annual meeting of the Staff each year. Only Staff

appointees accorded the prerogative to vote for general staff officers under Article IV shall be eligible to vote. Voting shall be by secret written ballot, and voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority of the valid votes cast on the first ballot; a run-off election shall be held immediately between the two (2) candidates receiving the highest number of votes. Each active staff member will receive a second ballot and a run-off election shall be conducted at that time.

If there is a tie in the run-off election, the Board of Trustees shall cast the deciding vote.

11.1-5 Exceptions

Sections 11.1-3 and 11.1-4 shall not apply to the offices of Chief of Staff and Immediate past Chief of Staff. The Vice-Chief of Staff shall, upon the completion of his/her term of office in that position, immediately succeed to the office of Chief of Staff and then to the office of Immediate past Chief of Staff.

11.1-6 Term of Elected Office

Each officer shall serve a one-year term, commencing on the first day of the Medical Staff year, following his/her election. Each officer shall serve until the end of his/her term and until a successor is elected, unless he/she shall resign sooner or be removed from office.

11.1-7 Vacancies in Elected Office

If a vacancy occurs in the office of Chief of Staff, the Vice-Chief of Staff shall succeed to that office for the remaining term. A vacancy occurring in the office of Vice-Chief of Staff shall be filled by a special election. A vacancy occurring in the office of Immediate past Chief of Staff shall be filled by the previous person serving in such capacity; if he is unable or unwilling to serve again, the office shall remain vacant for the remainder of the term. A vacancy occurring in the office of Secretary-Treasurer, departments, or any of the departmental executive committees shall be filled by the MEC.

11.1-8 Duties of Elected Officers

- a. The Chief of Staff shall serve as the principal elected officer of the staff. As such, he/she shall:
 1. Aid in coordinating the activities and concerns of the Medical Center administration and of the nursing and other non-physician patient care services with those of the Medical Staff;
 2. Be responsible to the Trustees, in conjunction with MEC, for the quality and efficiency of clinical services and professional performance within the Medical Center and for the effectiveness of the patient care evaluations and the quality maintenance functions delegated to the Staff;
 3. Develop and implement, in cooperation with the Department Chairperson, methods for credentials review and for delineation of privileges, continuing medical education programs, utilization review, continued monitoring function and patient care evaluation studies;
 4. Participate in the selection (or appointment) of Staff representatives to Staff and Medical Center management committees to include the Medical Quality and Resource Committee;
 5. Communicate and represent the opinions, policies, concerns, needs, and grievances of the Medical Staff to the Board, the Administrator

and other officials of the Staff;

6. Be responsible for enforcement of Medical Staff Bylaws, Rules and Regulations, for the implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;
 7. Call, preside at, and be responsible for the agenda of all general meetings of the Staff;
 8. Serve as Chairperson of the MEC, as an ex-officio member of the Joint Conference, without vote of all other Staff committees or functions;
 9. Serve as an ex-officio member of the Board; and
 10. Be a member of the Nominating Committee.
- b. The Vice-Chief of Staff shall be a member of the MEC. In the temporary absence of the Chief of Staff, he or she shall assume all the duties and have the authority of the Chief of Staff; he shall perform such additional duties as may be assigned to him or her by the Chief of Staff, the MEC or the Board of Trustees.
 - c. Immediate Past Chief of Staff: The Immediate Past Chief of Staff shall be a member of the MEC and the Joint Conference Committee and shall perform such other advisory duties as are assigned to him/her by the Chief of Staff, MEC, or the Trustees. He/she shall also serve as Chairman of the Nominating Committee and the Bylaws Committee.
 - d. Secretary-Treasurer: The Secretary-Treasurer shall be a member of the MEC and ex-officio member without vote of other Staff committees or functions. His/her duties shall be to perform such duties as ordinarily pertain to his or her office.

11.1-9 Removal & Resignation

An officer of the Medical Staff may be removed from office for failing to perform duties upon a vote of no less than two thirds of the appointees to the active category of the Medical Staff. In addition, an officer of the Medical Staff may be removed from office by the Board of Trustees if the officer ceases to meet the qualifications for office and the Medical Staff fails to remove him/her within one month following a request by the Board of Trustees to the Medical Staff that the officer be removed. An officer of the Medical Staff may resign at any time by submitting his/her written resignation to the MEC.

11.2 OTHER OFFICIALS OF THE STAFF

11.2-1 Department Chairperson

a. Qualifications:

Candidates shall be a member of the Active Staff with admitting privileges; shall be board certified or, through the privilege delineation process, demonstrate comparable competence; practicing in at least one of the clinical areas covered by the department; and shall be willing and able to faithfully discharge the functions of his/her office.

b. Selection:

The members of his/her department shall elect the Chairperson of each department.

c. Term of Office:

A Department Chairperson shall serve a one-year term commencing with his/her appointment. A Department Chairperson shall be eligible to succeed himself or herself, but may serve no more than two (2) consecutive terms in office, except as otherwise provided by the Trustees.

d. Removal:

Removal of a Department Chairperson from office may be done by the Trustees acting upon its own recommendation, or upon the recommendation of the MEC or a two-thirds majority vote of the department members eligible to vote. Removal from office shall be accomplished pursuant to these Bylaws.

e. Duties: Each Chairperson is responsible for the following:

1. Be Chairperson of the Department Executive Committee;
2. Account to the MEC for professional, clinical, and administrative activities within his/her department;
3. Continuing surveillance of the professional performance of individuals in the department who have delineated clinical privileges;
4. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department;
5. Recommending clinical privileges for each member of the department;
6. Assessing and recommending to the relevant medical center authority off-site sources for needed patient care services not provided by the department or the medical center;
7. The integration of the department or service into the primary functions of the medical center;
8. The coordination and integration of interdepartmental and intradepartmental services;
9. The Development and implementation of policies and procedures that guide and support the provision of care, treatment and services;
10. The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and service;
11. The determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;
12. The continuous assessment and improvement of the quality of care, treatment, and services provided;
13. The maintenance of quality control programs as appropriate;
14. The orientation and continuing education of all persons in the department or service;
15. Recommendations for space and other resources needed by the department or service.

11.3 Medical Executive Committee

- a. Relationships
The organized medical staff delegates to the Medical Staff Executive Committee (MEC) the authority to carry out medical staff responsibilities. The MEC carries out its work within the context of the hospital functions of leadership and performance improvement. The MEC has the primary authority for activities related to self-governance of the medical staff and for performance improvement of the professional services provided by LIPs and other Practitioners privileged through the medical process.
- b. Composition
The MEC shall consist of six members. The Chief of the Medical Staff shall be its Chairperson and shall preside at meetings. The Vice Chief of Staff, the Immediate Past Chief of Staff and the Secretary of the Staff shall be members. The remaining medical staff members of the Committee shall be the Chiefs of the Departments of Medicine and Surgery. All Active Medical Staff members are eligible for MEC membership. All voting members of the MEC are fully licensed physicians on the Active staff. The CEO, CFO, CNO and Director, Quality Resource Management shall be *ex officio* members without vote.
- c. Duties
 1. The MEC makes recommendations directly to the Board of Trustees regarding the structure of the organized medical staff, the process used to review credentials and delineate privileges, the delineation of privileges of each Practitioner through the medical staff process, and the criteria for medical staff membership, as well as termination of such membership (see Policy on Appointment)
 2. The MEC reviews and acts upon reports of medical staff committees, departments and/or other assigned activity groups concerning matters within the purview of the Medical Staff and acts on behalf of the medical staff in between meetings of the General Medical Staff.
 3. Report results and recommendations concerning Medical Staff functions to the Medical Staff and the Board of Trustees;
 - a. Coordinate the activities of and policies adopted by the Medical Staff, its departments, its services and its committees;
 - b. Make recommendations to the Board of Trustees on all matters relating to appointments, reappointments, Medical Staff category, departmental assignment and structure, Clinical Privileges (to include the mechanism used to review and to delineate clinical privileges), and the removal or limitation thereof (to include the mechanism for fair hearing procedures), and assure the qualifications and competence of Practitioners through a credentials procedure, including mechanisms for appointment and reappointment and the delineation of Clinical Privileges;
 - c. Initiate an investigation of any incident, course of conduct, or allegation indicating that an appointee to the Medical Staff and any other individuals holding clinical privileges may not be complying with the Bylaws, may be rendering care below the standards established for appointees to the Medical Staff, or may otherwise not be qualified for continued enjoyment of Medical Staff appointment or Clinical Privileges without limitation, further training, or other safeguards;
 - d. Account to the Board of Trustees and to the Medical Staff for overall

quality and efficiency of medical care rendered to patients at the Hospital, including participation in an annual reappraisal of the Hospital's performance improvement program;

- e. Make recommendations on matters pertaining to the management and administration of the Hospital;
- f. Inform the Medical Staff of the accreditation program and the accreditation of the Hospital;
- g. Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;
- h. Maintain a continuing education program inclusive of topics arising from the needs demonstrated through the quality assessment program;
- i. Review the utilization of the Hospital resources;
- j. Develop and monitor compliance with these Bylaws, and the Medical Staff Rules and Regulations, and the Medical Staff Policies and Procedures as well as other Hospital standards;
- k. Establish and maintain the other committees of the Medical Staff as set forth in Medical Staff Policies and Procedures, or discharge the duties and functions thereof in the absence of such a committee; and
- l. Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws.

d. Meetings

The Executive Committee shall maintain a full and accurate permanent record of its proceedings and actions. Recommendations of the Executive Committee shall be transmitted to the Board with a copy to the Chief Executive Officer. The Chairperson of the Executive Committee shall be available to meet with the Board or its applicable committee on all recommendations that the Executive Committee may make.

11.4 Committees of the Medical Staff

a. General

Communication among the Medical Staff, Governing Board, and Administration will be provided through representation of Administration at all Medical Staff meetings and representation of Administration and the Medical Staff at Governing Board meetings. The Medical Staff must be represented and participate in any Hospital deliberation affecting any discharge of Medical Staff responsibilities.

The MEC shall retain the right to establish and maintain any committees or mechanisms necessary to carry out the responsibilities of the medical staff, as set forth below or shall itself, discharge such duties and functions. These responsibilities include but are not limited to performance improvement, patient safety, high risk procedures such as medication use, blood use and operative/invasive procedures, focused review of Practitioner performance, bio-ethical issue resolution, risk management, resource management, timeliness and quality of health information, and assurance of a single level of care, appointment/reappointment of the members of the medical staff or those credentialed as Allied Health Professionals (See the policy "Performance Improvement and Patient Safety Plan" for details of the program. Policy on Committees of the Medical Staff contains more specific descriptions of committees and their duties.)

b. Composition

Committees of the MEC, established to perform one or more of the staff functions required by the bylaws, rules/regulations, policies or accrediting/licensing standards, shall consist of appointees to the active and associate categories and may include, where appropriate, Allied Health Professionals and representatives from hospital management, nursing, medical records, pharmaceutical, or social services, and such other departments as are appropriate to the function(s) to be discharged. Maximum use shall be made of non-Medical Staff personnel to participate on committees and to discharge committee functions not requiring medical judgment. (See Policy on Committees)

c. Appointment

Medical Staff members of committees shall be appointed by the Chief of Staff and may be removed by a majority vote of the MEC. Non-Medical Staff members of committees shall be appointed or removed by the CEO. A committee member shall serve on the committee until the earlier of the expiration or termination of his Medical Staff appointment, his removal as set forth above, or the appointment of his/her successor. The Chief Executive Officer and the Chief of the Medical Staff or their respective designees shall be members, *ex officio*, without vote, of all committees.

d. Duties

1. Be accountable to the MEC on a regular basis and maintain accurate minutes of their meetings and activities;
2. All minutes will be maintained as confidential;
3. Be responsible for recommending policies, rules/regulations, and revisions thereof designed to implement and enforce Hospital and Medical Staff goals and standards within such committee's area of responsibility;
4. Request an investigation of any Medical Staff appointee or any other individual(s) holding clinical privileges whose activities as monitored by the committee, which appear not to comply with these Bylaws and/or standards of care or practice;
5. Assist in focused review of a Practitioner's performance based upon findings of the Quality Improvement Organization (QIO), denial of payment, imposition of sanctions, or similar action, and assist in educating Practitioners in QIO standards and compliance;
6. Require the special appearance of a Practitioner to carry out the above listed activities. Failure of said special appearance may result in a recommendation for Corrective Action.
7. Perform such other duties as may be assigned from time to time by the MEC or the Chief of Staff; and other more specific duties as described in the Policy on Committees.
8. Meet as often as necessary to discharge their assigned duties.

e. Meetings Of he Medical Staff

The departments and committees of the medical staff can have both regular and special meetings. There are specific mechanisms to schedule meetings, notify the members, schedule the work for the meetings, determination of a quorum, attendance requirements, mechanisms for decision making, and for record creation and retention. The above components are described in detail in the Policy on Committees.

f. Medical Peer Review Committee Status

Each committee (whether Medical Staff, Department, Ad Hoc, Subcommittee or Joint) and each department, as well as the Medical Staff when meeting as a whole, shall be constituted and operate as a medical peer review committee/medical committee/professional review body, as such terms are defined by law, and are authorized by the Board of Trustees to engage in medical peer review.

The Chief of Staff, department chief, or chair of a committee may appoint Practitioners or other individuals to serve as agents of a committee, a department, or the Medical Staff to assist in carrying out the functions and responsibilities of the

committee, department, or Medical Staff. The CEO or his designee, the Hospital's legal counsel, and Hospital employees shall be considered agents of the committee, department, or Medical Staff when performing these functions and responsibilities. An authorized action by an agent or member of a committee, department, or the Medical Staff in performing these functions and responsibilities shall be considered an action taken on behalf of the appropriate committee, department, or Medical Staff, not an action taken in the agent's or member's individual capacity.

ARTICLE XII MEETINGS

12.1 ANNUAL STAFF MEETING

12.1-1 Meeting Time

The Annual Staff Meeting shall be held within sixty (60) days before the end of the Staff year of the Medical Center, usually in December.

12.1-2 Order of Business and Agenda

The Chief of Staff shall determine the order of business at the annual meeting. The agenda shall include at least:

- a. Reading and acceptance of the minutes of the last regular and of special meetings held since the last regular meeting;
- b. Administrative reports from the Chief Executive Officer, the Chief of Staff, and appropriate committee chairpersons;
- c. The election of officers of the Medical Staff as required by these Bylaws;
- d. Recommendations for maintenance and/or improvement of patient care; and
- e. Other old and new businesses as appropriate.

12.2 REGULAR STAFF MEETINGS

12.2-1 Meeting Time

The Staff may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall then be required. If the date, hour or place of a regular Staff meeting must be changed for any reason, the "Notice of Meetings" procedure shall be followed.

12.2-2 Order of Business and Agenda

The Chief of Staff shall determine the order of business at the regular meeting. The agenda shall include at least:

- a. Reading and acceptance of the minutes of the last regular and special meetings held since the last regular meeting;
- b. Administrative reports from the Administrator, the Chief of Staff, departments and committees;
- c. Reports by responsible officers, committees and departments on the overall results of patient care evaluation studies and other quality maintenance activities of the Staff, and on the fulfillment of other required Staff functions;

- d. The election of officers and other officials of Staff when required by the Bylaws; and
- e. Other old and new businesses as appropriate.

12.2-3 Special Meetings

Special meetings of the Staff may be called at any time by the Trustees, the Chief of Staff, the CEO, the MEC or not less than 20% of the appointees of the Active Staff, and shall be held at the time and place designated in the meeting notice. In the event that it is necessary for the Staff to act on a question without being able to meet, the voting Staff may be presented with the question by mail or other electronic means. Such a vote shall be binding so long as the question is voted on by the majority of the Staff eligible to vote. No business shall be transacted at any special meeting except that stated in the meeting notice.

12.3 NOTICE OF MEETINGS

Written or printed notice stating the place, day and hour of any General Staff meeting, of any special meeting, or of any regular committee or department meeting not held pursuant to resolution, shall be delivered either personally or by mail to each person entitled to be present thereat not less than seven (7) days nor more than thirty (30) days before the date of such meeting. Notice of department or committee meetings may be given orally or by resolution.

12.4 QUORUM

12.4-1 General Staff Meetings

The presence of 51% of the voting appointees of the Active Staff at any regular or special meeting shall constitute a quorum for the purposes of amendment to these Bylaws. The presence of 51% of such members shall constitute a quorum for the transaction of other business. This quorum must be found before any action may be taken, but once found, the business of the meeting may continue and actions taken thereafter shall be binding even though less than a quorum may be present at a later time in the meeting.

12.4-2 Department and Committee Meetings

At least two (2) members shall constitute a quorum at any meeting of such department or committee.

12.4-3 Quorum Not Present

When a quorum is not present, *ad hoc* members may be appointed by CEO, or designee, or by other committee members, to make a quorum with rights and responsibilities of a quorum.

12.5 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the appointees present and voting at a meeting at which a quorum is present shall be the action of the group. Action may be taken without a meeting by a department or committee if unanimous consent in writing setting forth the action so taken is obtained by each appointee entitled to vote thereat.

12.6 MINUTES

The Secretary, or designee shall prepare minutes of meetings and shall include a record of attendance and the vote taken on each matter. The presiding officer or the individual recording the minutes, approved by the attendees at the next regular meeting, and

forwarded to the MEC and made available to the Staff shall sign copies of such minutes. A permanent file of the minutes of each meeting shall be maintained.

12.7 ATTENDANCE REQUIREMENTS

12.7-1 Regular Attendance

Each appointee of a Staff category required to attend meetings under Article IV shall be required to attend:

- a. The Annual Staff meeting, unless excused by the Chief of Staff;
- b. One written excuse per year for the quarterly Medical Staff meetings;
- c. At least 50% of all meetings of each department or committee of which he or she is an appointee.

12.7-2 Special Appearance

A practitioner whose patient's clinical course of treatment is scheduled for discussion at a regular department or committee meeting may be so notified to attend the meeting. The Chairperson of the meeting shall give the practitioners at least fourteen (14) days advance written notice of the time and place of the meeting. Whenever further clinical review by the Department Committee finds apparent or suspected deviation from standard clinical practice is involved, special notice shall be given and shall include a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to which he was given such special notice shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the MEC may direct. Such suspension shall remain in effect until the matter is resolved by subsequent action of the MEC or of the Trustees, or through corrective action, if necessary.

ARTICLE XIII CONFIDENTIALITY, IMMUNITY, AND RELEASES

13.1 SPECIAL DEFINITIONS

For the purposes of this Article, the following definitions shall apply:

- a. INFORMATION means record of proceedings, minutes, records, reports, memoranda, statements, recommendations, data and other disclosures whether in written or oral form relating to any of the subject matter specified in Section 14.5-2.
- b. MALICE means the intentional dissemination of a known falsehood or of information with a reckless disregard for whether or not it is true or false.
- c. REPRESENTATIVE means a Board, any director or committee thereof; an Administrator; a Medical Staff Organization, any officer, department or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.
- d. THIRD PARTIES mean both individuals and organizations providing information to any representative.

13.2 AUTHORIZATIONS AND CONDITIONS

By applying for, or exercising, clinical privileges or providing specified patient care services within this Medical Center, a practitioner:

- a. Authorizes representatives of the Medical Center and the Medical Staff to solicit,

provide and act upon information bearing on his/her professional ability and qualifications;

- b. Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative or third party who acts in accordance with the provisions of the Article; and
- c. Acknowledges that the provisions of this Article are express conditions to his/her application for or acceptance of Staff membership, or his/her exercise of clinical privileges or provision of specified patient services at this Medical Center.

13.3 CONFIDENTIALITY OF INFORMATION

Information with respect to any practitioner submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality, shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a representative of the medical examining board as required by law or used in any way except as provided herein. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's file or of the general Medical Center's records.

13.4 IMMUNITY FROM LIABILITY

13.4-1 For Action Taken

No representative of the Medical Center or Medical Staff shall be liable in any judicial proceeding for damages or other relief for any action taken or statement or recommendation made within the scope of his/her duties as a representative if such representative acts in good faith and without malice after a reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the action, statement, or recommendation is warranted by such facts. Regardless of the provisions of state law, truth shall be an absolute defense in all circumstances.

13.4-2 For Providing Information

No representative of the Medical Center or Medical Staff and no third party shall be liable in any judicial proceeding for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this Medical Center or Medical Staff or to any other hospital, organization of this Medical Center or Medical Staff or to any other hospital organization concerning a practitioner or affiliate who is or has been an applicant to or member of the Staff or who did or does exercise clinical privileges or provide specified services at this Medical Center, provided that such representative or third party acts in good faith and without malice.

13.5 ACTIVITIES AND INFORMATION COVERED

13.5-1 Activities

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

- a. Applications for appointment, clinical privileges or specified services;
- b. Periodic reappraisals for reappointment, clinical privileges or specified services;

- c. Corrective action;
- d. Hearings and appellate reviews;
- e. Patient care evaluation studies;
- f. Utilization reviews;
- g. Other Medical Center, department or committee activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

13.5-2 Information

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics or any other matter that might directly or indirectly affect patient care.

13.6 RELEASES

Each practitioner shall, upon request of the Medical Center, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this state. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

13.7 CUMULATIVE EFFECT

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

ARTICLE XIV GENERAL PROVISIONS

14.1 STAFF RULES AND REGULATIONS

Subject to approval by the Trustees, the Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each Staff appointee or affiliate of the Medical Center. Such Rules and Regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present and without previous notice or at any special meeting on notice by a two-thirds vote of those present and eligible to vote. Such changes shall become effective when approved by the Trustees.

14.2 DEPARTMENTAL RULES AND REGULATIONS

Subject to the approval of the MEC and the Trustees, each department shall formulate its own Rules and Regulations for the conduct of its affairs and the discharge of its responsibilities. Such Rules and Regulations shall not be inconsistent with these Bylaws, the general Rules and Regulations of the Staff or other policies of the Medical Center.

14.3 FORMS

Application forms and any other prescribed forms required by these Bylaws for use in connection with Staff appointments, reappointment, delineation of clinical privileges, corrective action, notices, recommendations, reports, and other matters shall be subject to

adoption by the Trustees after considering the advice of the MEC.

14.4 CONSTRUCTION OF TERMS AND HEADINGS

Words used in these Bylaws shall be read as the masculine or feminine gender and as the singular or plural, as the context requires. The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws

14.5 TRANSMITTAL OF REPORTS

Reports and other information, which these Bylaws require the Medical Staff to transmit to the Trustees, shall be deemed so transmitted when delivered, unless otherwise specified, to the Administrator.

**ARTICLE XV
ADOPTION AND AMENDMENT OF BYLAWS**

15.1 MEDICAL STAFF RESPONSIBILITY AND AUTHORITY

Medical Staff Bylaws shall be reviewed at least annually. The Medical Staff shall have the initial responsibility to formulate, adopt, and amend the Bylaws and Rules and Regulations by the affirmative vote of a majority of the Staff members eligible to vote on this matter who are present and voting at a meeting at which a quorum is present, provided at least thirty (30) days written notice, accompanied by the proposed Bylaws and/or alternatives, has been given of the intention to take such action.

The Medical Staff recommends to the Trustees Staff Bylaws and amendments, which shall be effective when, approved by the Trustees. Bylaws and/or Rules and Regulation may not be unilaterally adopted, amended or repealed, and unresolved differences may be referred to the Joint Conference Committee. Such responsibility shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interest of providing patient care of the generally recognized professional level of quality and efficiency and of maintaining a harmony of purpose and effort with the Chief Executive Officer, the Trustees and with the community.

ADOPTED by the:

Active Medical Staff on September 27, 2005

Board of Trustees on October 13, 2005

Chief of Staff

Chairperson of the Board

Secretary of the Medical Staff

Secretary of the Board