HILL COUNTRY MEMORIAL

REVISED AND RESTATED

MEDICAL STAFF BYLAWS

OF

HILL COUNTRY MEMORIAL HOSPITAL

APPROVED BY THE BOARD OF TRUSTEES

November 3, 2020

HILL COUNTRY MEMORIAL HOSPTIAL
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PREAMBLE

Recognizing that Hill Country Memorial Hospital, a private not-for-profit hospital formed under the laws of the State of Texas, is operated to serve as a general hospital for the provision of health care services;

Recognizing that the principal objective of the Hill Country Memorial Hospital Medical Staff is to promote the delivery of health care services by practitioners at a level of quality and efficiency consistent with accepted standards;

Recognizing that the Board of Trustees must rely on the members of the Medical Staff practicing at Hill Country Memorial Hospital to evaluate and advise the Board of Trustees as to the qualifications and competence of practitioners and the quality of such services, and to fulfill certain legal obligations;

Therefore, these Bylaws are created to set forth principles and requirements within which the members of the Medical Staff practicing at Hill Country Memorial Hospital shall carry out their responsibilities, and to set forth the procedures pursuant to which they shall act in carrying out those responsibilities, subject to the ultimate authority of the Board of Trustees.

DEFINITIONS

1. “Hill Country Memorial Hospital” or “Hospital” is defined as Hill Country Memorial Hospital, a private not-for-profit hospital.

2. "Medical Staff" is defined as all practitioners who are granted medical staff membership by the Board of Trustees.

3. "Board of Trustees" or “Board” of the Hill Country Memorial Health System is defined as the governing body of the Hospital for legal and accreditation purposes and which shall be deemed to act through its officers and through the Chief Executive Officer of the Hospital.

4. "Chief Executive Officer" or “CEO” is defined as the individual appointed by the Board of Trustees to act on its behalf in the overall management of the Hospital. The term "Chief Executive Officer" includes a duly appointed Acting Administrator or other designee serving when the Chief Executive Officer is away from the Hospital. The Medical Staff may rely upon all actions of the CEO as being the actions of the Board of Trustees taken pursuant to a proper delegation of authority from the Board of Trustees.

5. "Member" is defined as any practitioner appointed to, and maintaining membership in, any category of the Medical Staff in accordance with these Bylaws.

6. "Patient" is defined as any person undergoing diagnostic evaluation or receiving medical care under the auspices of the Hospital.

7. “Patient Contacts” is defined as: direct patient contacts that includes but is not limited to: admissions, inpatient consultations, outpatient invasive procedures, inpatient surgical procedures, and surgical assisting or any other activity that establishes a practitioner-patient relationship in the Hospital setting.

8. “Medical Staff Year” is defined as the calendar year.

9. “Notice” means notice in writing and delivered by (1) hand, (2) by regular mail, or (3) by secure email. “Special Notice” means notice in writing and delivered by: (1) hand, (2) by certified mail, return receipt requested, or (3) by an express mail service, to the addressee thereof. Any notice delivered by hand, certified mail, or express mail service shall be deemed delivered on the actual date of delivery or the date refused. Delivery may be made to office staff of the practitioner. There shall be a rebuttable presumption that any notice or request sent by regular mail shall conclusively be deemed to have been received by the addressee thereof on the day following the day said notice or request was enclosed on a post-paid, properly addressed wrapper, in a post office or official depository under the care and custody of the United States Post Office. Notice that is refused by a practitioner shall be deemed delivered on that date. Notice by email shall be deemed delivered on the day following the date sent.

   Unless otherwise provided herein, any notice required or permitted hereunder from the Medical Executive Committee shall be transmitted by the Chief of Staff, and any notice required or permitted hereunder from the Board of Trustees shall be transmitted by the CEO. All notices required or permitted hereunder from the affected practitioner shall be addressed to the CEO, unless otherwise directed in writing.

   Any notices to members of the Medical Staff provided for in these Bylaws shall be deemed valid if made using the contact information that the member provided that is currently on file in the Medical Staff Office.

10. “Practitioner” is defined as a physician, dentist, or podiatrist who has applied for or who has received Medical Staff membership or clinical privileges in the Hospital.

11. “Service Area” is defined as Gillespie County and all adjacent counties (Kimble, Mason, Llano, Blanco, Kendall and Kerr).

12. “Bylaws” or “Medical Staff Bylaws” mean these Medical Staff Bylaws, as may be amended from time to time by the Medical Staff and approved by the Board of Trustees, as provided herein.

13. “Adverse Recommendation or Action” is a recommendation or action as defined in Article Ten.

14. “Medical Staff Policy and Procedure Manual” is the manual containing all of the Medical Staff policies adopted in accordance with Article Thirteen.

15. “Good Standing” means a practitioner has/had documented compliance with the requirements for maintaining membership and privileges on the Medical Staff, including professional and interpersonal standards, maintenance of current competence in his/her specialty, the ability to perform the privileges held at this facility, adherence to the Medical Staff Bylaws and Policies and Procedures at the time of the last appointment or reappointment, and that no corrective actions have/had been taken against the practitioner.

16. “Telemedicine” is defined as a health care service delivered by a physician licensed in Texas, or a health professional acting under the delegation and supervision of a physician licensed in Texas, and acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunications or information technology. (Source: Texas Occupations Code Sec. 111.001(4))

17. “Medical peer review” is defined in Article Twelve.

18. “Policy” means a policy of the Medical Staff unless the context indicates otherwise.

19. “Allied Health Professionals” are health care providers other than practitioners who are approved to provide health care services in the Hospital as detailed in Article Three, Section 3.9.

20. “Senior Administration Leaders” means, in addition to the CEO, the Chief Medical Officer (CMO), the Chief Operating Officer (COO), the Chief Nursing Officer (CNO), and Chief Clinical Officer (CCO). These defined terms may or may not be capitalized in the Bylaws.

ARTICLE ONE
PURPOSE

The purpose of the Medical Staff is to bring the practitioners who practice at the Hospital together into a cohesive body to promote quality patient care and assist the Board in complying with all applicable legal and accreditation requirements. To this end and under the authority of the Board of Trustees, it will: assist in screening applicants for staff membership;

review and make recommendations regarding privileges of members and other health care professionals eligible for privileges; evaluate and assist in improving quality of patient care; provide education; offer assistance to the Board and Chief Executive Officer regarding medical peer review and other clinical issues; and initiate, maintain, and enforce these Medical Staff Bylaws and other rules of operations to implement these purposes.

The Medical Staff and its members shall enforce and comply with the Bylaws and any Medical Staff policies as set forth herein, as well as Hospital policies. The Board shall uphold the approved Bylaws and Medical Staff policies approved by the Board. These Bylaws and Medical Staff policies, the Bylaws of the Board, and Hospital policies shall be compatible with each other and comply with law and regulation.

ARTICLE TWO
MEDICAL STAFF MEMBERSHIP

Section 2.1 Medical Staff Appointment. Appointment to the Medical Staff of the Hospital is a privilege that shall be extended only to competent practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated policies of the Medical Staff and Hospital.

Section 2.2 Qualifications for Membership.

A. Only physicians with Doctor of Medicine or Doctor of Osteopathy degrees, dentists, or podiatrists who hold a current professional license to practice in the State of Texas, as well as a current Federal Drug Enforcement Agency (DEA) controlled substance certificate*, professional liability insurance in the amount specified by the Board, who can document their background, experience, training, judgment, individual character and demonstrated clinical competence, health status, adherence to the ethics of their profession, ability to work with others professionally and cooperatively in the delivery of patient care, and ability and health status necessary to fulfill the essential functions of Medical Staff membership and perform the clinical privileges requested in accordance with accepted professional standards and without posing a direct threat to patient safety, sufficient to assure the Medical Staff and Board of Trustees that any patient treated by them in the Hospital will receive quality patient care, shall be eligible to apply for membership to the Medical Staff. No practitioner may be entitled to membership on the Medical Staff or to exercise clinical privileges in the Hospital merely by virtue of licensure to practice in this or any other state, or of membership in any professional organization, or of privileges at another hospital. No practitioner may be a member of the Medical Staff or hold clinical privileges if he/she is included on the List of Parties Excluded from Federal Procurement and Non-procurement Programs.

*Pathologists are exempt from holding required controlled substances certificates and registrations if these are not required for their exercise of clinical privileges.

B. In documentation of experience and training, effective October 2, 2007, completion of an ACGME, AOA or Council on Podiatric Medical Education approved residency is required of physicians and podiatrists applying to the Medical Staff for initial appointment as follows: Physicians and podiatrists applying to the Medical Staff must have completed (or are in the last six (6) months of and subsequently complete) an approved residency program of at least three (3) years duration in the specialty in which clinical privileges are held or are being requested. Dentists are not required to complete a residency but must provide documentation of any post-graduate training.

C. Effective January 1, 2018, physicians and podiatrists applying for initial appointment to the Medical Staff must be board certified or board eligible with certification to be obtained within three (3) years of initial appointment. An applicant who was previously board certified shall be deemed to have satisfied this requirement. *Maintenance of board certification is highly recommended but not required for continued Medical Staff membership.*

1. For physicians, only certification by a member board of the American Board of Medical Specialties, American Board of Physician Specialties or the American Osteopathic Association qualifies as "board certification." For podiatrists, only certification by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine qualify as "board certification."

2. Failure to secure board certification within three (3) years of initial appointment shall result in automatic termination of appointment and all clinical privileges on that date. There are no procedural rights of review under these Bylaws or otherwise for an automatic termination.

3. Board certification must be in the area for which the physician or podiatrist is requesting clinical privileges or the primary area of practice in the Hospital.

D. Practitioners and residents seeking initial appointment must:

1. Have been in active practice or residency at least six (6) of the 12 months prior to submission of an application for initial appointment; and

2. Have practiced in a Joint Commission-accredited hospital at least two (2) of the five (5) years prior to submission of an application for initial appointment unless the practitioner or resident documents that his/her practice on initial appointment will be limited to the outpatient setting.

E. Office and Residence Requirements.

1. For applicants to or members of the Active Staff, practitioners must document (or document plans to establish which are carried out on securing membership) an office and residence within the Service Area or document evidence of acceptable patient coverage by other members with offices and residences in the Service Area. A finding of acceptable patient coverage or utilization is at the sole discretion of the Medical Executive Committee, subject to the approval of the Board. There are no procedural rights under these Bylaws or otherwise for denial of acceptable patient coverage.

2. For applicants to or members of the Courtesy Staff, practitioners are not required to document an office and residence in the Service Area but must provide acceptable information as to how they plan to support and utilize Hill Country Memorial.

3. Practitioners who are requesting or exercising clinical privileges as hospitalists are not required to document an office or residence in the Service Area, but must document how they will be present in the Service Area when on duty or on call.

4. This office and residence requirement does not apply to practitioners whose clinical privileges are limited to telemedicine.

F. Maintain professional liability insurance coverage meeting the minimum requirements established by the Board of Trustees with the exception of Honorary/Emeritus Status which is exempt from this requirement.

G. Exceptions to any of the above requirements for membership and/or privileges may be made only by the Board after a recommendation of the Medical Executive Committee when in the best interests of the Hospital, the Medical Staff and/or the patients served by the Hospital. Granting an exception is at the sole discretion of the Medical Executive Committee subject to the approval of the Board. Denial of an exception does not entitle the practitioner to any procedural rights of review under these Bylaws or otherwise.

Section 2.3 Membership Dues. Each member of the Active Staff shall be required to pay annual dues assessed by the Medical Executive Committee in January of each year for the purpose of compensating Medical Staff officers. These dues shall be due and payable

within thirty (30) days of the notice of assessment, will be deposited in a separate account solely for this purpose, and shall not exceed $350.00 in any year. Any disbursement of dues shall require the approval of the Medical Executive Committee and must be consistent with this provision.

A. Dues shall be used to compensate the Chief of Staff and Chief of Staff Elect for their time in performing their duties as officers and will be matched by funds from the Hospital. The amount of any compensation paid to a Medical Staff leader shall be reasonable and shall be established biennially, in writing, by the Medical Executive Committee and the Board prior to the election of the Medical Staff officers.

B. Failure of an Active Staff member to pay the amount of assessed dues after special notice and expiration of sixty (60) days from the date of the original notice of assessment shall result in an automatic temporary suspension of clinical privileges and membership from the Medical Staff. There are no procedural rights under these Bylaw or otherwise as a result of such action. Only full payment of all dues currently outstanding shall reverse or terminate the temporary suspension. If the dues have not been paid in full within 30 days of the temporary suspension, the practitioner's clinical privileges and membership shall be automatically relinquished and shown as a resignation.

C. Membership dues shall be in addition to application processing fees that may be assessed by the Hospital.

Section 2.4 Nondiscrimination. No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, race, creed, color, national origin, or other grounds not permitted by law. Medical Staff members shall treat patients without regard to race, creed, color, national origin, or other grounds not permitted by law.

Section 2.5 Application for Membership and Processing.

A. Applications for appointment and reappointment to the Medical Staff will be processed as outlined in the Medical Staff Initial Appointment Plan and the Medical Staff Reappointment Plan policies. The basic steps of the processes for appointment and reappointment are:

1. Completion of a written application in the form required by the Hospital;

2. Primary source verification and collection of any requested information by the Medical Staff Office on behalf of the Medical Staff committees, to verify compliance with membership qualifications to include querying the National Practitioner Data Bank;

3. Review of the complete application by the Credentials/Recruitment Committee within thirty (30) days of receipt and issuance of a written recommendation (or deferral for up to thirty (30) days followed by a recommendation);

4. Review of the complete application and the recommendation of the Credentials/Recruitment Committee by the Medical Executive Committee within thirty (30) days of receipt and issuance of a written recommendation (or deferral for up to thirty (30) days followed by a recommendation);

5. Review of the application and the committees' recommendations by the Board of Trustees within thirty (30) days of receipt and issuance of a final decision; and

6. The procedural rights in Article Ten in the event of an Adverse Recommendation or Action as defined in that article.

B. Any practitioner who is subject to a final Adverse Recommendation or Action shall not be eligible to reappoint to the Medical Staff for a period of two (2) years from the date the decision was final (or the date the practitioner withdrew his/her application following an Adverse Recommendation or Action). A reapplication shall be processed as an initial application for membership and only after the practitioner submits such additional information as may be required to demonstrate that the basis for the earlier Adverse Recommendation or Action no longer exists.

Section 2.6 Conditions and Duration of Appointment.

A. Initial appointments and reappointments to the Medical Staff shall be made by the Board of Trustees after receipt and review of the Medical Executive Committee's recommendation.

B. Appointments to the Medical Staff will be for no more than two (2) years.

C. At the time of reappointment, the member must document continuing compliance with all qualifications of Staff membership. The procedures for reappointment shall be the same as for initial appointment and shall be set out in the Medical Staff Reappointment Plan.

Section 2.7 Responsibilities of Membership. Each Staff member and other practitioner with clinical privileges will:

A. Act in an ethical and professional manner.

B. Submit specific request if practitioner seeks modification of privileges or new privileges in the interim between reappointments.

C. Provide patients with continuous quality of care meeting the professional standards of the Medical Staff of this Hospital, including the supervision of the work of any Allied Health Professionals under his/her direction.

D. Comply with Medical Staff Bylaws, Medical Staff Code of Conduct, Medical Staff Membership Expectations and all Medical Staff and Hospital policies, including the Hospital's anti-harassment and Hill Country Memorial Health System's compliance policies.

E. Help develop when requested and comply with all Medical Staff and Hospital policies related to medical peer review including quality improvement, credentialing, utilization review, and risk management activities and assist the Hospital in disaster preparedness/response as outlined in the Hospital Emergency Preparedness Plan.

F. Provide written notice, and any requested information, to the Chief of Staff or Chief Executive Officer within five (5) days of learning of any of the following occurrences:

    a. a complaint, investigation, order, or sanction of any kind involving the member's professional license in any state or any state or federal controlled substances registration;

    b. failure to maintain required levels of professional liability insurance;

    c. felony conviction or guilty or nolo contendere pleas;

    d. felony indictment (the Medical Executive Committee will review the indictment to determine if any corrective action should be recommended to the Board while the matter is pending); or

    e. Sanctions or exclusions by Medicare, Medicaid or other federal health care programs.

G. Provide written notice, and any requested information, to the Chief of Staff or Chief Executive Officer within fourteen (14) days of learning of any of the following occurrences:

        a. the filing of any professional liability claim, judgment or settlement;

b. change in professional liability insurance (other than failure to maintain required levels which is covered above);

c. any change in health status which affects or could affect the practitioner's ability to fulfill the essential functions of Medical Staff membership and/or perform the clinical privileges requested;

d. voluntary or involuntary limitation, reduction, loss, termination, suspension, or relinquishment of Medical Staff membership or clinical privileges at another health care facility, or the initiation of proceedings to that effect;

e. any removal from a health plan or managed care organization's provider panel for quality of care reasons or unprofessional conduct; or

f. the filing of any criminal charges and any change in the status of a criminal matter previously reported.

H. Pay processing fees, as determined by the Board of Trustees, at time of application for appointment or reappointment.

I. Pay annual membership dues, if applicable.

J. Comply within the required time period with a request for information or documentation from a Medical Staff committee or department or Medical Staff officer in connection with medical peer review, including verification of qualifications, clinical competence and obligations of Staff membership and clinical privileges and verification of required health status.

ARTICLE THREE
MEDICAL STAFF MEMERSHIP CATEGORIES

Specialty	Active Staff	Courtesy Staff
Emergency Medicine	Must average 10 shifts per month annually	Must document at least one shift worked but may not average more than 10 shifts worked per month annually
Pathology	1000+ readings biennially	2-999 readings biennially
Radiology	500+ readings biennially	2-499 readings biennially
All Other Specialties	30 direct patient contacts biennially	2-30 direct patient contacts biennially

Section 3.1 Active Staff Membership.

Qualifications: Appointees to this category must:

A. Meet the basic qualifications for membership as defined in Article Two of the Bylaws; and

B. Document a minimum number of patient contacts at the Hospital biennially as defined by these Bylaws.

Prerogatives: Appointees to this category may:

A. Exercise the privileges granted without limitation, except as otherwise provided in these Bylaws or in Medical Staff Policies or on the individual practitioner's delineation of privileges;

B. Vote on all matters presented at general and special meetings of the Medical Staff and the department and committees to which he/she is appointed; and

C. Hold Medical Staff or department office and be appointed to or be chairperson of any committee, if qualified and unless otherwise specified elsewhere in these Bylaws.

Responsibilities: Appointees to this category must:

A. Actively participate in recognized functions of Staff appointment, including medical peer review and other quality improvement and monitoring activities, in monitoring appointees undergoing initial FPPE, and in discharging other Staff functions as may be required from time to time; and

B. Participate in emergency room and other specialty coverage programs as scheduled or as required by the Medical Executive Committee subject to Board approval and in compliance with the Hospital's policies and regulatory standards.

C. See Article Eight, Sections 8.5-8.6 regarding meeting attendance.

Limitations:

A. On initial appointment to the Active Staff or any initial grant of clinical privileges, the member will be required to successfully complete an initial focused professional practice evaluation (FPPE) as detailed in Article Four.

B. Until the member has completed the initial FPPE, the member shall not be eligible to vote, hold Medical Staff or department office, serve as a Medical Director, or chair a committee unless granted a waiver by the Medical Executive Committee subject to approval by the Board.

Section 3.2 Courtesy Staff Membership.

Qualifications: Appointees to this category must:

A. Meet the basic qualifications for membership as defined in Article Two of the Bylaws; and

B. Document biennially the number of patient contacts as defined by these Bylaws.

If a member of the Courtesy Staff does not meet the required minimum patient contacts during the current term of appointment, the member must provide written notification of intent to utilize the Hospital for the next appointment period and meet the required patient contacts within 180 days. The Board may, at the recommendation from the Medical Executive Committee, allow the practitioner to be reappointed to the Courtesy Staff for one additional term of up to two (2) years during which the practitioner must meet the minimum patient contacts requirement. If the practitioner has not met the patient contacts requirement after the additional term of

appointment, the Credentials/Recruitment Committee will forward their recommendation regarding continued membership to the Medical Executive Committee.

Prerogatives: Appointees to this category may:

A. Exercise privileges granted in the same manner as an Active Staff member;

B. Serve on Medical Staff committees, voting or nonvoting; and

C. Attend meetings of the Medical Staff and the Medical Staff department to which assigned and, following completion of the initial FPPE in Article Four, vote on Medical Staff and department issues.

Responsibilities: Appointees to this category must:

A. Comply with the Medical Staff Bylaws and Policies, and the Hospital's policies and regulatory standards.

B. See Article Eight, Sections 8.5-8.6 regarding meeting attendance.

Limitations:

A. Courtesy Staff members shall not be eligible to hold Medical Staff or department office.

B. Courtesy Staff members cannot chair a committee or serve as a Medical Director.

Section 3.3 Affiliate Staff Membership.

Qualifications: Appointees to this category must:

A. Meet the basic qualifications for membership as defined in Article Two of the Bylaws.

B. Competency, reputation and professional performance data will be gathered by requesting reference letters from current Active or Courtesy Staff members to whom the practitioner refers patients or other practitioners who are familiar with the applicant.

Prerogatives: Appointees to this category may attend meetings of the Medical Staff and department to which assigned. They may be appointed to serve on committees, voting or non-voting.

Affiliate Staff may refer patients to other members of the Medical Staff for admission and may follow their patients during hospitalization subject to patient authorization. Specifically, subject to patient authorization, the Affiliate Staff members may:

A. Visit patients in the Hospital;

B. Review medical records and write in the progress notes for patients referred for admission or services;

C. Discuss their patients' care with the attending practitioner;

D. Observe diagnostic or surgical procedures with the approval of the attending practitioner and the patient;

E. Perform outpatient pre-admission history and physical exams; and

F. Order non-invasive outpatient diagnostic tests and services.

Responsibilities:

A. Comply with the Medical Staff Bylaws and Policies, and the Hospital's policies and regulatory standards.

B. See Article Eight, Sections 8.5-8.6 regarding meeting attendance.

Limitations: Appointees to this category:

A. Are not eligible to admit patients to the Hospital or to hold any other clinical privileges; and

B. Are not eligible to vote on Medical Staff or department issues, hold Medical Staff or department office, or serve as chair of a committee.

Section 3.4 Telemedicine Staff Membership. Practitioners who are affiliated with the Hospital solely through contracted services providing a telemedicine link are eligible for Medical Staff membership in this category only and only for telemedicine clinical privileges. The Medical Executive Committee shall establish by written Policy, subject to the approval of the Board, what services are appropriate for telemedicine.

Qualifications: Appointees to this category must:

A. Meet the basic qualifications for membership as defined in Article Two of the Bylaws except for office and residence requirements; and

B. Document biennially the number of patient contacts as defined by these Bylaws.

Prerogatives: Appointees to this category may:

A. Exercise the privileges granted without limitation, except as otherwise provided in these Bylaws or in Medical Staff Policies or on the individual practitioner's delineation of privileges;

B. Attend Medical Staff and department meetings and, following completion of the initial FPPE in Article Four, vote on department issues; and

C. Be appointed to serve on committees, voting or non-voting.

Responsibilities: Appointees to this category must:

A. Comply with the Medical Staff Bylaws and Policies, and the Hospital's policies and regulatory standards.

B. See Article Eight, Sections 8.5-8.6 regarding meeting attendance.

Limitations: Appointees to this category:

A. Shall not be eligible to vote on Medical Staff issues or hold Medical Staff or department office; and

B. Cannot chair a committee.

Unless otherwise provided by the Board following consultation with the Medical Executive Committee, credentialing and privileging of Telemedicine Staff practitioners will be done by the distant site hospital (remote location where the imaging/test is interpreted) or telemedicine company providing the telemedicine services, pursuant to a written agreement with the Hospital that meets legal and accreditation requirements including those of CMS. Telemedicine practitioners shall be subject to FPPE and OPPE in the same manner as any other practitioner with clinical privileges.

Section 3.5 Honorary/Emeritus Status. Honorary/Emeritus Status is extended as a courtesy only to practitioners who are retired from active full-time practice and who were former members of the Medical Staff in good standing at the time of retirement. This is not a Staff membership category and does not involve the granting of any clinical privileges. Therefore, the practitioner is not required to satisfy the requirements of Medical Staff membership or clinical privileges or undergo appointment and reappointment. Honorary/Emeritus practitioners may attend Medical Staff and department meetings and educational presentations at the Hospital, but have no voting rights.

Section 3.6 Request for Modification of Membership Status. A Staff member may, either in connection with reappointment or at any other time, request modification of his/her Staff category by submitting a written application/request that includes the reason for the request to the Credentials/Recruitment Committee. The basic steps are set out in Section 2.5 and the procedures and time frames for processing a modification request shall follow the Medical Staff Initial Appointment Plan. If the request is denied and the denial constitutes an Adverse Recommendation or Action, the Staff member is entitled to the procedural rights provided by Article Ten.

Section 3.7 Waiver of Utilization Requirements. Upon the written request of a practitioner, the Medical Executive Committee shall issue a recommendation on whether to waive any admission requirements or limitations for a member of a particular Staff category because the waiver is in the best interest of the Hospital, the Medical Staff and/or the patients served by the Hospital. The basis for the recommendation shall be documented in writing and forwarded to the Board. If the waiver is denied, the Board shall afford the practitioner an opportunity to personally appear before the Board at the next scheduled meeting for the purpose of requesting consideration. A practitioner shall have no procedural rights under these Bylaws or otherwise in the event of a denial of waiver.

Section 3.8 Leave of Absence. Members of the Medical Staff may apply for a leave of absence not to exceed six (6) months, renewable under the Medical Staff Leave of Absence Policy. Reinstatement of Staff privileges following an approved leave may be requested through the Medical Executive Committee without formal reapplication as provided in the policy. Failure to request reinstatement shall be deemed a voluntary resignation from the Medical Staff on the last date of the approved leave and the practitioner shall not be entitled to procedural rights under these Bylaws or otherwise in the event of failure to request reinstatement and voluntary resignation.

Section 3.9 Allied Health Professionals. Certain health care professionals who are not physicians, podiatrists, or dentists may be authorized to provide patient care services in the Hospital in the capacity of Allied Health Professionals as detailed below. Allied Health Professional status shall be limited to those disciplines (and the practice and level of practitioner direction-delegation-supervision) approved by the Board of Trustees, following consultation with the Medical Executive Committee. Approval of a discipline shall be documented but shall not require amendment of these Bylaws. Members of the Medical Staff utilizing Allied Health Professionals and the Allied Health Professionals must comply with any practitioner direction-delegation-supervision requirements and conditions or limitations on their practice.

A. Allied Health Professionals Categories.

1. Category One: Category One shall be those health care professionals who are granted clinical privileges and shall include but are not limited to approved categories of advanced practice registered nurses and physician assistants, including those employed by the Hospital. They may exercise judgment within their areas of competence and/or

participate directly in the management of patients under the specified level of delegation, supervision and/or direction of a member of the Medical Staff, provided that a physician member of the Medical Staff shall have the ultimate responsibility for the primary medical care of the patient.

Allied Health Professionals – Category One shall be governed by a written Hospital policy and procedure approved by the Medical Executive Committee and the Board of Trustees. The policy shall provide that they shall be credentialed using the Medical Staff process and procedures. The policy shall require that they have written authority for any delegated medical acts. They shall be individually assigned to an appropriate department and shall carry out their activities subject to department policies and procedures, as applicable.

2. Category Two: Category Two shall include those health care professionals who are not eligible for clinical privileges, but practice pursuant to a scope of practice authorization. They participate directly in the management of patients under a specified level of delegation, supervision and/or direction of a member of the Medical Staff. Credentials for Allied Health Professionals – Category Two shall be processed by Human Resources. The practice authorization shall set out the required level of practitioner delegation, supervision and/or direction. Category Two shall not include any Hospital employees.

B. Obligations. Allied Health Professionals will:

- Act in an ethical and professional manner.
- Submit a specific written request if the supervising, delegating or directing practitioner seeks modification of the Allied Health Professional's clinical privileges or practice authorization in the interim between reappointments.
- Provide patients with continuous quality of care meeting the professional standards of Allied Health Professionals and this Hospital.
- Comply with applicable sections of the Medical Staff Bylaws and all Hospital policies including the Anti-Harassment and corporate compliance policies.
- Comply with all Medical Staff and Hospital policies related to medical peer review, including without limitation quality improvement, credentialing, utilization review and risk management activities, and assist the Hospital in disaster preparedness/response as outlined in the Hospital Emergency Preparedness Plan.

Additional obligations and responsibilities may be set out on the delineation of clinical privileges or practice authorization and Medical Staff and Hospital policies.

C. Prerogatives and Limitations. Allied Health Professionals may be appointed to Medical Staff committees, either voting or nonvoting, but may not chair a committee. They may attend Medical Staff meetings, meetings of the department to which assigned, and continuing education presentations of the Medical Staff. They are not members of the Medical Staff or entitled to any of the rights or prerogatives of practitioners or members of Medical Staff, including but not limited to the procedural rights in Article Ten and the Fair Hearing and Appellate Review Plan. They cannot vote on Medical Staff or department issues or hold office, nor do they pay membership dues.

D. Procedural Rights. Procedural rights for Allied Health Professionals shall be set out in Hospital policy. Concerns regarding possible impairment of an Allied Health Professional will be handled in accordance with MS-11 Impaired Medical Staff Member Policy.

ARTICLE FOUR
CLINICAL PRIVILEGES

Section 4.1 General. Every Practitioner shall hold only those clinical privileges granted by the Board in accordance with these Bylaws and the Medical Staff Clinical Privileges Delineation Policy. Requests for clinical privileges shall be considered only when the request includes evidence of satisfaction of minimum or threshold criteria pertaining to: education; training; experience; and demonstrated current competence. Evaluation of requests shall be based on: prior and continuing education; training and experience; utilization practice patterns; current ability to perform the privileges requested; and demonstrated current competence, ability, and judgment. The Medical Staff committees and Board may also consider patient care needs, the Hospital's capability to support the type of privileges being requested, and the availability of qualified coverage in the requesting practitioner's absence. This Article shall also apply to Allied Health Professionals – Category One unless otherwise provided in these Bylaws.

Section 4.2 Process for Granting Clinical Privileges. Clinical privileges shall be granted for a period not to exceed two (2) years and shall be subject to reappointment or renewal. The process for granting clinical privileges, and reappointment or renewal of those privileges, shall be set out in written Medical Staff policies and shall include the following basic steps:

A. The practitioner must submit a written request for the specific clinical privileges requested in the form required by the Hospital;

B. Primary source verification and collection of all required and requested information by the Medical Staff Office on behalf of the Medical Staff committees, to verify compliance with qualifications to include querying the National Practitioner Data Bank;

C. Review of the complete application by the Credentials/Recruitment Committee within thirty (30) days of receipt and issuance of a written recommendation (or deferral for up to thirty (30) days followed by a recommendation);

D. Review of the complete application and the recommendation of the Credentials/Recruitment Committee by the Medical Executive Committee within thirty (30) days of receipt and issuance of a written recommendation (or deferral for up to thirty (30) days followed by a recommendation);

E. Review of the application and the committees' recommendations by the Board of Trustees within thirty (30) days of receipt and issuance of a final decision;

F. Review of the results of ongoing professional practice evaluation (OPPE) in the case of reappointment; and

G. The procedural rights in Article Ten in the event of an Adverse Recommendation or Action.

Section 4.3 FPPE and OPPE

A. Initial FPPE. Every practitioner granted initial clinical privileges shall be subject to a focused professional practice evaluation or FPPE. The terms of the FPPE shall be as set forth in the MS-16 Focus Performance Practice Evaluation Policy. Upon completion of the terms of the FPPE, the Credentials/Recruitment Committee will issue a recommendation to the Medical Executive Committee that the practitioner has successfully completed the initial FPPE, that the FPPE should be extended for a stated period of time or cases, or that the practitioner has not documented the requisite current clinical competency or other qualifications and recommend termination of the affected clinical privileges. The remaining steps shall be as set out in Section 4.2. Extending the initial FPPE or a decision not to do so shall not entitle the practitioner to procedural rights under the Bylaws or otherwise.

B. Failure to Utilize Hospital. A practitioner who fails to utilize the Hospital during the initial FPPE will not be eligible for an extension of the FPPE and will automatically be ineligible for reappointment to the Medical Staff for a period of at least 6 months unless the Board, at the recommendation

of the Medical Executive Committee, grants an exception based on Hospital or Medical Staff needs to the needs of the community. Failure to grant an exception does not constitute an Adverse Recommendation or Action or entitle the practitioner to the procedural rights of review under these Bylaws or otherwise.

C. FPPE for Cause. FPPE may also be utilized when indicated for cause as set forth in Medical Staff Policy MS-16 Focus Performance Practice Evaluation.

D. OPPE. Every practitioner with clinical privileges shall be subject to an ongoing professional practice evaluation or OPPE to verify continued competence for the clinical privileges granted. The findings from FPPE and OPPE shall be utilized in medical peer review, including without limitation at the time of reappointment. OPPE is further detailed in Medical Staff Policy MS-8 Ongoing Performance Practice Evaluation.

Section 4.4 Request for Modification of Clinical Privileges. A Staff member may, either in connection with reappointment or at any other time, request modification of his/her clinical privileges by submitting a written request. The request will be forwarded to the Credentials/Recruitment Committee which shall make a recommendation to the MEC and Board. If the request is denied and the denial constitutes an Adverse Recommendation or Action, the Staff member is entitled to the procedural rights in Article Ten.

Section 4.5 Temporary Privileges. Temporary clinical privileges may be granted by the Chief Executive Officer following approval of the Chief of Staff and Chair of the Credentials/Recruitment Committee:

A. when a practitioner has a complete application that is awaiting approval by the Medical Executive Committee and Board and meets the criteria in the written Medical Staff policy; or

B. to fulfill an important patient care need.

The process for temporary privileges shall include the basic steps of: temporary privileges may not exceed 120 days; temporary privileges may be terminated at any time by the Chief of Staff or the Chief Executive Officer; and termination of temporary privileges or the failure to grant temporary privileges is not an Adverse Recommendation or Action and does not entitle a practitioner to procedural rights under these Bylaws or otherwise. Temporary privileges for an applicant shall automatically terminate on issuance of an Adverse Recommendation or Action and on fulfillment of the important patient care need. Temporary privileges may not be renewed.

Section 4.6 Authorization in an Emergency Situation. In the event of an emergency, a qualified Staff member or other practitioner with clinical privileges is authorized to do everything possible, to the degree permitted by the member's license, but

regardless of department affiliation, Staff category or privileges, to save a patient's life or save a patient from serious harm. An "emergency" is defined as a condition which could result in serious or permanent harm to a patient and in which any delay in administering treatment would add to that harm. When the emergency situation no longer exists or other practitioners with the required clinical privileges are able to assume care of the patient, the practitioner's emergency authorization shall automatically terminate.

Section 4.7 Disaster Privileges. Disaster privileges may be granted to practitioners who are not members of the Medical Staff by the CEO in accordance with the procedures in the Medical Staff Emergency Privileging of Non-Medical Staff Members, which process shall include the basic steps of: verification of identity; issuance of identification to the volunteer as having been granted disaster privileges and maintenance of a file for each volunteer; a process for oversight; and processing of the request for privileges using customary procedures as the emergency permits.

Section 4.8 History and Physical Examination Privileges. As further detailed in Medical Staff Policy, a complete admission history and physical examination shall be performed and placed in the Hospital patient record within twenty-four (24) hours of admission and before any surgery or procedure involving anesthesia, except in emergencies which preclude such documentation. If a complete history and physical examination has been performed and recorded within thirty (30) days prior to admission, it may be used in the medical record as a preliminary history and physical examination; provided it was recorded by a Staff member and an updated note is documented within twenty-four (24) hours of admission and before any surgery or procedure involving anesthesia that includes any changes or additions or a note that there are none. Except as provided below, histories and physical examinations shall be performed by physicians (or qualified oral maxillofacial surgeons for their own patients). Dentists and podiatrists shall perform that part of the history and physical examination relating to their applicable discipline, and are responsible to secure a physician member of the Staff to perform the remaining portion of the history and physical examination in accordance with the above requirements. Histories and physical examinations may be performed by Allied Health Professionals who have been granted those clinical privileges subject to any conditions in their delineation of privileges.

Section 4.9 Clinical Privileges Delineation Policy. The procedures for considering and granting clinical privileges, including temporary privileges, are set out in the Medical Staff Clinical Privileges Delineation Policy.

ARTICLE FIVE
OFFICERS

Section 5.1 Officers of the Medical Staff. The officers of the Medial Staff shall be:

A. Chief of Staff

B. Chief of Staff Elect

C. Past Chief of Staff

Section 5.2 Qualifications of Officers.

A. Chief of Staff

1. Be an MD or DO;

2. Be an Active Staff member, having held such position for at least three (3) years;

3. Have prior experience as a Chief of Staff Elect, department chair, Medical Executive Committee member, Board member, or a similar Medical Staff leadership position;

4. Have an exemplary record of clinical practice; and

5. Possess interpersonal and leadership skills, as well as the ability to communicate and adjudicate clinical and administrative issues.

B. Chief of Staff Elect

1. Be an MD or DO;

2. Be an Active Staff member, having held such position for at least three (3) years;

3. Have prior experience as a department chair, Medical Executive Committee member, Board member, or a similar Medical Staff leadership position;

4. Have an exemplary record of clinical practice; and

5. Possess interpersonal and leadership skills, as well as the ability to communicate and adjudicate clinical and administrative issues.

C. Exceptions to Qualifications of Officers require Medical Executive Committee and Board approval.

Section 5.3 Election of Officers.

A. Officers shall be elected either at a Medical Staff meeting and/or by electronic or mail ballot, as determined by the Medical Executive

Committee. See Article Eight for procedures. Elected officers shall be subject to confirmation by the Board of Trustees.

B. An ad hoc nominating committee shall be appointed by the Medical Executive Committee and may include members of the Medical Executive Committee. This committee shall offer one (1) or more nominees for the office of Chief of Staff Elect. Nominations must be announced and the names of the nominees distributed to all members of the Active and Courtesy Staff at least thirty (30) days before a Medical Staff meeting or at least thirty (30) days before the written ballots are mailed.

C. Nominations may also be made by a petition signed by at least ten percent (10%) of the members of the Active Staff. Such a petition must be submitted to the Chief of Staff at least fifteen (15) days prior to a Medical Staff meeting or issuance of electronic or mail ballots. If the practitioner nominated meets the qualifications and is willing to serve, the name will be added to the list of nominees presented at the meeting or on the electronic or mail ballot.

D. Election will be determined by a majority vote of the Active and Courtesy Staff members voting.

Section 5.4 Term of Office. All officers shall take office on the first day of the calendar year and serve a term of two (2) years.

Section 5.5 Vacancies in Office. Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of Staff membership or eligibility to serve as officer of the Medical Staff. If there is a vacancy in the office of the Chief of Staff, the Chief of Staff Elect shall serve the remainder of the term. If the Chief of Staff Elect is unable to serve, a special election will be called using the procedures in Section 5.3. If the Chief of Staff Elect is able to serve as Chief of Staff, the Medical Executive Committee will decide whether to hold a special election for a new Chief of Staff Elect using the procedures in Section 5.3 or appoint a qualified Active Staff member to serve the remainder of the Chief of Staff Elect term. In the event of a vacancy in the position of Past Chief of Staff, the Medical Executive Committee may request that the next most immediate Past Chief of Staff available and willing to serve fill the position.

Section 5.6 Duties of Officers.

A. Chief of Staff: The Chief of Staff of the Medical Staff provides leadership and guidance to the Medical Staff and promotes effective communication among the Medical Staff, Medical Executive Committee, Administration, and the Board. The Chief of Staff will fulfill those duties as specified in the Medical Staff Chief of Staff Position Description policy.

B. Chief of Staff Elect: The Chief of Staff Elect of the Medical Staff provides continuity in leadership when the Chief of Staff of the Medical Staff is absent or otherwise unable to perform his or her assigned duties. In the absence of the Chief of Staff, the Chief of Staff Elect shall assume all the duties and have the authority of the Chief of Staff as outlined in the Medical Staff Chief of Staff Elect Position Description policy.

C. Past Chief of Staff: The Past Chief of Staff will assist the Chief of Staff with advice and counsel as requested by the Chief of Staff.

Section 5.7 Removal from Office. The Board may remove any officer but only after a recommendation of the Medical Executive Committee. The Medical Staff may remove any officer by petition signed by twenty-five percent (25%) of the Active and Courtesy Staff members and a subsequent two-thirds (2/3rds) vote of the Active and Courtesy Staff present and voting at a Medical Staff meeting called or by electronic or mail ballot conducted for such a purpose by the Medical Executive Committee. See Article Eight for procedures. Removal shall be for failure to conduct those responsibilities assigned within these Bylaws or other Medical Staff and Hospital approved policies and procedures. Such position shall be filled as described in Article Five, Section 5.5.

ARTICLE SIX
DEPARTMENTS

Section 6.1 Organization of Departments. The Medical Staff shall be organized into departments. Each department shall have a chair and vice chair(s) that have responsibility for the supervision and satisfactory discharge of assigned functions of the department.

Section 6.2 Department Chairs and Vice Chairs.

A. Each chair and vice chair shall be a member in good standing of the Active Staff and be willing and able to discharge the functions of his/her office.

B. Department chairs and vice chairs must be certified by the specialty board appropriate to their clinical privileges. If not certified, the education, training, experience and competence must be determined as comparable through the credentialing process. Chairs must be an Active Staff member for at least three (3) years and vice chairs must be an Active Staff member for at least one (1) year prior to nomination. Chairs and vice chairs must have an exemplary record of clinical practice and professional conduct, and hold delineated clinical privileges in a specialty or subspecialty of the department.

Section 6.3 Functions of Departments. Each department will develop and implement policies and procedures, subject to the approval of the Medical Executive

Committee, for medical peer review and other quality improvement measures that are consistent with the Hospital's performance improvement plan. The department will also recommend to the Credentials/Recruitment Committee, subject to the approval of the Medical Executive Committee and the Board, the criteria for clinical privileges that are relevant to the care provided in the department, as well as orient and provide continuing education of all persons in the department.

Section 6.4 Assignment to Departments. The Medical Executive Committee will approve department assignments for all Medical Staff members and others with clinical privileges.

Section 6.5 Department Meetings. The departments shall meet as often as necessary, but not less than quarterly to fulfill its responsibilities and will maintain a permanent record of its proceedings and actions. Written notice of each regular meeting shall be given to department members at least three (3) days before the date of such meeting and such notice shall include the date, time and place of the meeting and may include the business of the meeting. Notice may be given in person, by mail, e-mail or by facsimile. If an Active or Courtesy Staff member is unable to attend a meeting, he/she may designate another Active or Courtesy Staff member to represent the practitioner and vote on his/her behalf. Proxy forms are available through the Medical Staff Office. Utilization of a proxy will not constitute an excused absence.

Section 6.6 Department Chairs and Vice Chairs Election and Removal.

A. Department chairs and vice chairs shall be elected by simple majority vote of Active and Courtesy Staff members of their individual departments at a year-end meeting, subject to approval by the Medical Executive Committee, for a two (2) year term to begin on the first day of the calendar year, and will also be members of the Medical Executive Committee.

B. The department by a two-third (2/3) vote of Active and Courtesy Staff members may recommend the removal of any chair or vice chair to the Medical Executive Committee. The affected member will not be present for the vote but may address the members prior to the vote. The Medical Executive Committee, acting on its own or with the recommendation of the department, may elect to remove a department chair or vice chair. Removal shall be for failure to conduct those responsibilities assigned by these Bylaws or other Medical Staff approved policies and procedures.

C. The removed chair or vice chair will be replaced by simple majority vote of Active and Courtesy Staff members of the respective department at the next regularly scheduled department meeting or a special called meeting for that purpose.

Section 6.7 Department Chair Roles and Responsibilities. The following roles and responsibilities shall be conducted, as appropriate, in accordance with the Medical Staff's

overall performance improvement program and in coordination with Hospital Administration. The department chair and vice chair are accountable and report to the Medical Executive Committee. The department chair may appoint a subcommittee of the department to assist with carrying out any role or responsibility, provided the subcommittee reports to the department chair and shall not have the authority to take any action.

A. Performance Improvement

1. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;

2. Continuous assessment and improvement of the quality of care, treatment, and services provided by the department;

3. Maintenance of quality control programs, as appropriate.

B. Credentialing

1. Recommend to the Medical Executive Committee the criteria for clinical privileges that are relevant to the care provided in the department;

2. Recommend to the Medical Executive Committee a list of clinical privileges for each member of the department, based on established criteria, evidence of ongoing monitoring, and demonstrated competence; and

3. Determination of the qualification and competence of department or service personnel who are not licensed independent practitioners or do not hold clinical privileges, and who provide patient care, treatment, and services.

C. Patient Care Services

1. Recommendation for a sufficient number of qualified and competent persons to provide care, treatment, and services;

2. Recommend space and other resources needed by the department or service;

3. Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization; and

4. Responsible for clinically related activities of the department

D. Leadership and Management

1. Administratively related activities of the department, unless otherwise provided by the hospital;

2. Integration of the department or service into the primary functions of the organization;

3. Coordination and integration of interdepartmental and intradepartmental services;

4. Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services; and

5. Orientation and continuing education of all persons in the department or service.

Section 6.8 Department Vice-Chair Roles and Responsibilities.

1. Assist the department chair as needed; and

2. Function as the department chair in the chair's absence.

ARTICLE SEVEN
COMMITTEES

Section 7.1 Organization of Committees. The Medical Executive Committee may organize standing and ad hoc committees of the Medical Staff to oversee and carry out specific functions. Committees may also meet jointly with the approval of the Medical Executive Committee. Each committee shall have a chair with overall responsibility for the supervision and satisfactory discharge of assigned functions of the committee. Unless otherwise provided in these Bylaws, a standing committee chair is authorized to appoint subcommittees or ad hoc committees to act as extensions of the standing committee as necessary for the performance of certain duties of the standing committee. All standing committees shall report to the Medical Executive Committee. All subcommittees or ad hoc committees shall report to the committee of the appointing chair, and shall not have the authority to take action, only to make recommendations. See Article Twelve on protections for Medical Staff committees.

Section 7.2 Functions of Committees and Use of Agents. Each committee will develop and implement policies and procedures that guide and support the provision of care, treatment, and services within the service line, provided such policies and procedures are consistent with these Bylaws. The functions of the Care Oversight Committee and Medical Executive Committee are described below. The Chief of Staff or chair of a committee may

also appoint practitioners or other individuals to serve as an agent of a committee, whether standing, ad hoc, or joint, and assist in carrying out the functions and responsibilities of the committee.

Section 7.3 Assignment to Committees. The Medical Executive Committee, after consideration of the committee chair's recommendations, will make assignments for Medical Staff members and others with clinical privileges in accordance with their qualifications and interests. Voting members of standing committees, subcommittees and ad hoc committees must be members of the Medical Staff unless otherwise provided in these Bylaws or a Medical Staff Policy, or approved by the Medical Executive Committee.

Section 7.4 Committee Meetings. Subject to any requirements in these Bylaws, the committees shall meet as often as necessary to fulfill its responsibilities on call of the chair and will maintain a permanent record of its proceedings and actions. Notice of each regular meeting shall be given to committee members at least three (3) days before the date of such meeting and such notice shall include the date, time and place of the meeting and may include the business of the meeting.

Section 7.5 Committee Chairs.

A. Committee chairs must be certified by an appropriate specialty board. If not certified, the education, training, experience and competence must be determined as comparable through the credentialing process. Chairs must be an Active Staff member in good standing for at least three (3) years, have an exemplary record of clinical practice and professional conduct, and hold delineated clinical privileges in a specialty or subspecialty of the committee.

B. Unless otherwise provided herein, committee chairs shall be selected by the Chief of Staff and be approved by the Medical Executive Committee for a term of two (2) years to begin at the time the committee is organized or the start of the calendar year for existing committees, unless filling a vacancy. Committee chairs have the option of serving another term with approval of the Medical Executive Committee. Chairs of standing committees will also be members of the Medical Executive Committee.

C. The committee by a two-thirds (2/3) vote of the voting members may recommend the removal of its chair to the Medical Executive Committee. The affected member may not be present for the vote but may address the members prior to the vote. The Medical Executive Committee, acting on its own or with the recommendation of the committee, may elect to remove a committee chair. Removal shall be for failure to conduct those responsibilities assigned by these Bylaws or other Medical Staff approved policies and procedures. Vacancies shall be filled using the procedures in Subsection B. above.

Section 7.6 Medical Executive Committee.

A. Composition: The Medical Executive Committee shall be composed of the following members: the three officers of the Medical Staff, the Chair and Vice Chair(s) of each department, the chair of each standing committee, and, as non-voting members, a representative each from the Telemedicine Staff category and the Allied Health Professional Staff appointed by the current Medical Executive Committee. The Chief of Staff shall serve as chair of the Medical Executive Committee.

1. Members of the Medical Executive Committee are expected to attend meetings on a regular basis. If a member cannot attend at least 50% of the meetings, that member shall consult with the Chief of Staff and another member of the involved department/committee/Staff category shall be selected by the Chief of Staff and confirmed by the Medical Executive Committee to serve as a representative.

2. A majority of the voting members shall be physicians on the Active Staff.

3. Ex officio non-voting members are the CEO and Senior Administration Leaders.

4. Removal of a voting member of the Medical Executive Committee shall be accomplished using the appropriate procedures in Section 5.7 for Medical Staff officers or Section 6.6 for department officers. The two representatives appointed by the Medical Executive Committee may be removed by the Medical Executive Committee by 2/3rds vote. Removal shall be for failure to conduct those responsibilities assigned by these Bylaws.

B. Duties: By approval of these Bylaws, the Medical Staff delegates and empowers the Medical Executive Committee to represent and act on behalf of the organized Medical Staff between meetings of the Medical Staff on all matters, provided such actions are not inconsistent with these Bylaws and subject to any limitations in these Bylaws. The following duties shall be performed by the Medical Executive Committee:

1. Provide for and enforce current Medical Staff Bylaws and Medical Staff Policies using the procedures set forth in these Bylaws, subject to the approval of the Board;

2. Coordinate the activities and general Policies of the Medical Staff;

3. Receive and act upon department/committee reports;

4. Implement Policies of the Medical Staff not otherwise the responsibility of the departments;

5. Provide a liaison between the Medical Staff and the Chief Executive Officer and the Board;

6. Participate in strategic planning;

7. Ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital;

8. Fulfill the Medical Staff organization's accountability to the Board for performance improvement and other medical peer review, and the medical care of patients in the Hospital;

9. Review the report of the Credentials/Recruitment Committee chair on all applicants and make recommendations to the Board for individual Staff membership and delineation of clinical privileges for those privileged through the Medical Staff process;

11. Take all reasonable steps to ensure professionally ethical conduct and competent clinical performance for all members and others with clinical privileges, requesting evaluations when indicated, and initiate corrective action when indicated;

12. Conduct such other functions as are necessary for the effective operation of the Medical Staff;

13. Report at each general Medical Staff meeting; and

14. Make recommendations directly to the Board with regard to:
    i. The Medical Staff structure;
    ii. The process used to review credentials and to delineate individual clinical privileges;
    iii. The Medical Executive Committee's review of and actions on reports of Medical Staff committees, departments, and other assigned activity groups.

Removal of one or more of these duties shall require amendment of these Bylaws.

C. Meetings: The Medical Executive Committee shall meet as often as necessary, but no less than quarterly, to fulfill its responsibility and shall maintain a permanent record of its proceedings and actions. The Chief of Staff may call regular or special meetings of the Medical Executive

Committee at any time. The Medical Executive Committee shall report to the Medical Staff and the Board.

Section 7.7 Care Oversight Committee.

A. Composition: The Care Oversight Committee shall be composed of at least seven voting members of the Active Staff to include a diverse representation of members appointed by the Medical Executive Committee after consultation with the Chief of Staff Elect. Non-voting ex officio members will include, but are not limited to the CEO, Senior Administration Leaders, and Director of Case Management. The Chief of Staff Elect will serve as chair.

The Care Oversight Committee may appoint subcommittees or ad hoc committees to act as extensions of the Care Oversight Committee for the performance of certain duties described in this section 7.7(B) below, including but not limited to medical peer review oversight and root cause analysis/action plans.

B. Responsibilities: Responsibilities include:

1. Medical Peer Review Oversight

2. Interdisciplinary Process Improvement

3. Physician Ongoing Professional Practice Evaluation (OPPE)

4. Physician Focused Professional Practice Evaluation (FPPE)

5. Clinical Process Improvement Oversight

6. Regulatory Compliance

7. Root Cause Analysis/Action Plan

8. Utilization Review

D. Meetings: The Care Oversight Committee shall meet as often as necessary, but no less than quarterly. The Chief of Staff Elect may call regular or special meetings of the Care Oversight Committee at any time.

Section 7.8 Other Standing Committees. Other standing committees, and their composition, duties and meetings requirements, shall be set out in Medical Staff policy.

Section 7.9 Ex-Officio Members. The Chief Executive Officer and Senior Administration Leaders shall be ex officio members of all Medical Staff committees,

including subcommittees, ad hoc committees or otherwise, and may be present during any meeting including without limitation when a meeting is in executive session. They shall be non-voting members unless otherwise provided in these Bylaws.

ARTICLE EIGHT
MEDICAL STAFF MEETINGS

Section 8.1 Annual Medical Staff Meeting.

A. An annual meeting of the Medical Staff shall be held each year. The Chief of Staff shall select the date, time and place of the annual meeting. The notice for such annual meeting shall be mailed, hand delivered or sent by e-mail or facsimile to all members of the Medical Staff at least fourteen (14) days prior to the meeting and shall include the date, place and time of the meeting.

B. The primary objective of the annual meeting shall be to report on the activities of the Staff and to hold election of Medical Staff officers, unless the election is conducted by electronic or mail ballot. See Section 8.12 below. A permanent written record will be maintained of the meeting's proceedings and actions.

Section 8.2 Special Meetings.

A. Medical Staff.

1. The Chief of Staff may call a special meeting of the Medical Staff at any time. The Chief of Staff shall call a special meeting within thirty (30) days after receipt of a written request for such a meeting signed by not less than one-fourth (1/4th) of the Active Staff, or upon a request by the Medical Executive Committee. Such request shall state the purpose of the meeting. The Chief of Staff shall designate the time and place of any special meeting.

2. Written notice stating the time, place, and purposes of any special meeting of the Medical Staff will be sent to all members of the Medical Staff by mail, hand delivered, e-mail or facsimile at least ten (10) days before the date of such meeting.

3. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

B. Committee or Department. A special meeting of any Medical Staff committee or department may be called by: the chair thereof, the Medical Executive Committee, the Chief of Staff or by written request of one-third (1/3rd) of the current voting members of that committee or department.

Written notice stating the time, place, and purposes of any special meeting will be sent to all members of the committee or department by mail, hand delivered, e-mail or facsimile at least three (3) days before the date of such meeting.

Section 8.3 Regular Meetings.

A. Medical Staff. The Chief of Staff, at his discretion, may call additional Medical Staff meetings as needed throughout the year. See Section 8.1.A. for meeting notification.

B. Committee or Department. Except as otherwise specified in these Bylaws, the committee and department chairs shall establish the times for holding regular meetings. The chair shall disseminate the meeting dates to the members with prior notice. See Section 7.4 for committees and Section 6.5 for departments for meeting notification.

Section 8.4 Proxy Voting. If an Active or Courtesy Staff member is unable to attend a Medical Staff meeting at which there is a right to vote, the member may designate another Staff member with the same voting right to represent the practitioner and vote on his/her behalf. This must be done using a written proxy forms available through the Medical Staff Office. Utilization of a proxy will not constitute an excused absence and a proxy vote may not be counted in establishing a quorum. Proxy voting is not permitted for the Medical Executive Committee meetings.

Section 8.5 Quorums. Unless otherwise provided in these Bylaws, the quorum requirement for the following meetings shall be:

A. Medical Staff Meetings: Those present and voting but at least twenty-five percent (25%) of the voting members.

B. Medical Executive Committee Meetings: Fifty percent (50%) of the voting members of the committee.

C. Committee or Department Meetings: Those present and voting but at least two (2) of the voting members of the committee or department.

Section 8.6 Attendance Requirements.

A. Active Staff and Department Meetings. Active Staff members shall be required to attend at least fifty percent (50%) of their assigned department meetings in a calendar year unless excused by the department chair for good cause or one of the exemptions set out below applies. Attendance at committee, general or special Medical Staff meetings will count towards meeting the attendance requirement. Meeting attendance will be used in evaluating members at the time of reappointment.

1. If a member is unable to attend department meetings due to day and time of meetings, the department chair may allow the requirement to be met by serving on one or more committees, subcommittees or ad hoc committees or participating in chart reviews during the calendar year.

2. Active Staff members whose primary practice is outside of the Service Area and who are members of a group practice may count the attendance of another member in the group for up to twenty-five percent (25%) of the meetings in a calendar year. The group member must attend the department meetings as a representative of the group and communicate department issues to the other members of the group.

3. Active Staff members whose primary practice is outside of the Service Area and who have solo practices or do not have other group members on the Active Staff will be required to attend at least twenty-five percent (25%) of department meetings in a calendar year, instead of fifty percent (50%).

4. Medical Staff leaders who serve on two (2) or more Medical Staff committees during a calendar year will be exempt from the department meeting attendance requirement if they attend at least fifty percent (50%) of other committee meetings.

B. Other Staff Categories. All other Staff category members of the Medical Staff are encouraged to attend meetings of the Medical Staff. Meeting attendance will be used in evaluating such members at the time of reappointment.

C. Medical Executive Committee Meetings. See Section 7.6.

D. Attendance using Videoconferencing. Unless otherwise provided by the Medical Executive Committee and except for Medical Executive Committee meetings, a member may attend a meeting and will be considered "present" if attending by videoconferencing or other approved mechanism that allows for contemporaneous participation. Any such mechanism must ensure confidentiality of the proceeding.

E. Proxy. Attending a meeting by proxy does not count toward any required attendance nor does it qualify as an excused absence.

Section 8.7 Special Attendance Requirements.

A. Educational Program. Whenever a Staff, committee or department educational program is prompted by findings of medical peer review/quality assessment/improvement activities, the practitioner(s) whose performance prompted the program will be given special notice at least five (5) days prior to the program of the time, date, and place of the program, the subject matter to be covered, and its special applicability to the practitioner's practice, and the requirement to be present at the program. Except in unusual circumstances, as determined by the Chief of Staff, department or committee chair, the practitioner shall be required to be present. If the practitioner fails to attend the meeting, the issue will be referred to the Medical Executive Committee.

B. Individual Conference or Provision of Information. Whenever a pattern of suspected deviation from standard clinical or professional practice is identified, the Chief of Staff or the applicable department or committee chair may require the practitioner to confer with him/her or with a standing or ad hoc committee. The practitioner will be given special notice of the conference to discuss the issue. Notice will be at least five (5) days prior to the conference and will include the date, time, place, and a statement of the issue involved and a statement that the practitioner's appearance at the conference is mandatory. A practitioner may also be required by special notice to provide information pertaining to his or her qualifications for membership and/or clinical privileges, including documentation of necessary health status, within a specific time period by the Chief of Staff or a department or committee chair. The special notice shall include notice that the failure of the practitioner to appear at any such conference or to provide requested information within the required time period will result in an automatic suspension of the practitioner's clinical privileges. A suspension under this Section will remain in effect until the practitioner attends another scheduled meeting which must be within 14 days, or the matter is resolved by subsequent action of the Medical Executive Committee and the Board of Trustees. Such resolution shall be made in a timely manner. Automatic action is not an Adverse Recommendation or Action and does not entitle the practitioner to any procedural rights under these Bylaws or otherwise.

C. Personal Attendance Required. Attendance authorized by Section 8.6.D. is not permitted to fulfill the obligations of this section.

Section 8.8 Participation by Chief Executive Officer. In addition to the provisions of Section 7.9, the Chief Executive Officer and any representative assigned by the Chief Executive Officer may attend any Medical Staff committee or department meetings of the Medical Staff, including those in executive session.

Section 8.9 Action of Staff/Committee/Department. The action of a majority of the voting members present and voting at a meeting at which a quorum is present shall be the action of the Medical Staff, a committee or department unless otherwise provided in the Bylaws.

Section 8.10 Rights of Ex Officio Members. Except as otherwise provided in these Bylaws, persons serving as ex officio members of a committee or department shall have all rights and privileges of regular members thereof, except they shall not vote or be counted in determining the existence of a quorum.

Section 8.11 Minutes and Other Records. Minutes of each regular and special meeting of a committee, department or the Medical Staff shall be prepared by Medical Staff Services as agent for the body and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding chair and shall be maintained in a permanent file in the Medical Staff Office.

Section 8.12 Electronic or Mail Ballots. The Medical Executive Committee, with the approval of the CEO, may utilize an electronic or mail ballot for voting on any matter including but not limited to, an election of officers, instead of voting at a regular or special meeting, unless otherwise provided in these Bylaws.

A. In such case, the voting members of the Staff shall be presented with the question by electronically delivered or mail ballot. See definition on "notice" for when deemed delivered.

B. Electronic or mail ballots shall allow at least ten (10) days for return and affirmative action shall require the simple majority vote of those ballots returned by electronic transmission, mailing or hand delivered by the required date.

C. Proxy voting is not permitted with electronic or mail ballots.

ARTICLE NINE
MEMBERS RIGHTS AND CONFLICT MANAGEMENT

Section 9.1 Meet with Medical Executive Committee. Each practitioner on the Medical Staff has the right to an audience with the Medical Executive Committee if the practitioner and his/her respective department chair cannot resolve an issue. In the event a practitioner is unable to resolve an issue by working with his/her respective department chair, that practitioner may, upon presentation of a written notice to the Chief of Staff at least seven (7) days prior to the next scheduled meeting specifying the reason or purpose for the request, meet with the Medical Executive Committee to discuss the issue.

Section 9.2 Initiate Removal Election. Any practitioner has the right, as described in Article Five, Section 5.7, Article Six, Section 6.6, and Article Seven, Section 7.5, to initiate an election to remove a Medical Staff officer, department chair or vice chair, and/or committee chair.

Section 9.3 Initiate Scheduling General Staff Meeting. Any practitioner may initiate the scheduling of a special meeting of the General Staff as outlined in Article Eight, Section 8.2.

Section 9.4 Conflict Regarding Medical Staff Policy. Any practitioner may raise a challenge to any Medical Staff Policy adopted, amended or repealed by the Medical Executive Committee as provided in Article Thirteen. To raise a challenge, the practitioner must submit a petition signed by at least ten percent (10%) of the Active and Courtesy Staff members. The petition must be received in the Medical Staff Office within thirty (30) days of the notice to the Medical Staff of the Medical Executive Committee's action as provided in Article Thirteen, Section 13.4.A. Within thirty (30) days of receipt of such petition, the Medical Executive Committee will: (1) provide the petitioners with written information clarifying the intent of such policy; and/or (2) schedule a meeting with the petitioners to discuss the issue. Nothing in this process is intended to prevent a member from communicating directly with the Board with regard to a Medical Staff Policy, in the manner prescribed by the Board.

Section 9.5 Department/Committee Meeting Request. Consistent with Article Eight, Section 8.2.B, a certain number of members of a department/committee may request a special meeting of the department/committee.

Section 9.6 Exclusions of Sections 9.1 through 9.5. Sections 9.1 – 9.5 do not pertain to issues involving disciplinary action, denial of request for appointment or clinical privileges, or any other matter relating to individual credentialing or other medical peer review actions. Article Ten and the Fair Hearing and Appellate Review Plan provide the sole recourse in these matters in the event of an Adverse Recommendation or Action.

ARTICLE TEN
FAIR HEARING AND APPELLATE REVIEW

Section 10.1 Adverse Recommendation or Action. Only the following recommendations or actions, when taken by the Medical Executive Committee (or by the Board following a recommendation by the Medical Executive Committee which was not an Adverse Recommendation or Action as defined below), shall be considered an Adverse Recommendation or Action and entitle the affected practitioner to a hearing and appellate review as herein provided:

1. Denial of initial Medical Staff appointment or reappointment;

2. Revocation of Medical Staff membership;

3. Denial of requested appointment to, or advance in, a Medical Staff category or a reduction in category (other than Honorary/Emeritus) unless the practitioner does not meet the established eligibility

requirements for the category;

4. Suspension, revocation or restriction of any clinical privileges, including involuntary reduction or revocation of clinical privileges;

5. Denial of requested clinical privileges;

6. Imposition of a consultation or concurrent supervision requirement where the consultant's or supervisor's approval is required before the practitioner can exercise clinical privileges; and

7. Summary corrective action involving suspension or restriction of any clinical privileges that is continued by the Medical Executive Committee following its review pursuant to the Article Eleven and the Medical Staff Corrective Action Plan or, if terminated by the Medical Executive Committee following that review, is reinstated by the Board of Trustees.

Section 10.2 Actions which are **not** an Adverse Recommendation or Action. The following recommendations or actions, and any others specified in these Bylaws, shall not constitute an Adverse Recommendation or Action and shall not entitle the affected practitioner to any procedural rights under these Bylaws or otherwise:

1. Failure to process an application for appointment, reappointment, clinical privileges, or modification of Staff category or clinical privileges or denial due to: (a) failure to provide a complete application or requested information, (b) failure to satisfy minimum or threshold criteria established for appointment, Staff category or certain clinical privileges, (c) the existence of an exclusive contract or other arrangement for the clinical privileges requested, or (d) determination that an application will not be processed due to a misstatement or omission;

2. Automatic action, including those pursuant to Article Eleven below;

3. Any action as to temporary or emergency privileges, including but not limited to termination of temporary privileges;

4. Imposition of any limitation or restriction on a practitioner that is imposed equally on all practitioners or in connection with certain privileges or requirements imposed during an initial Focused Professional Practice Evaluation (FPPE);

5. Imposition of a temporary suspension pending investigation pursuant to Article Eleven and the Medical Staff Corrective Action Plan;

6. Issuance of a letter of guidance, warning, or reprimand, probation, a requirement to obtain additional education or training, therapy, or treatment, or other action that does not limit or restrict the practitioner's exercise of clinical privileges;

7. Denial of a request for a leave of absence, or for an extension of a leave of absence;

8. Automatic relinquishment or voluntary resignation of appointment or clinical privileges;

9. Summary corrective action that is not continued by the Medical Executive Committee following its review pursuant to Article Eleven and the Medical Staff Correction Action Plan; and

10. Automatic termination of appointment or a change or denial of Staff category due to failure to comply with utilization requirements or a failure to grant a waiver unless the Bylaws specifically provide otherwise.

Section 10.3 Procedural Rights of an Adverse Recommendation or Action. The procedural rights to which a practitioner is entitled in the case of an Adverse Recommendation or Action are outlined in the Fair Hearing and Appellate Review Plan and include the following basic steps:

A. Special notice shall be given to the practitioner of an Adverse Recommendation or Action, the right to a hearing, and the procedures for requesting the hearing;

B. Scheduling of a properly requested hearing shall be within thirty (30) days of receipt of the practitioner's request, to begin within sixty (60) days of receipt of the request, and the practitioner shall be given special notice of the date, time and place of the hearing at least thirty (30) days in advance;

C. The right of the practitioner (and the Medical Executive Committee or Board, whichever's decision resulted in the hearing right) to representation by an attorney or other person of the party's choice in the hearing;

D. The hearing will be held before a hearing committee of at least three (3) practitioners or a hearing officer (hereinafter referred to as "Hearing Committee");

E. The hearing may be forfeited if the practitioner fails, without good cause as determined by the Hearing Committee's presiding officer, to appear at the hearing;

F. The opportunity of the parties to call, examine, cross-examine and challenge for prejudice or bias witnesses and rebut any evidence (witnesses other than the affected practitioner and representatives of the Medical Executive Committee or Board shall not be permitted to attend the hearing and shall only be present when testifying);

G. The opportunity of the parties to present evidence determined to be relevant by the hearing's presiding officer regardless of its admissibility in a court of law;

H. The right of the parties to submit a written statement within three (3) days of the close of the hearing;

I. The Hospital shall have a record made of the proceedings, copies of which may be obtained by the affected practitioner upon written request and payment of any reasonable charges associated with the preparation of the copy; and

J. Upon completion of the hearing, each party shall receive a copy of the written recommendations of the Hearing Committee, including a statement of the basis for the recommendations and receive a copy of the written decision of the Board of Trustees, including a statement of basis for the decision.

Section 10.4 Mediation. If a practitioner is entitled to and requests mediation pursuant to the Texas Health & Safety Code Section 241.101(d), the mediation must be requested and completed prior to the scheduling of a hearing under this Article Ten.

Section 10.5 Exclusive Remedy. All procedural rights after issuance of an Adverse Recommendation or Action shall be in accordance with the procedural safeguards set forth in the Fair Hearing and Appellate Review Plan. Once the procedures in the Fair Hearing and Appellate Review Plan have been afforded (or waived), the practitioner shall have no further right of review, reconsideration, or challenge pursuant to these Bylaws or otherwise.

ARTICLE ELEVEN
CORRECTIVE ACTION AND AUTOMATIC ACTION

Section 11.1 Corrective Action. Corrective action may be taken if a practitioner:

- Exhibits activities or unprofessional conduct disruptive to the operations of the Hospital and/or Medical Staff, or

- Exhibits performance lower than the standards of the Medical Staff or accepted professional standards, or detrimental (or potentially detrimental) to patient safety, or

- Is in violation of the requirements of the Medical Staff Bylaws, Medical Staff Policy and Procedure Manual, or any Hospital policies and procedures.

The process for corrective action shall be detailed in the Medical Staff Corrective Action Plan and include the following basic steps:

A. A request for corrective action must be made in writing to the Medical Executive Committee which will decide whether to initiate an investigation or the investigation may be initiated by the Medical Executive Committee on its own;

B. The investigation may be conducted by the Medical Executive Committee or a committee or individual(s) appointed by the Medical Executive Committee ("investigating committee"), and may involve an interview with the practitioner;

C. None of the procedural rights in Article Ten or the Fair Hearing and Appellate Review Plan apply to the investigation;

D. The results of the investigation shall be reviewed by the Medical Executive Committee which shall recommend no action, an Adverse Recommendation or Action, or another action which is not an Adverse Recommendation or Action;

E. The Board shall make the final decision on corrective action and written notice of the final action shall be provided to the practitioner by special notice; and

F. The practitioner shall be entitled to the procedural rights in Article Ten in the event of an Adverse Recommendation or Action.

Section 11.2 Summary Corrective Action. Whenever the failure to take action may result in imminent danger to the health or safety of any person, a practitioner may be subject to summary corrective action as to all or any portion of his/her clinical privileges. Such action shall become effective immediately upon imposition, however, shall not be considered a final professional review action until the Board has made a final decision. The process for summary corrective action shall be detailed in the Medical Staff Corrective Action Plan and shall include the following basic steps:

A. Only the Medical Executive Committee or Chief of Staff acting on its behalf, the Chief Executive Officer (in consultation with the Chief of Staff) acting on behalf of the Board, or the Board may impose a summary corrective action;

B. The Medical Executive Committee shall review the summary corrective action within ten (10) days of imposition and may terminate, continue or modify the action; and

C. The Medical Executive Committee's review shall afford the practitioner an opportunity for an interview with the committee.

Section 11.3 Temporary Suspension. Any individual or committee authorized to impose summary corrective action may impose a temporary suspension or limitation of all or any portion of a practitioner's clinical privileges of up to fourteen (14) days during which an investigation is conducted to determine the need for corrective action**.**

A. The procedures for temporary suspension shall be detailed in the Medical Staff Corrective Action Plan and shall provide for automatic expiration of the temporary suspension or limitation on the fourteen (14^{th}) day.

B. The Medical Executive Committee shall review the temporary suspension within ten (10) days of the suspension and may terminate, continue or modify the action.

Section 11.4 Automatic Action.

A. Any of the following shall result in automatic suspension of all clinical privileges and the practitioner shall be considered to have voluntarily resigned from the Medical Staff if the deficiency has not been eliminated within sixty (60) days in order to maintain eligibility for Staff membership:

- Failure to renew, revocation or suspension of a practitioner's Texas license to practice;
- Failure to renew, revocation or suspension of a DEA certificate or a required state controlled substances registration (suspension of prescribing clinical privileges only);
- Exclusion by Medicare, Medicaid or other federal health program;
- Failure to maintain professional liability insurance in the amounts set by the Board; or
- Failure to comply with health testing or evaluation requested pursuant to the Medical Staff Impaired Medical Staff Member Policy.

B. Failure to Disclose. A practitioner who fails to disclose as required by Section 2.7, Subsections F or G, shall be considered to have automatically relinquished Staff appointment and clinical privileges, effective on the

Hospital's receipt of notice of the failure to disclose and special notice to the practitioner of the failure to comply with Section 2.7

C. Automatic Relinquishment of Membership. A practitioner who has been convicted of, or pled guilty or nolo contendere to, a felony shall be considered an automatic relinquishment of Staff appointment and/or clinical privileges effectively immediately upon such conviction or plea, regardless of whether an appeal is filed.

D. Failure to Secure Board Certification. See Section 2.2.C. on automatic termination of Medical Staff membership and all clinical privileges for failure to secure board certification within three (3) years of initial appointment.

E. On imposition of automatic action, the Medical Staff Office shall provide special notice to the practitioner. Automatic action is not an Adverse Recommendation or Action and does not entitle the practitioner to any procedural rights under these Bylaws or otherwise. Automatic action does not preclude corrective action in accordance with these Bylaws for the same event.

Section 11.5 Voluntary Agreement with Practitioner. A practitioner may voluntarily agree not to exercise any or all clinical privileges in the Hospital or to a condition on those privileges for a specified or unlimited period of time. A voluntary agreement shall not constitute a surrender of clinical privileges. The agreement shall be in writing and shall allow the practitioner to terminate the agreement on written prior notice to the Chief Executive Officer under the terms set out in the agreement.

ARTICLE TWELVE

MEDICAL PEER REVIEW, CONFIDENTIALITY AND IMMUNITY

Section 12.1 Medical Peer Review Committee Status. Each committee of the Medical Staff (whether standing, ad hoc, special, or subcommittee and including without limitation a hearing committee), as well as each department and its committees, and the Medical Staff when meeting as a whole, shall be constituted and operate as a "medical peer review committee," "professional review body" and "medical committee," as such terms are defined by the Texas Occupations Code and the federal Health Care Quality Improvement Act, and are authorized by the Board to engage in medical peer review.

Section 12.2 Medical Peer Review Defined. The term "medical peer review" as used in these Bylaws shall include the definition of "medical peer review" or "professional review action" set out in the Texas Occupations Code, such as evaluation of medical and health care services, including evaluation of the qualifications and professional conduct of practitioners, AHPs, and the health care services they provide; and evaluation of the merits of complaints relating to these professionals or others providing health care services in the

Hospital. The term shall also include "professional review activity" as defined in the federal Health Care Quality Improvement Act.

Section 12.3 Members and Agents. Members of a committee, a department, or the Medical Staff shall act as members of and on behalf of the medical peer review committee, professional review body and medical committee when performing a function or responsibility of the committee, department, or Medical Staff.

The CEO, Senior Administration Leaders, and other representatives of Administration, including without limitation staff of Medical Staff Services, and Hospital Legal Counsel shall serve as agents of the Medical Staff, its committees and departments when assisting them in fulfilling their roles and responsibilities. Other individuals may be designated as agents of the Medical Staff, a committee or a department as needed.

An authorized action by an agent or member of the Medical Staff, a committee or a department in performing these functions and responsibilities shall be considered an action taken on behalf of the Medical Staff, committee or department, not an action taken in the agent or member's individual capacity.

Section 12.4 Confidentiality.

A. All records and proceedings of the Staff, a department, or committee shall be confidential in accord with applicable law. This information is considered records and proceedings of a medical peer review committee, professional review body, and medical committee, and shall be privileged and confidential to the fullest extent permitted by law. Participants in meetings or other proceedings may not electronically record proceedings or otherwise disclose records and proceedings without the written permission of the Chief of Staff and the Chief Executive Officer, unless specifically required by law. Breach of this confidentiality by a practitioner, unless required by law, shall be grounds for corrective action.

B. All information generated in connection with medical peer review may be used to evaluate the clinical competence, professional conduct, and other qualifications of a practitioner and/or to evaluate the quality of health care services provided.

C. Minutes and all other documents generated by or received at the request of the committee, department or the Medical Staff shall be maintained in a confidential manner and any applicable privileges of confidentiality may only be waived in writing by chair of the department or committee or Chief of Staff and the Chief Executive Officer.

Section 12.5 Immunity and Releases of Liability. Each practitioner agrees, as a condition of applying for, as a condition of accepting Staff membership and/or clinical privileges and as a condition of maintaining Staff membership and/or clinical privileges, that

to the fullest extent permitted by law, there shall be absolute immunity from civil liability for: (i) the Staff, the Hospital, and the Board and their officers, directors, members, agents, and employees, (ii) all Staff, Hospital, and Board committees and their members, agents, and employees, and (iii) any third parties that provide information to any of the above, arising out of any act, communication, report, recommendation or disclosure in the course of or for the purpose of medical peer review. Each practitioner shall execute releases of liability to this effect, but the execution of such releases shall not be required to give effect to this provision. This immunity shall be in addition to any afforded by state or federal law.

Section 12.6 Further Details. The provisions in this Article shall be further detailed in written Medical Staff Policies.

Section 12.7 Mandatory Reporting.

A. Duty. The CEO, in consultation with the Chief of Staff, shall be responsible to comply with any mandatory reporting requirements of the Hospital under Texas and federal law pertaining to Staff membership and/or clinical privileges. Nothing in this section or the other provisions of the Bylaws shall prevent an individual Staff member or member of the Board from making any other report to Texas and/or federal agencies as permitted or required by law.

B. Investigation Defined. For purposes of mandatory reporting pursuant to the federal Health Care Quality Improvement Act and/or Texas law, an "investigation" is only:

1. An investigation initiated by the Medical Executive Committee for purposes of possible corrective action as set forth in Section 10.1 based on competence or professional conduct;

2. That period of time following issuance of an Adverse Recommendation or Action, as defined in Section 10.1, based on competence or professional conduct; or

3. That period of time following issuance of a summary corrective action as provided in Section 11.1.

An investigation continues until issuance of a final decision by the Board, acceptance of a resignation from the practitioner by the Board, or withdrawal of the application from processing. Any other use of the term "investigation" in these Bylaws or a Medical Staff Policy does not constitute an investigation for purposes of mandatory reporting.

ARTICLE THIRTEEN
REVIEW, REVISION, ADOPTION, AND AMENDMENT OF THE BYLAWS AND MEDICAL STAFF POLICIES

Section 13.1 Medical Staff Responsibility. The Medical Staff shall have the responsibility to formulate, review, adopt, and recommend to the Board the Medical Staff Bylaws and amendments thereto, which shall be effective when approved by the Board. Such responsibility may not be delegated, shall be exercised in good faith and in a reasonable, responsible, and timely manner, and shall incorporate the use of a Medical Staff Bylaws Committee appointed as provided in Article Seven for that purpose. A comprehensive review of the Bylaws and Medical Staff policies will be conducted as often as needed to comply with regulatory and organization changes. Neither the Medical Staff nor the Board of Trustees may unilaterally adopt or amend the Bylaws.

Section 13.2 Methods of Adoption and Amendment of Bylaws.

A. The Medical Executive Committee shall have the power only to adopt such amendments to the Bylaws as are, in the committee's judgment, technical or legal modifications or clarifications; reorganization or renumbering; or amendments needed because of punctuation, spelling, or other errors of grammar or expression. Such amendments shall be effective when approved by the Board of Trustees.

B. Upon the request of the Chief of Staff, the request of the Medical Executive Committee, or upon written petition signed by at least twenty-five percent (25%) of the members of the Active and Courtesy Staff, consideration shall be given to the adoption, amendment, or repeal of these Bylaws. Such action shall be taken at a regular or special meeting of the voting members of the Medical Staff, provided written notice including copies of the proposed change(s) was sent to all voting members of the Staff not less than fourteen (14) days prior to the date of the meeting at which the proposed changes are to be presented, or by electronic or mail ballot using the procedures in Section 8.12.

C. Any proposal for amendment, adoption or repeal of the Bylaws that does not originate with the Medical Executive Committee shall be sent to the Medical Executive Committee for review and comment prior to submission for voting. Any comments of the Medical Executive Committee on the proposal must be included with the ballot.

Section 13.3 Medical Staff Policies. The Medical Staff will maintain a Medical Staff Policy and Procedures Manual with the Medical Staff Policies that set out the procedural details of the processes contained in these Bylaws. This manual will be incorporated by reference and become part of these Medical Staff Bylaws. Policies and procedures regarding appointment, reappointment, credentialing, fair hearing, corrective action, and any other Medical Staff policy the Medical Executive Committee deems appropriate will require Board

approval and shall be effective only on that approval. The Board can also direct that other policies obtain Board approval and those policies are effective when approved by the Board. All other Medical Staff Policies and Procedures will be effective when approved by the Medical Executive Committee or Medical Staff. The Medical Staff Office shall provide notice to the Staff of Medical Staff policies within three (3) days of final approval. In the event of any conflict between a Medical Staff policy and the Bylaws, the Bylaws shall control.

Section 13.4 Method of Adoption and Amendment of Medical Staff Policies.

A. The Medical Executive Committee may amend, adopt or repeal a Medical Staff Policy at any regular or special meeting of the committee on the approval of a majority of the members present and voting. The Medical Staff Office shall notify the members of the Staff of the adoption, amendment or repeal of any Medical Staff Policy. See Article Nine in the event of conflict regarding a Policy approved by Medical Executive Committee.

B. Subject to the procedures below, the Medical Staff may amend, adopt or repeal a Medical Staff Policy at any regular or special Medical Staff meeting. At least thirty (30) days prior to presentation of the proposal at the Staff meeting, a written petition signed by at least twenty-five percent (25%) of the members of the Active and Courtesy Staff must be submitted to the Medical Executive Committee for review and comment. The comments must be presented at the Staff meeting prior to the vote on the proposal.

Section 13.5 Recommendation Resolution. If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee or the Medical Staff directly with regard to the Medical Staff Bylaws or a Medical Staff Policy, the Medical Executive Committee is entitled to meet with the Board Executive Committee. Such meeting shall be for purposes of further communicating the Board's rationale for its contemplated action, and to permit the officers of the Medical Staff to fully articulate the rationale for the Medical Executive Committee's or Medical Staff's recommendation. The Chief Executive Officer will schedule such a meeting within two (2) weeks of the request submitted by the Chief of Staff.

Section 13.6 Conflict with Board Bylaws. The Medical Staff Bylaws and the Medical Staff Policy and Procedure Manual do not conflict with the bylaws of the Board. ADOPTED by the Medical Staff on October 28, 2020.

Signature on File

Chief of Staff, Medical Staff

Signature on File

Chief of Staff Elect, Medical Staff

ADOPTED by the Board of Trustees on November 3, 2020.

Signature on File

Chairman of the Board

Signature on File

Secretary