SWEENY COMMUNITY HOSPITAL

MEDICAL STAFF BYLAWS

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PREAMBLE

These Bylaws are adopted in order to provide for the organization of the Medical Staff of Sweeny Community Hospital and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Directors, and relations with applicants to and members of the Medical Staff.

DEFINITIONS

1. ALLIED HEALTH PROFESSIONAL means an individual health care provider, other than a licensed physician, dentist or podiatrist, who holds a license, certificate or other credentials as required by applicable State or other law and who is granted and may exercise delineated clinical privileges or work within an assigned scope of practice within the area of his/her professional competence. AHPs shall include, but are not limited to, physician assistants, advance practice nurses, clinical psychologists and qualified therapists (e.g., occupational, physical, respiratory).

2. APPLICANT means any Practitioner who has submitted a completed application for initial appointment to the Medical Staff.

3. AUTHORIZED REPRESENTATIVE means the individual designated by the Hospital and approved by the Medical Executive Committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these Bylaws.

4. BOARD OF DIRECTORS means the governing body of Sweeny Hospital District. As appropriate to the context and consistent with the Bylaws of the Hospital and delegations of authority made by the Board of Directors, it may also mean any committee of the Board of Directors or any individual authorized by the Board of Directors to act on its behalf on certain matters.

5. BYLAWS means the Bylaws of the Medical Staff of the Hospital. The Bylaws of the Sweeny Hospital District shall be referred to specifically as such.

6. CHIEF EXECUTIVE OFFICER or CEO means the individual appointed by the Board of Directors as the chief executive officer of the Hospital to manage the affairs of the Hospital. The CEO may, consistent with his or her responsibilities under the Bylaws of the Sweeny Hospital District, designate a representative to perform his or her responsibilities under these Medical Staff Bylaws and related policies.

7. CHIEF OF STAFF means the chief officer of the Medical Staff elected by members of the Medical Staff.

8. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to Medical Staff members to provide patient care and includes unrestricted access to those Hospital resources (including equipment, facilities and Hospital personnel) which are necessary to effectively exercise those privileges.

9. COMPLETE APPLICATION means an application which contains all necessary documentation to verify the applicant's qualifications for Medical Staff membership and/or clinical privileges. In general, this requires that (a) each question on the application has been answered; (b) all verifying information has been received; (c) the applicant has signed the forms; and (d) the applicant has provided all requested information regarding current valid license to practice in the State of Texas, DEA controlled substance registrations, and proof of liability insurance.

10. DENTIST means an individual with a D.D.S. degree or its equivalent who is fully licensed to practice dentistry in the State of Texas.

11. EX OFFICIO means service as a member of a body by virtue of office or position held and, unless otherwise expressly provided, means without voting rights.

12. HOSPITAL means Sweeny Community Hospital located in Sweeny, Texas.

13. INVESTIGATION means a formal, targeted process used when issues related to a specific Practitioner's professional competence or conduct have been identified. An investigation runs from the start of an inquiry until the Board makes a final decision to take action or not further pursue the matter. The Hospital's routine peer review process under which it evaluates, against clearly defined measures, the privilege-specific competence of all Practitioners is not considered an investigation.

14. MEDICAL STAFF or STAFF means those Practitioners who have been appointed and are privileged to attend patients or to provide other diagnostic or therapeutic services at the Hospital pursuant to the terms of these Bylaws.

15. MEDICAL STAFF YEAR means the twelve-month period from January 1st to December 31st of each year.

16. MEMBER means a Practitioner who holds a current appointment to the Medical Staff of Sweeny Community Hospital.

17. PHYSICIAN means an individual with an M.D. or D.O. or equivalent degree who is licensed to practice medicine in the State of Texas.

18. PODIATRIST means an individual with a D.P.M or equivalent degree who is licensed to practice podiatry in the State of Texas.

19. PRACTITIONER means any physician, dentist, oral and maxillofacial surgeon, or podiatrist applying for or exercising clinical privileges or providing other diagnostic or therapeutic services at the Hospital.

20. SUSPENSION means temporary removal from the Medical Staff or temporary loss of clinical privileges from the Hospital.

21. TERMINATION means removal from the Medical Staff and/or loss of clinical privileges.

ARTICLE I
NAME AND PURPOSES

1.1 NAME

The name of this organization is the Medical Staff of Sweeny Community Hospital.

1.2 PURPOSES OF THE MEDICAL STAFF

The Medical Staff is organized under these Bylaws to:

1.2.1 Improve the quality and safety of care for patients in the Hospital and in the communities they serve;

1.2.2 Initiate and maintain Medical Staff Bylaws, Rules and Regulations and Policies and Procedures governing the Medical Staff;

1.2.3 Organize the Medical Staff to credential Practitioners and Allied Health Professionals, recommend clinical privileges based on training and experience, review caregiver performance on a periodic basis, and administer discipline as required to ensure quality and safety of medical care;

1.2.4 Assist the Hospital in obtaining and maintaining licensure by the Texas Department of State Health Services; and

1.2.5 Be accountable to the Board of Directors of the District.

ARTICLE II
MEMBERSHIP

2.1 NATURE OF MEMBERSHIP

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

2.1.1 No physician or practitioner shall admit or provide medical or health-related services to patients in the Hospital unless he or she is a member of the Medical Staff or has been granted temporary privileges in accordance with the procedures set forth in these Bylaws.

2.1.2 Appointment to the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these Bylaws.

2.1.3 By applying for and/or accepting appointment to the Medical Staff, or by applying for, accepting and/or exercising clinical privileges within the Hospital, each Applicant and each Member agrees to abide by the terms and provisions of these Bylaws, the Rules and Regulations of the Medical Staff, any departmental rules, policies and procedures and any other policies and procedures of the Hospital, all as adopted and amended and in effect from time to time.

2.1.4 The Hospital, by contract, by granting or withholding privileges, or otherwise shall not restrict a Practitioner's ability to communicate with a patient with respect to:

2.1.4.1 The patient's coverage under a health plan;

2.1.4.2 Any subject related to the medical care or health services to be provided to the patient, including treatment options that are not provided under a health plan;

2.1.4.3 The availability or desirability of a health care plan or insurance or similar coverage, other than the patient's health care plan; or

2.1.4.4 The fact that the Practitioner's clinical privileges or contract with the Hospital or a health care plan have terminated or that the Practitioner will no longer be providing medical care or health care services at the Hospital or under the health care plan.

2.2 QUALIFICATIONS FOR MEMBERSHIP

Every practitioner who seeks or holds appointment to the Staff must, at the time of application and initial appointment and continuously thereafter, demonstrate to the satisfaction of the appropriate authorities of the Medical Staff and of the Board of Directors the following qualifications and any additional qualifications and procedural requirements as are set forth in other Sections of these Bylaws, Rules and Regulations, or related policies:

2.2.1 Licensure. A currently valid license and permit issued by the State of Texas to practice medicine, dentistry, or podiatry.

2.2.2 DEA Registration. A current and unrestricted DEA registration to dispense controlled substances unless an exception is made by the Medical Staff based on the practitioner's specific professional practice.

2.2.3 Professional Education and Training. Graduate of an approved school of medicine, osteopathy, dentistry or podiatry, or certified by the Educational Council for Foreign Medical Graduates; and, if a physician, satisfactory completion of an approved residency; if a dentist or podiatrist, satisfactory completion of at least one year in an approved postgraduate/residency training program. For purposes of this section, an "approved" school is one fully accredited throughout the period of the practitioner's attendance by the Liaison Committee on Medical Education, by the American Osteopathic Association, by the Commission on Dental Accreditation, or by the Council on Podiatric Medical Education of the American Podiatric Medical Association. An "approved" residency or postgraduate training program is one fully accredited at the time of the practitioner's training by the Accreditation Council for Graduate Medical Education, by the American Osteopathic Association, by the Commission on Dental Accreditation, or by the Council on Podiatric Medical Education of the American Podiatric Medical Association.

2.2.4 Clinical Performance. Current experience, clinical results and utilization practice patterns, documenting a continuing ability to provide patient care services at an acceptable level of quality and efficiency given the current state of the healing arts and consistent with available resources.

2.2.5 Cooperativeness. Demonstrated ability to work with others consistent with the Code of Conduct set forth in these Bylaws.

2.2.6 Satisfaction of Responsibilities. Satisfactory compliance with the basic responsibilities accompanying appointment to the Staff as set forth in Section 2.5 of these Bylaws and equitable participation, as determined by the appropriate Staff and Board of Directors authorities, in the discharge of Staff obligations specific to Staff appointment category.

2.2.7 Professional Ethics and Conduct. Compliance with the code of ethics established by the Member's profession, e.g., for physicians, the American Medical Association's Principles of Medical Ethics.

2.2.8 Disability. To be free of or have under adequate control any significant physical or behavioral impairment that interferes with, or presents a substantial probability of interfering with, the qualifications required by this Section 2.2 such that patient care is or is reasonably likely to be adversely affected.

2.2.9 Professional Liability Insurance. Professional liability insurance of a kind and in an amount consistent with the practitioner's risk classification and satisfactory to the Board of Directors.

2.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership in the Medical Staff merely because that person holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at another health care facility. Medical staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in contracts with a third party which contracts with this Hospital.

2.4 NONDISCRIMINATION

Clinical privileges shall not be granted or denied on the basis of sex, age, race, creed, color, national origin, physical or mental disability not threatening quality of physical care, or on the basis of any other criteria unrelated to the delivery of quality patient care in the Hospital, to professional ability and judgment, to community need, to the reasonable objectives of this institution, or to any requirements set forth in these Bylaws.

2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for the honorary and retired staff, the ongoing responsibilities of each member of the Medical Staff include:

(a) Providing patients with the quality of care meeting the professional standards of the Medical Staff of this Hospital;

(b) Abiding by the Medical Staff Bylaws, rules and regulations, and any applicable policies;

(c) Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership, including committee assignments;

(d) Preparing and completing in timely fashion medical records for all the patients to whom the member provides care in the Hospital;

(e) Abiding by the lawful ethical principles of the Texas Medical Association or member's professional association;

(f) Aiding in any Medical Staff approved educational programs for medical students, interns, resident physicians, resident dentists, staff physicians and dentists, nurses and other personnel;

(g) Working cooperatively with members, nurses, Hospital administration and others so as not to adversely affect patient care;

(h) Making appropriate arrangements for coverage for his or her patients as determined by the Medical Staff;

(i) Refusing to engage in improper inducements for patient referral;

(j) Participating in continuing education programs as determined by the Medical Staff;

(k) Participating in such emergency service coverage or consultation panels as may be determined by the Medical Staff; and

(l) Discharging such other staff obligations as may be lawfully established from time to time by the Medical Staff or Medical Executive Committee.

ARTICLE III
CATEGORIES OF MEMBERSHIP

3.1 CATEGORIES

The categories of the Medical Staff shall include the following: active, associate, affiliate, and honorary. At each time of reappointment, the member's staff category shall be determined.

3.2 ACTIVE STAFF

3.2.1 QUALIFICATIONS

The Active Staff shall consist of members who:

(a) Meet the qualifications for membership set forth in Section 2.2;

(b) Are reachable within thirty (30) minutes by the Hospital when serving as attending physician for any hospitalized patient to provide appropriate continuity of quality care (Physicians whose primary practice consists of pathology or radiology are exempt from this requirement.);

(c) Participate in the rotating call coverage panel for the specialty in which the Member holds clinical privileges. The practitioner on-call will be responsible to accept any unassigned and assigned patients that need to be admitted to the Hospital unless prior arrangements have been made by the primary care physician that he/she will take their own patients that need to be admitted to the Hospital. The Hospital may exempt certain specialties from maintaining a call coverage panel. (Physicians who are 65 years of age or older are exempt from the requirement to participate in call coverage.); and

(d) Are regularly involved in Medical Staff functions such as serving on committees, as determined by the Medical Staff.

3.2.2 PREROGATIVES

Except as otherwise provided, the prerogatives of an Active Staff member shall be to:

(a) Admit patients and exercise such clinical privileges as are granted pursuant to Article V; and

(b) Attend and vote on matters presented at general and special meetings of the Medical Staff and of the committees of which he or she is a member.

3.2.3 RESPONSIBILITIES

An Active Staff Member must, in addition to meeting the basic obligations set forth in Section 2.5, maintain minimum clinical activity to provide a means for assessment of performance at the conclusion of the initial provisional period and at reappointment.

3.3 ASSOCIATE STAFF

3.3.1 QUALIFICATIONS

The Associate Staff shall consist of members who:

(a) Meet the qualifications for membership set forth in Section 2.2;

(b) Provide physician services for the Emergency Department and Hospitalist program; and

(c) Are regularly involved in Medical Staff functions such as serving on committees, as determined by the Medical Staff.

3.3.2 PREROGATIVES

Except as otherwise provided, the prerogatives of an Associate Staff member shall be to:

(a) Admit patients and exercise such clinical privileges as are granted pursuant to Article V; and

(b) Attend and vote on matters presented at committees of which he or she is a member.

3.3.3 RESPONSIBILITIES

An Associate Staff Member must, in addition to meeting the basic obligations set forth in Section 2.5, maintain minimum clinical activity to provide a means for assessment of performance at the conclusion of the initial provisional period and at reappointment.

3.4 AFFILIATE STAFF

3.4.1 QUALIFICATIONS

The Affiliate Staff shall consist of members who:

(a) Meet the qualifications for membership set forth in Section 2.2;

(b) Do not regularly admit or care for (or reasonably anticipate admitting or regularly caring for) not more than twelve (12) patients per year in the Hospital; and

(c) If necessary, are willing and able to come to the Hospital or promptly respond when called to render clinical services within their area of competence.

3.4.2 PREROGATIVES

Except as otherwise provided, an Affiliate Staff member shall be entitled to:

(a) Admit no more than twelve (12) patients to the Hospital per year and exercise such clinical privileges as are granted pursuant to Article V; and

(b) Attend in a non-voting capacity meetings of the Medical Staff, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

3.4.3 LIMITATIONS

Affiliate Staff members who admit or care for more than twelve (12) patients at the Hospital in a year shall, upon review of the Medical Executive Committee, be obligated to seek appointment to the appropriate staff category. Affiliate Staff members shall not be eligible to hold office in the Medical Staff.

3.4.4 RESPONSIBILITIES

An Affiliate Staff Member must, in addition to meeting the basic obligations set forth in Section 2.5, maintain minimum clinical activity to provide a means for assessment of performance at the conclusion of the initial provisional period and at reappointment.

3.5 PROVISIONAL STATUS

3.5.1 TERM

All initial appointments to any category of the Medical Staff shall be provisional for a period of at least one (1) year. A Member shall not be eligible to advance to non-provisional staff

status until the completion of an initial appointment of at least one year. If membership is terminated while the Practitioner is on provisional status, the Practitioner shall have the due process rights accorded by Article VII of these Bylaws.

3.5.2 PREROGATIVES

Members on provisional status shall be entitled to:

(a) Admit patients and exercise clinical privileges, within the restrictions deemed appropriate by the Board of Directors;

(b) Serve on various committees to which they are be appointed; and

(c) Attend meetings of the Medical Staff, including open committee meetings and educational programs.

3.5.3 Limitations

Members on Provisional Status shall not be eligible to:

(a) Hold office in the Medical Staff; or

(b) Vote at Medical Staff meetings and Medical Staff committee meetings except for officer elections and within committees when the right to vote is specified at the time of appointment.

3.5.4 Responsibilities

Members on Provisional Status are required to discharge the same responsibilities as those specified for non-provisional Active, Associate or Affiliate Staff, as appropriate.

3.5.5 OBSERVATION OF PROVISIONAL STAFF MEMBER

Each member on provisional status shall undergo a period of observation by designated monitors. The observation shall be to evaluate the member's (1) proficiency in the exercise of clinical privileges initially granted and (2) overall eligibility for continued staff membership and advancement within staff categories. The Medical Executive Committee shall establish the frequency and format of observation it deems appropriate in order to adequately evaluate the provisional staff member including, but not limited to, assignment of a proctor, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records shall be maintained. The results of the observation shall be communicated by the Medical Executive Committee to the active Staff.

3.5.6 ACTION AT CONCLUSION OF PROVISIONAL STATUS

(a) If the member on provisional status has satisfactorily demonstrated his or her ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued Medical Staff membership, the member shall be eligible for placement in the active, associate, or affiliate staff as appropriate, upon recommendation of Medical Executive Committee; and

(b) In all other cases the Medical Executive Committee shall make its report to the Board of Directors regarding a modification or termination of clinical privileges, or termination of Medical Staff membership.

3.6 HONORARY STAFF

3.6.1 QUALIFICATIONS

The honorary staff shall consist of practitioners who do not actively practice at the Hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to health and medical science, or their previous long-standing service to the Hospital, and who continue to exemplify high standards of professional and ethical conduct.

3.6.2 PREROGATIVES

The honorary staff members are not eligible to admit patients to the Hospital or to exercise clinical privileges in the Hospital, or to vote or hold office in this Medical Staff organization, but they may serve upon committees with or without vote at the discretion of the Medical Executive Committee. They may attend Medical Staff meetings, including open committee meetings and educational programs.

ARTICLE IV
APPOINTMENT AND REAPPOINTMENT

4.1 GENERAL

Except as otherwise specified herein, no person shall exercise clinical privileges in the Hospital unless and until that person applies for and receives appointment to the Medical Staff or is granted temporary, disaster or emergency privileges as set forth in these Bylaws. By applying to the Medical Staff for appointment or reappointment (or, in the case of members of the honorary staff, by accepting an appointment to that category), the applicant acknowledges responsibility to first review these Bylaws and agrees that throughout any period of membership that person will comply with the responsibilities of Medical Staff membership and with the Bylaws and rules and regulations of the Medical Staff as they exist and as they may be modified from time to time. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these Bylaws.

4.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for denial of the applications. This burden may include submission to a medical or psychological examination once an offer of Medical Staff membership has been extended, at the applicant's expense, if deemed appropriate by the Medical Executive Committee who may select the examining physician. In this instance, the offer of Medical Staff membership may be conditioned upon the outcome of the medical or psychological examination in accordance with the facility's non-discrimination policy set forth in Section 2.4.

4.3 SUBMISSION OF APPLICATION

An Applicant for appointment and Medical Staff membership shall submit a complete application to the Hospital.

4.3.1 COMPLETE APPLICATION

The Medical Staff will not act on the application until the CEO or designee determines that all necessary information has been provided and that such application is complete. An application shall become incomplete if the need arises for new, additional or clarifying information or documentation at any time during the appointment process. It is the responsibility of the Applicant to assure that the application remains complete. An incomplete application will not be processed. The CEO or designee shall notify the Applicant in writing if an application is not complete or requested information has not been received within a reasonable time. Failure, without good cause, to respond in a satisfactory manner is deemed a voluntary withdrawal of the application. New applications which remain inactive or incomplete for six (6) months from receipt may be administratively withdrawn. Such administrative withdrawal shall not be deemed an adverse recommendation or action and shall not entitle the Applicant to the right to hearing and appellate review.

4.3.2 MISREPRESENTATION, MISSTATEMENT OR OMISSION

Any substantive misrepresentation or misstatement in or omission from the Member's application, whether intentional or not, may constitute cause for automatic and immediate rejection of the application. The Practitioner will then be entitled to the rights of review as provided in Article 8 of these Bylaws. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatement, or omission, such misrepresentation, misstatement or omission may constitute grounds for corrective action as provided in Article 7 of these Bylaws.

4.4 DURATION OF APPOINTMENT AND REAPPOINTMENT

Initial appointments to the Medical Staff shall be provisional for a period of at least one year. Reappointments shall be for a period of up to two (2) years. Reappointments shall be effective at the beginning of a Medical Staff Year.

4.5 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

4.5.1 APPLICATION FORM

The most current Texas Standardized Credentialing Application form and additional Hospital specific forms will be used to apply for membership and privileges. The form shall require detailed information which shall include, but not be limited to, information concerning:

(a) the applicant's qualifications, including, but not limited to professional training and experience, current licensures and registrations and continuing medical education information;

(b) peer references familiar with the applicant's professional competence and ethical character;

(c) requests for membership categories and clinical privileges;

(d) any medical malpractice action, including a report of outcomes to include final judgements and/or settlements of such action;

(e) any previous successful or currently pending challenges to or voluntary/involuntary relinquishment of licensure or registration, either through state or district licensure, agencies or Drug Enforcement Administration;

(f) voluntary or involuntary termination of membership in the Medical Staff organization of another Hospital;

(g) voluntary or involuntary limitation, reduction or loss of clinical privileges at another Hospital;

(h) physical and mental health status;

(i) physicians will be required to have professional liability in the minimum amounts required by the State of Texas. However, it is recommended that physicians have adequate professional liability limits according to their scope of practice. (minimum coverage - $100,000/$300,000)

Each application for initial appointment to the Medical Staff shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the applicant. When an applicant requests an application form, that person will have access to review a copy of these Bylaws, the Medical

Staff rules and regulations through the Hospital website and shall be given summaries of other applicable policies relating to clinical practice in the Hospital, if any.

4.5.2 EFFECTS OF APPLICATION

In addition to the matters set forth in Section 4.1, by applying for appointment to the Medical Staff each applicant:

(a) Signifies the Applicant's willingness to appear for interviews in regard to the application;

(b) Authorizes Hospital representatives to consult with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications, and performance, and directs such individuals and organizations to candidly provide all such information, whether or not such persons are listed as references by the applicant;

(c) Consents to inspection by Hospital representatives of all records and documents that may be material to an evaluation of the applicant's personal and professional qualifications including but not limited to licensure status, specific training and experience and current competence and the ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

(d) Releases from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the applicant in good faith and without malice to include disclosure of information concerning the applicant's ability, professional ethics, character, physical and mental health, emotional stability, and other qualifications for staff appointment and clinical privileges;

(e) Releases from any liability, to the fullest extent permitted by laws, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;

(f) Consents to the disclosure to other Hospitals, medical associations, licensing boards, and to other similar organizations as required by laws, any information regarding the applicants professional and or ethical standing that the Hospital or Medical Staff may have, and releases the Medical Staff and Hospital from liability for so doing to the fullest extent permitted by law;

(g) If a requirement then exists for Medical Staff dues, acknowledges responsibility for timely payment;

(h) Pledges to provide for continuous quality care for patients;

(i) Pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing continuous care of his or her patients, seeking consultation whenever necessary, refraining from providing "ghost" surgical or medical services and refraining from delegating patient care responsibilities to non-qualified or inadequately supervised practitioners.

(j) Represents and warrants that all information provided by the applicant is true, correct and complete in all material respects;

(k) Pledges to abide by the Bylaws, rules and regulations and policies of both the Hospital and its Medical Staff.

4.5.3 VERIFICATION OF INFORMATION

The applicant shall deliver a completed application to the Hospital. The Hospital shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. The Hospital's authorized representative shall query the National Practitioner Data Bank regarding the applicant or member and submit any resulting information to the Medical Staff executive committee for inclusion in the applicant's or members credentials file. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain the required information.

4.6 APPOINTMENT PROCESS

4.6.1 MEDICAL EXECUTIVE COMMITTEE ACTION

The Medical Executive Committee, acting as the Credentials Committee, shall review the application and supporting documentation and may conduct a personal interview with the applicant at the chair's or committee's discretion. The committee shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges granted. Within ninety (90) days after the date on which a complete application was submitted (as determined by the CEO or designee), the Medical Executive Committee shall determine whether to recommend to the Board of Directors that the Applicant be appointed to the Medical Staff or rejected for Medical Staff membership or that the application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by probationary conditions. If its recommendation is adverse to the Applicant, the Medical Executive Committee must provide the reasons and basis for its recommendation.

4.6.2 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

(a) Favorable Recommendation. When the recommendation of the Medical Executive Committee is favorable to the applicant, it shall be promptly forwarded, together with supporting documentation, to the Board of Directors.

(b) Adverse Recommendation. When a final recommendation of the Medical Executive Committee is adverse to the applicant, the Board of Directors and the applicant shall be promptly informed by the CEO, who will give written notice by certified mail, return receipt requested, to the applicant. The applicant shall then be entitled to request a hearing as provided in Article VII.

(c) Deferral. When the recommendation of the Medical Executive Committee is to defer the application for further consideration, such action must be followed within thirty (30) days with a subsequent recommendation either for appointment with specified clinical privileges or for denial of appointment.

4.6.3 ACTION ON THE APPLICATION

The Board of Directors may accept or reject the recommendation of the Medical Executive Committee or may refer the matter back to the MEC for further consideration, stating the purpose of such referral and setting a reasonable time limit for making a subsequent recommendation. The Board shall take final action on the application within sixty (60) days of receiving the initial recommendation of the Medical Executive Committee. The following procedures shall apply with respect to action on the application:

(a) If the Medical Executive Committee issues a favorable recommendation and the Board of Directors concurs in that recommendation, the decision of the Board shall be deemed final action.

(b) If the MEC issues a favorable recommendation and the tentative final action of the Board of Directors is unfavorable, the CEO shall give the applicant written notice of the tentative adverse recommendation by certified mail or hand delivery, and the applicant shall be entitled to the procedural rights set forth in Article VII. If the applicant waives his or her procedural rights, the decision of the board shall be deemed final action.

(c) In the event the recommendation of the Medical Executive Committee or any significant part of it is unfavorable to the applicant, the applicant may request a hearing as provided by Article VII.

(1) If the applicant waives his or her right to request a hearing, the recommendations of the Medical Executive Committee shall be forwarded to the Board for final action.

(2) If the applicant requests a hearing following the adverse Medical Executive Committee recommendation or an adverse Board of Directors tentative final action, the Board of Directors shall take final action only after the applicant has exhausted

the administrative process as set forth by Article VII. After exhaustion of the procedures set forth in Article VII, the Board shall make a final decision in writing and specifying the reasons for the action taken.

4.6.4 NOTICE OF FINAL DECISION

(a) The CEO shall, within twenty (20) days of the Board's final decision, give notice of the final decision to the Medical Executive Committee and the Applicant.

(b) A decision and notice to appoint or reappoint shall include, if applicable: (1) the staff category to which the applicant is appointed; (2) the clinical privileges granted; and (3) any special conditions attached to the appointment.

4.6.5 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

An applicant for appointment or reappointment who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of one year. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as the Medical Staff or the Board may require to demonstrate that the basis for the earlier adverse action no longer exists.

4.7 REAPPOINTMENTS AND REQUEST FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

4.7.1. APPLICATION

(a) At least five (5) months prior to the expiration date of the current staff appointment, a reapplication form developed by the Medical Executive Committee shall be mailed or delivered to the member. If an application for reappointment is not received at least four (4) months prior to the expiration date, written notice shall be promptly sent to the applicant advising that the application has not been received. At least three (3) months prior to expiration date, each Medical Staff member shall submit to the Medical Staff office the completed application form for renewal of appointment to the staff for the coming appointment period, and for renewal or modification of clinical privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 4.5.1, as well as other relevant matters. Upon receipt of the application, the information shall be processed as set forth in Section 4.6.

(b) A Medical Staff member who seeks a change in Medical Staff status or modification of clinical privileges may submit such a request in writing to the Medical Executive Committee, except that such application may not be filed within six (6) months of the time a similar request has been denied.

4.7.2 EFFECT OF APPLICATION

The effect of an application for reappointment or modification of staff status or privileges is the same as that set forth in Section 4.5.2. Incomplete applications will be not considered.

4.7.3 STANDARDS AND PROCEDURE FOR REVIEW

When a Member submits the first application for reappointment, and every two years thereafter, or when the member submits a request for modification of staff status or clinical privileges, the member shall be subject to an in-depth review generally following the procedures set forth in Section 4.6.

4.7.4 FAILURE TO FILE REAPPOINTMENT APPLICATION

Failure without good cause to timely file a completed application for reappointment shall result in the automatic suspension of the member's admitting privileges and expiration of other practice privileges and prerogatives at the end of the current staff appointment, unless otherwise extended by the Medical Executive Committee with the approval of the Board of Directors. If the member fails to submit a completed application for reappointment within thirty (30) days past the date it was due, the member shall be deemed to have resigned membership in the Medical Staff. In the event the membership terminates for the reasons set forth in this Section, the procedures set forth in Article VII shall not apply and the member will not have the right to request a hearing.

4.8 LEAVE OF ABSENCE

4.8.1 REASONS FOR LEAVE.

(a) Military Leave. A Medical Staff Member who enters active military service may request military leave of absence for the time period that the Member is on active military service.

(b) Medical Leave. A Medical Staff Member may request a medical leave of absence of up to six (6) months. Upon request by the Member, the Medical Staff may approve a one-time extension of the leave for up to an additional six (6) months. A Member on a medical leave of absence shall submit a medical clearance letter from the Member's attending physician prior to consideration of reinstatement.

(c) Maternity/Paternity Leave. A Medical Staff Member may request a leave of absence for up to six (6) months to care for the Member's child after birth or placement for adoption or foster care.

(d) Sabbatical. A Medical Staff Member may request a sabbatical not to exceed twelve (12) months to pursue further education and training, participate in medical volunteer service efforts, or for other purposes. Upon request by the Member, the Medical Executive

Committee may approve an extension of the leave for up to an additional twelve (12) months.

4.8.2 REQUEST FOR LEAVE

A Member seeking a leave of absence shall submit a written request to the CEO which shall be forwarded to the Medical Executive Committee and Board of Directors for approval. The request must specify the reason and the approximate period of time for the leave.

4.8.3 RESTRICTIONS

While on leave of absence, a Member shall not exercise privileges or be required to fulfill Medical Staff responsibilities.

4.8.4 REINSTATEMENT

A Member on a planned leave of absence of more than ninety (90) days or on an indefinite leave of absence must submit to the CEO at least forty-five (45) days prior to the expiration of the leave of absence a request for reinstatement. The Member must document continuing clinical competence and compliance with all the qualifications and obligations of appointment or reappointment set forth in the Bylaws by updating of the reappointment form. The Medical Executive Committee shall review and approve or deny all requests for reinstatement. Requests for reinstatement shall not be denied or result in denial of renewal of membership if the Member otherwise qualifies for membership. If the absence is for more than twelve (12) months, other than a leave for military service, the Member shall be required to comply with the procedures for initial appointment.

4.9 MEDICAL HISTORY AND PHYSICAL EXAMINATION PRIVILEGES

The privilege to perform medical histories and physical examinations shall be granted to qualified applicants by the Board of Directors. A physical examination and medical history must be done no more than thirty (30) days before or twenty-four (24) hours after an admission for each patient by a physician or other qualified practitioner who has been granted these privileges by the medical staff. The medical history and physical examination shall be placed in the patient's medical record within twenty-four (24) hours after admission. When the medical history and physical examination are completed within the thirty (30) days before admission, an updated examination for any changes in the patient's condition must be completed and documented in the patient's medical record within twenty-four (24) hours after admission.

4.10 USE OF OUTSIDE REVIEWERS

If approved by the Chief of Staff or the CEO, a physician, dentist, or podiatrist who is not a member of the Medical Staff of this Hospital may be used to assist the Medical Staff or the Hospital with the evaluation of a Practitioner for the purpose of appointment, reappointment, credentialing, corrective

action, and granting clinical privileges. Outside review may take place as deemed appropriate by the Chief of Staff or the CEO, including but not limited to the following situations:

1. When there is a lack of internal expertise in that no Medical Staff Member has adequate expertise in the clinical procedure or area under review; and

2. When advisable due to potential conflicts to promote impartiality in peer review.

ARTICLE V
CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

The Board of Directors shall determine the clinical privileges granted to Members in accordance with the application procedure and based upon written criteria established by the Board for the granting of clinical privileges as set forth in these Bylaws. Every Practitioner practicing in this hospital by virtue of Medical Staff membership or otherwise shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to the Practitioner by the Board.

5.2 DELINEATION OF PRIVILEGES IN GENERAL

5.2.1. REQUESTS

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. A request by a member for a modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request.

5.2.2 BASIS OF PRIVILEGES DETERMINATION

Requests for clinical privileges shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, clinical performance, and the documented results of patient care and other quality review and monitoring which the Medical Staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges.

5.3 PROCTORING

5.3.1 GENERAL PROVISIONS

Except as otherwise determined by the Medical Executive Committee, all initial appointees to the Medical Staff and all members granted new clinical privileges shall be subject to a

period of proctoring. Each appointee or recipient of new clinical privileges shall be assigned to the appropriate proctor where performance on an appropriate number of cases as established by the rules and regulations shall be observed by the proctor or the proctor's designee, during the period of proctoring specified in the Medical Staff rules and regulations, to determine suitability to continue to exercise the clinical privileges granted. The member shall remain subject to such proctoring until the Medical Executive Committee has been furnished with a report signed by the proctor to which the member is assigned describing the types and numbers of cases observed and the evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualifications for unsupervised practice in the Hospital, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made.

5.3.2 FAILURE TO OBTAIN CERTIFICATION

If an initial appointee fails to furnish the certification required while on provisional status, or if a member exercising new clinical privileges fails to furnish such certification within the time allowed by the rules and regulations, those specific clinical privileges shall automatically terminate, and the member shall be entitled to a hearing pursuant to Article VII.

5.3.3 MEDICAL STAFF ADVANCEMENT

The failure to obtain certification for any specific clinical privileges shall not, of itself, preclude advancement to non-provisional status. If such advancement is granted absent such certification, continued proctorship on the uncertified procedure shall continue for the specified time period.

5.4. ALLIED HEALTH PROFESSIONALS

Allied health professionals (AHPs) include various categories of persons other than Practitioners who:

(a) Are qualified by training, experience and current competence in a health care discipline which the Board of Directors has defined as individuals who may provide services in the Hospital; and

(b) Function under the supervision and sponsorship of a Member of the Medical Staff in good standing.

5.4.1 QUALIFICATIONS OF AHPS

Every AHP who applies for or is providing services in the Hospital must, at the time of initial application and, if approved, continuously thereafter, demonstrate the following qualifications:

(a) Current license, registration, certification or such other credential, if any, as may be required by Texas law for the provision of the services being requested.

(b) Appropriate professional education and training or experience for the services requested.

(c) Current ability, as evidenced by experience and results, to provide services at an acceptable level of quality and efficiency.

(d) Ability to work with others in the hospital setting in a cooperative, professional manner.

(e) High moral character and adherence to generally recognized standards of professional ethics and to all State regulations and conditions applicable to the practice.

(f) Current professional liability insurance coverage in an amount acceptable to the Board of Directors.

5.4.2 PARTICIPATION OF AHPS

An allied health professional may:

(a) Provide such specifically designated patient care services as are granted to him under the supervision and direction of the member of the Medical Staff as specified in the grant of services and consistent with any limitations stated in any applicable Medical Staff or Hospital policies.

(b) Attend, when invited, clinical, scientific and education meetings of the Staff.

(c) Exercise such other prerogatives as the Medical Staff may accord AHPs in general or a specific type of AHP.

5.4.3 OBLIGATIONS OF AHPS

Each allied health professional must:

(a) Provide patients with care at the level of quality and efficiency generally recognized as appropriate at facilities such as the Hospital.

(b) Participate, when requested, in quality review program activities and in discharging such other functions as may be required from time to time.

(c) Refrain from any conduct or acts that are or could be reasonably interpreted as being beyond, or an attempt to exceed, the scope of practice authorized within the Hospital.

(d) Abide by the Medical Staff Bylaws, the Hospital Bylaws, and all other standards, policies and rules of the Medical Staff and the Hospital.

(e) Prepare and complete in timely fashion those portions of patient medical records documenting services provided.

(f) When requested, attend clinical and education meetings of the Staff and any individual conference requested by the Chief of Staff.

5.4.4 APPLICATION PROCEDURE

AHP Applicants shall fill out the appropriate AHP application and delineate all requested clinical privileges. Each AHP Applicant shall be evaluated by the Medical Executive Committee which shall recommend the scope of practice and/or clinical privileges the AHP Applicant shall be permitted to exercise in the Hospital, either in general or on a per case basis. The recommendations of the Medical Executive Committee shall be sent to the Board for final decision. The delineation of an AHP's scope of practice shall be based upon the AHP Applicant's academic and clinical training, experience, judgment and demonstrated competence to provide patient care under the supervision and responsibility of a licensed physician.

5.4.5 ASSIGNMENT; SUPERVISION

An AHP may be individually assigned to work in the Hospital as appropriate to the AHP's professional training. All AHPs must be sponsored by a Member of the Medical Staff in good standing. The Sponsoring Practitioner shall supervise the activities of the AHP in the Hospital and is responsible for assuring that the AHP performs only those activities that the AHP is credentialed to perform. Failure to exercise this responsibility will subject the Sponsoring Practitioner to corrective action.

5.4.6 TERM OF ASSIGNMENT

The initial assignment of an AHP's clinical privileges or scope of practice shall be no more than twelve (12) months. Subsequent reassignments shall be for a period of up to twenty-four (24) months. Review of the AHP, the Sponsoring Practitioner, and the AHP's practice shall be conducted prior to reassignment of the AHP's clinical privileges or scope of practice.

5.4.7 CONDITIONS OF ASSIGNMENT

AHPs shall not be considered members of the Medical Staff, but are credentialed by the Medical Executive Committee to assure appropriate education and experience. AHPs may

only engage in acts within the scope of practice specifically approved by the Board. AHPs are credentialed on the recommendation of the Medical Executive Committee and on the approval of the Board of Directors.

5.4.8 RESPONSIBILITIES OF AHPS

Each Allied Health Professional shall:

(a) Retain appropriate responsibilities within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing services.

(b) Participate as appropriate in quality improvement activities as required by the Medical Staff, and in discharging such other staff functions as required from time to time.

(c) Satisfy the requirements of these Bylaws as it concerns attendance at meetings of committees of which the AHP is a member.

(d) If the AHP provides services to patients in the Hospital, participate in call coverage as assigned by the Hospital.

(e) Exercise such other prerogatives implemented through administrative resolution or written policy and approved by the Medical Executive Committee and the Board.

5.4.9 PROCEDURAL REVIEW AND NOTICE.

(a) Modification or Revocation of Privileges. The privileges of an AHP may be modified or revoked at the discretion of the CEO following consultation with the Chief of Staff. The CEO shall provide the AHP with a written notification of the proposed modification or revocation of privileges stating the proposed effective date of the modification or revocation (if the modification or revocation is not to be effective immediately upon receipt of the notice); the specific reasons for the modification or revocation; and notice of the right to appeal the decision as provided herein, with a summary of the AHP's rights under this section.

(b) Appeal of Decision. The AHP shall have thirty (30) days following receipt of notice of the proposed modification or revocation of privileges to submit a request for appeal of the decision. The request shall be in writing addressed to the CEO.

(c) Review Committee/Review Officer. If the AHP requests an appeal within the thirty (30) day time period, the Chief of Staff shall appoint a Review Officer and/or a Review Committee of one to three members of the Medical Staff to review the modification or revocation of privileges.

(1) The Review Committee may include an AHP with privileges at the Hospital. The Review Committee shall not include any member of the Medical Staff who participated in the initiation, investigation or recommendation to modify or revoke the AHP's privileges.

(2) A Review Officer may or may not be a member of the Medical Staff, but shall be an individual not in direct economic competition with the AHP, and may not have advised the Chief of Staff or the CEO regarding the adverse recommendation or action. A Review Officer may or may not be an attorney at law. When a Review Officer is appointed in addition to a Review Committee, the Review Officer shall act as the presiding officer of the review, provide advice and counsel to the Review Committee, and attend and participate in deliberations, but may not vote.

(d) Notice of Review. The CEO shall give the AHP written notice, by certified mail, return receipt requested, of the place, time and date of the review, which date shall be at least fifteen (15) days after the date of such notice; the notice shall include a list of the members of the Review Committee.

(e) Review.

(1) The Review Committee shall conduct the review in the form of a dialogue and inquiry review format, not as an adversarial hearing.

(2) The Review Committee shall present a written report, including a recommendation regarding the modification or revocation of the AHP's privileges, to the Medical Staff. The Medical Staff shall, within thirty (30) days of the date of the review, forward the Review Committee's report to the Board of Directors along with (1) a recommendation in support of the Review Committee's findings, (2) a statement of disagreement with the Review Committee's findings, or (3) no comment.

(3) The Board of Directors shall review the findings of the Review Committee and the recommendation of the Medical Staff, if any, and shall, within thirty (30) days of the receipt of the report and recommendation, make a final decision regarding the modification or revocation of the AHP's privileges. The AHP shall have no further rights to appeal the Board's decision.

(f) Failure to Appeal. In the event the AHP does not appeal the CEO's decision within the time and in the manner described, the AHP shall be deemed to have waived any right to an appeal and to have accepted the modification or revocation of privileges.

(g) Effect of this Section. This Section does not grant the AHP the right to a hearing under Article VII of these Bylaws and does not affect the at-will employment status of an AHP employed by the Hospital or by a member of the Medical Staff. This section applies only to the modification and revocation of clinical privileges and not to the initial granting or delineation of clinical privileges. This Section does not apply to an automatic suspension pursuant to Section 6.3 of these Bylaws. An AHP whose privileges are terminated pursuant to the termination of the AHP's sponsorship or employment by a member of the Medical Staff is not entitled to the rights of review provided by this section.

(h) Nursing Peer Review. The review process provided for in this Section is not intended to and does not preclude or replace any nursing peer review required for APNs, including CRNAs, under Chapter 303 of the Texas Occupations Code and the applicable regulations of the Board of Nursing.

5.5 TEMPORARY CLINICAL PRIVILEGES

Temporary privileges may be granted in two circumstances: (1) to fulfill an important patient care, treatment, and service need; or (2) when a new applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Executive Committee and the Board.

5.5.1 PATIENT CARE NEED

Temporary clinical privileges may be granted on a case-by-case basis by the CEO or designee, upon recommendation of the Chief of Staff, to fulfill an important patient care need that mandates an immediate authorization to practice for a limited period of time, while the full credentials information is verified and approved. When temporary privileges are granted to meet an important patient care need, the Chief of Staff shall verify the Practitioner's current licensure and current competence. Examples would include, but are not limited to situations where:

(a) A Member becomes ill or takes a leave of absence and a Practitioner would need to cover his/her practice until he/she returns.

(b) A specific Practitioner has the necessary skills to provide care to a patient that no Member currently privileged possesses.

5.5.2 NEW APPLICANTS

When an Applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Executive Committee and the Board, the CEO or designee, upon recommendation of the Chief of Staff, may grant the Applicant temporary privileges for no more than 120 days upon verification of:

(a) Current licensure;

(b) Relevant training or experience;

(c) Current competence;

(d) Ability to perform the privileges requested;

(e) A query and evaluation of National Practitioner Data Bank information;

(f) A complete application;

(g) No current or previously successful challenge to the Applicant's licensure or registration;

(h) Applicant has not been subject to involuntary termination of Medical Staff membership at another organization;

(i) Applicant has not been subject to involuntary limitation, reduction, denial or loss of clinical privileges at another organization; and

(j) Current professional liability insurance coverage in an amount acceptable to the Board of Directors.

5.5.3 Special requirements of supervision and reporting may be imposed on any Practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the CEO or designee with concurrence of the Chief of Staff upon notice of any failure by the Practitioner to comply with such special conditions.

5.5.4 The CEO or designee, with concurrence of the Chief of Staff, may at any time terminate a Practitioner's temporary privileges effective upon discharge from the hospital of the Practitioner's patient(s). However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the Practitioner, the termination may be imposed by any person entitled to impose a summary suspension pursuant to Section 6.3 of these Bylaws and shall be immediately effective. The Chief of Staff shall assign a member of the Medical Staff to assume responsibility for the care of such terminated Practitioner's patient(s) until they are discharged from the hospital. The wishes of the patient(s) shall be considered where feasible in selection of such substitute Practitioner.

5.5.5 The CEO or his/her designee must receive a written request from the Practitioner requesting temporary privileges. The requesting Practitioner will supply the CEO or designee with copies of current curriculum vitae, Drug Enforcement Agency and Texas Department of Public Safety certificates, and Texas medical license certificate prior to privileges being granted.

5.6 EMERGENCY PRIVILEGES

In the case of an emergency, any member of the Medical Staff, to the degree permitted by his or her license and regardless of clinical service, staff status, or clinical privilege, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The member shall make every reasonable effort to communicate promptly with the members of the Medical Executive Committee and CEO concerning the need for emergency care and assistance by members of the Medical Staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to a qualified physician with respect to further care of the patient at the Hospital.

5.7 MODIFICATION OF CLINICAL PRIVILEGES

On its own or pursuant to a request from the Member, the Medical Executive Committee may recommend a change in the clinical privileges of a member subject to monitoring in accordance with procedures similar to those outlined in Section 5.3.1.

5.8 LAPSE OF APPLICATION

If a Medical Staff member requesting a modification of clinical privileges fails to timely furnish the information necessary to evaluate the request, the application shall automatically lapse, and the applicant shall not be entitled to a hearing as set forth in Article VII.

5.9 DISASTER PRIVILEGES

5.9.1 DEFINITION

Disaster Privileges may be granted when the Hospital's Emergency Management Plan has been activated and there is a need for additional licensed health practitioners at Sweeny Community Hospital.

5.9.2 GRANTING OF PRIVILEGES

The Chief of Staff, Chief Executive Officer, or appropriate chief of service or their designee will review and grant temporary disaster privileges on behalf of the Board. The individual granting privileges is not required to grant privileges to any individual and is expected to make such decisions promptly to the extent practicable, on a case-by-case basis at his or her discretion. All licensed independent practitioners requesting temporary disaster privileges are to be referred to the Chief of Staff. Volunteers considered eligible to act as a licensed independent practitioner must at a minimum present a valid government issued photo ID issued by a state or federal agency (driver's license or passport) and at least one of the following before disaster privileges may be granted:

(a) Current license to practice;

(b) A current picture identification card from a health care organization that clearly identifies the practitioner's professional designation;

(c) Primary source verification of licensure;

(d) Identification indicating that the individual is a member of a disaster medical assistance team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group.

(e) Identification indicating that the individual has been granted authority by a government entity to render patient care in disaster circumstances; or

(f) Confirmation by current Medical Staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

5.9.3 ADDITIONAL INFORMATION REQUIRED FROM PRACTITIONER

At the completion of the declared emergency and before the practitioner leaves the disaster area, he/she will be required to give the following additional information for verification purposes:

(a) Primary Hospital Affiliation: The name of the practitioner's primary hospital affiliation shall be ascertained.

(b) Information required by the Hospital to query the National Practitioner Data Bank (Practitioner's name including maiden or previous names used, home and work address, date of birth, Medical School attended and year completed, Texas Medical License number, specialty, DEA number and NPI number).

5.9.4 PRIMARY SOURCE VERIFICATION

Primary source verification of license begins as soon as the immediate situation is under control and is completed within 72 hours from the time the volunteer practitioner presents to the organization. The privileging process will include (1) verification of licensure; (2) verification of current clinical competence; and (3) verification of current professional liability insurance coverage in an amount required by the Board of Directors. In the extraordinary circumstances that primary source verification cannot be completed within 72 hours (e.g. no means of communication or a lack of resources) verification will be done as soon as possible. In these extraordinary circumstances, the following will be documented:

(a) Why primary source verification could not be performed in the required timeframe;

(b) Evidence of a demonstrated ability to continue to provide adequate care, treatment and services; and

(c) An attempt to rectify the situation as soon as possible.

In the event the practitioner does not provide care, treatment, or services under the disaster privileges, primary source verification is not required.

As soon as possible, the persons responsible for verification will also query the National Practitioner Data Bank, state license agency, OIG, and hospital where current privileges are held by the volunteer. Records of the query will be retained.

5.9.5 PRIVILEGE CONTINUATION OR TERMINATION

The Hospital will make a decision within 72 hours related to the continuation of the disaster privileges initially granted. A practitioner's disaster privileges will be immediately terminated in the event that any information received through the verification process indicates any adverse information or suggests the person is not capable of rendering services in an emergency. Any information that is not consistent with that provided by the physician must be referred to the Chief of Staff immediately who will determine any additional necessary action including but not limited to termination of temporary disaster privileges.

5.9.6 MAINTENANCE OF RECORD

Once temporary disaster privileges are granted, a record of the practitioner's actions shall be maintained. The record shall indicate that the practitioner exercising the "disaster privileges" does so at the request of an attending physician currently on Sweeny Community Hospital Medical Staff. Practitioner granted temporary disaster privileges must practice under the direction of an attending physician currently on the Medical Staff at Sweeny Community Hospital.

5.9.7 ID BADGE

The practitioner who is granted disaster privileges will be issued an ID badge identifying them as having temporary disaster privileges through Human Resources.

5.9.8 CONCLUSION OF DECLARED EMERGENCY DISASTER

The practitioner's privileges will be for the period needed during the duration of the disaster only and will automatically terminate at the end of the disaster as determined by the CEO, Chief of Staff, or designee.

5.10 PRIVILEGES FOR PODIATRISTS/DENTISTS/ORAL SURGEONS

5.10.1 All podiatric and dental patients must be admitted by a physician member of the Medical Staff who will be responsible for performing a history and physical of the patient and for management of any medical problem or condition that may exist at the time of the

admission or that might arise during hospitalization that is beyond the scope of practice of the podiatrist, dentist or oral surgeon caring for the patient.

5.10.2 Clinical privileges for podiatrists, dentists, and oral and maxillofacial surgeons shall be granted on a case by case basis in accordance with licensure, education, training, current competence, experience, and other qualifications deemed applicable.

5.11 PRELIMINARY PROCEDURES INVOLVING IMPAIRED MEMBERS

5.11.1 When the Chief of Staff has reason to believe that a Member has a disturbance of physical or mental function which interferes, or its likely to interfere, with the staff Member's capacity to provide care for patients in accordance with the standards set forth in the Medical Staff Bylaws, and Rules and Regulations, the Chief of Staff shall promptly arrange a meeting with the Member to consider the nature of the disturbance of physical or mental function and appropriate remedies, which may include a leave of absence to obtain the necessary medical or psychiatric care, voluntary acceptance of a reduction of clinical privileges, or voluntary resignation from the Medical Staff. The Chief of Staff shall submit a report of such conference to the Medical Executive Committee.

5.11.2 In the event that the Chief of Staff and the Member are not able to reach agreement on an appropriate remedy, the Chief of Staff may either refer the matter to the Medical Executive Committee or appoint a special three (3) Member panel to meet with the individual and review the matter.

5.11.3 Minutes or other records of this conference shall be maintained and every effort shall be made to assure its privacy and confidentiality.

5.11.4 After such conference the panel may, if it concludes that there is reasonable cause to believe that the Member lacks capacity to provide appropriate care to the Hospital's patients, recommend to the Member that he/she apply for a leave of absence in order to seek assistance through existing programs of the Texas Physician Health Program or seek a satisfactory alternative means of assistance.

5.11.5 In the event that the affected Member shall fail to follow the recommendation of the special panel, the Chief of Staff can suspend the clinical privileges of the Member and take other corrective action as provided by these Bylaws.

ARTICLE VI
CORRECTIVE ACTION

6.1 CRITERIA ACTION

6.1.1 CRITERIA FOR INITIATION

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members. When reliable information indicates a member may have exhibited acts, demeanor, or conduct known or reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the Hospital; (2) unethical; (3) contrary to the applicable ethical standards or Bylaws, policies, rules or regulations of the Hospital, or its Board or Medical Staff including but not limited to the Hospital's Performance Improvement, Risk Management and Utilization Review programs; (4) below professional standards; or (5) disruptive to the orderly operation of the Hospital or its Medical Staff to include the inability to work harmoniously with others, a written request may be made by any member of the Medical Staff, Board of Directors of the Hospital or the Hospital CEO for an investigation or action against such member and shall be addressed to the Medical Executive Committee, or may be initiated by the Medical Executive Committee.

6.1.2 INITIATION

A request for an investigation must be in writing, submitted to the Medical Executive Committee, and supported by reference to specific activities or conduct alleged. If the Medical Executive Committee initiates the request, it shall make an appropriate record of the reasons.

6.1.3 INVESTIGATION

If a determination is made to investigate formally the necessity or advisability of corrective action, as a result of an informal investigation or otherwise, the Medical Executive Committee shall investigate the matter. Alternatively, at the discretion of the Chief of Staff, the Chief of Staff may create an ad hoc committee ("Ad Hoc Committee") to investigate the matter.

(a) Investigation by Medical Staff.

(1) The Practitioner or AHP against whom corrective action has been requested shall have an opportunity for an interview with the Medical Executive Committee. At such interview, the Member or AHP shall be informed of the general nature of the investigation and shall be invited to discuss, explain, or refute the charges.

(2) This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply.

(3) A record of the interview shall be made and maintained by the Medical Executive Committee.

(b) Investigation by Ad Hoc Committee. If an Ad Hoc Committee is appointed, the committee shall consist of the Chief of Staff (or his/her designee), and two

Medical Staff members, one appointed by the Chief of Staff and one appointed by the CEO. The Chief of Staff (or his/her designee) shall serve as Chairman. The CEO shall be an ex-officio, non-voting member of the committee. Within thirty (30) days after the receipt of the request for an investigation, the Ad Hoc Committee shall make a report of its investigation to the Medical Executive Committee.

(1) Prior to the making of such report, the Practitioner against whom corrective action has been requested shall have an opportunity for an interview with the Ad Hoc Committee. At such interview, the member shall be informed of the general nature of the investigation and shall be invited to discuss, explain, or refute the charges.

(2) This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto.

(3) A record of such interview shall be made and included in the report to the Medical Executive Committee.

6.1.4 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as practical after the conclusion of the investigation, but in no event later than 30 days after completion of the investigation, the Medical Executive Committee shall take action which may include, without limitation:

(a) determining no corrective action be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the member's file;

(b) deferring action for a reasonable time where circumstances warrant;

(c) issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file;

(d) recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admission, mandatory consultation, proctoring or monitoring;

(e) recommending reduction, modification, suspension or revocation of clinical privileges;

(f) recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;

(g) recommending suspension, revocation or probation of Medical Staff membership;

(h) recommending continuing medical education in the area of concern; and

(i) taking other actions deemed appropriate under the circumstances.

6.1.5 SUBSEQUENT ACTION

(a) If corrective action is recommended by the Medical Executive Committee, that recommendation shall be transmitted to the Board of Directors. If the recommendation would entitle the individual being investigated to request a hearing, the recommendation will be forwarded to the CEO who will notify the member in writing by certified mail, return receipt requested. No final action will be taken by the Board of Directors until after hearings are held as requested or the right to a hearing is deemed to be waived.

(b) So long as the recommendation is supported by substantial evidence the recommendation of the Medical Executive Committee shall be adopted by the board as final action unless the member requests a hearing, in which case the final decision shall be determined as set forth in Article VII.

6.1.6 INITIATION BY BOARD OF DIRECTORS

If the Medical Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Board of Directors may direct the Medical Executive Committee to initiate investigation or disciplinary action, but only after consultation with the Medical Executive Committee. If the Medical Executive Committee fails to take action in response to that direction, the Board of Directors may initiate corrective action, but this corrective action must comply with Articles VI and VII of these Medical Staff Bylaws.

6.2 SUMMARY RESTRICTION OR SUSPENSION

6.2.1 CRITERIA FOR INITIATION

Whenever failure to take immediate action may result in an imminent danger to the health or safety of any individual, the chief of staff, acting as an agent of the Medical Executive Committee, or the Medical Executive Committee may summarily restrict or suspend the Medical Staff membership or clinical privileges of such member. A summary suspension shall become effective immediately, and the CEO shall promptly notify the Member. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the Medical Executive Committee or by the chief of staff, considering where feasible, the wishes of the patient in the choice of a substitute member.

6.2.2 INVESTIGATION

Within not more than seven (7) days of the imposition of a summary suspension, the Medical Executive Committee shall investigate the grounds for the summary suspension and issue a recommendation as to whether corrective action is warranted. The Medical Executive Committee shall not be limited to the examination of any particular event or incident and may review events or incidents occurring within the Hospital or outside the Hospital. Outside consultants and third parties may be utilized. If the summary suspension was imposed within thirty (30) days of a recommendation of the Medical Executive Committee for corrective action following an investigation based on the same or similar grounds as the summary suspension, there shall be no requirement for further investigation by the Medical Executive Committee.

6.2.3 MEC RECOMMENDATION

(a) If the recommendation is favorable to the Member, the summary suspension will terminate immediately, and the CEO will forward the recommendation to the Board. The Member will not be entitled to the procedural rights of review as provided for in Article VII of these Bylaws.

(b) If the recommendation is to terminate the summary suspension but to impose concurrent consultation, direct supervision, or a reduction in clinical privileges, the Member will be notified by certified mail or hand delivery and will be entitled to the procedures provided for in Article VII of these Bylaws and all further procedures shall be conducted in accordance with Article VII. If the procedural rights of review are waived by the Member, the recommendation will be forwarded to the Board.

(c) If the recommendation is to continue the suspension of clinical privileges, the Member will be notified by certified mail or hand delivery and will be entitled to the procedures provided for in Article VII of these Bylaws and all further procedures shall be conducted in accordance with Article VII.

6.2.4 BOARD DECISION

Upon receipt of the recommendation by the Medical Executive Committee, the Board shall review and may investigate the matter as deemed necessary and issue a decision.

(a) If the decision of the Board is adverse to the applicant, the CEO shall notify the applicant of the decision by certified mail or hand delivery, provide the applicant with a copy of the decision, and notify the applicant of the procedural rights of review as provided in Article VII of these Bylaws.

(b) The Board may defer making a decision pending further investigation. In doing so, they must state the reason for such deferral, provide direction, state time limits for further investigation, and identify a time frame for reaching its decision.

(c) Unless rights to procedural review are afforded to the applicant and these rights are exercised by the Member as provided for in Article VII of these Bylaws, the decision of the Board shall be effective as of the date of the decision.

6.3 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the member's privileges or membership shall be automatically suspended or limited as described.

6.3.1 LICENSURE

(a) Revocation and Suspension: Whenever a member's license or other legal credential authorizing practice in this state is revoked or suspended, lost or allowed to lapse, for any reason, Medical Staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.

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

(c) Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

6.3.2 CONTROLLED SUBSTANCES

(a) Revocation or Suspension: Whenever a member's DEA registration is revoked, limited or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

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

6.3.3 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

Failure of a member without good cause to appear and satisfy the requirements of Section 10.5.3 shall be a basis for corrective action.

6.3.4 MEDICAL RECORDS

Members of the Medical Staff are required to complete medical records within such reasonable time as may be prescribed by the Medical Executive Committee. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed, shall be imposed by the CEO or his or her designee, after notice of delinquency for failure to complete medical records within such period. For the purpose of this Section, "related privileges" means scheduling of contractual on-call service for the emergency room, scheduling surgery, assisting in surgery, consulting on Hospital cases, and providing professional services within the Hospital for future patients. Bona fide vacation or illness may constitute an excuse subject to approval by the Medical Executive Committee. Members whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations or as part of their staff on-call responsibilities. The suspension shall continue until lifted by the CEO or his or her designee.

6.3.5 FAILURE TO PAY DUES/ASSESSMENTS

If a Member fails without good cause as determined by the Medical Executive Committee, to pay dues or assessments, as required under Section 12.2, the Member's clinical privileges shall be automatically suspended, and if within two months after written warnings of the delinquency the member does not pay the required dues or assessments, the member's membership shall be automatically terminated.

6.3.6 PROFESSIONAL LIABILITY INSURANCE

If a Member fails to maintain professional liability insurance in the amount required, the Member's clinical privileges shall be automatically suspended, and if within 90 days after written warnings of the delinquency the member does not provide evidence of required professional liability insurance, the member's membership shall be automatically terminated.

6.3.7 MEDICARE/MEDICAID EXCLUSION

If a Practitioner or AHP is excluded from participating in any federal or state health care program, his/her clinical privileges shall be automatically suspended.

6.3.8 REINSTATEMENT

(a) A Practitioner whose license is reinstated after revocation or suspension may seek reappointment by following the procedures for initial appointment as set forth in these Bylaws. When the license is restored after having been restricted, before full clinical privileges are restored, the Medical Executive Committee shall review the matter as discussed in Section 6.1 for corrective action procedures and may

recommend corrective action. If a request for corrective action is made, clinical privileges shall not be restored until resolution of the request for corrective action.

(b) When probation of a Practitioner's medical license is imposed, an automatic suspension of clinical privileges shall be imposed and the Medical Executive Committee shall investigate the matter as discussed in Section 6.1 above as an automatic request for corrective action. Clinical privileges shall not be restored until there has been a resolution of this request for corrective action.

(c) When a controlled substance registration is restored following revocation, suspension, limitation, or probation, before full clinical privileges to prescribe are restored, the Medical Executive Committee shall review the matter as discussed in Section 6.1 for corrective action procedures, and may recommend corrective action. If a request for corrective action is made, clinical privileges shall not be restored until there has been a resolution of the request for corrective action.

(d) An automatic suspension for lack of appropriate professional liability insurance coverage shall terminate when the Practitioner presents the CEO with proof of coverage as required by the Board.

(e) Upon completion of medical records as required in the Rules and Regulations of the Medical Staff, an automatic suspension of admitting and clinical privileges shall terminate. A Practitioner whose staff appointment and clinical privileges have been terminated for repeated failure to comply with medical records completion requirements as provided for in the Bylaws and Rules of the Medical Staff, shall be required to seek initial appointment in accordance with the procedures stated in these Bylaws.

(f) Practitioners having their privileges suspended with an automatic suspension are not entitled to procedural rights of review as provided for in Article VII of these Bylaws unless that action is reportable to the Texas Medical Board and National Practitioner Data Bank.

ARTICLE VII
HEARINGS AND APPELLATE REVIEWS

The appeal rights and procedures set forth in these Bylaws are for the purpose of resolving in an informal manner issues related to competence and professional conduct. Accordingly, the hearing and appellate review procedures set forth in these Bylaws shall only apply to recommendations or actions which (i) adversely affect a practitioner's appointment to or status as a member of the Medical Staff or the exercise of clinical privileges and which are (ii) based on such practitioner's competence or professional conduct.

7.1 GENERAL PROVISIONS

7.1.1 EXHAUSTION OF REMEDIES

If adverse action described in Section 7.2 is taken or recommended, the applicant or member must exhaust the remedies afforded by these Bylaws before resorting to legal action.

7.1.2 APPLICATION OF ARTICLE

For purposes of this Article the term “member” may include “applicant,” as it may be applicable under the circumstances, unless otherwise stated.

7.1.3 TIMELY COMPLETION OF PROCESS

The hearing and appeal process shall be completed within a reasonable time.

7.1.4 FINAL ACTION

Recommended adverse actions described in Section 7.2 shall become final only after the hearing and appellate rights set forth in these Bylaws have either been exhausted or waived.

7.2 GROUNDS FOR HEARING

Any one or more of the following actions related to competence or professional conduct or recommended actions shall be deemed actual or potential adverse action and constitute grounds for a hearing:

(a) denial of Medical Staff membership;

(b) denial of requested advancement in staff membership status, or category;

(c) denial of Medical Staff reappointment;

(d) suspension of staff membership;

(e) revocation of Medical Staff membership;

(f) denial of requested clinical privileges;

(g) involuntary reduction of current clinical privileges;

(h) suspension of clinical privileges;

(i) termination of all clinical privileges; or

(j) involuntary imposition of significant consultation or monitoring requirements (excluding monitoring incidental to provisional status and Section 5.3).

No other recommendations other than enumerated in (a) through (j) of this section shall entitle an individual to request a hearing.

7.3 REQUESTS FOR HEARING

7.3.1 NOTICE OF ACTION OR PROPOSED ACTION

The Chief Executive Officer shall, within fifteen (15) days of receiving written notice of an adverse action or recommended action under Section 7.1, give the practitioner notice thereof via certified mail or hand delivery. The notice shall:

(a) Advise the practitioner of the nature of and reasons for the proposed action and of his right to a hearing upon timely and proper request;

(b) Specify that the practitioner has thirty (30) days after receiving the notice within which to submit a request for a hearing and that the request must satisfy the conditions of this section;

(c) State that failure to request a hearing within that time period and in the proper manner constitutes a waiver of rights to a hearing and to an appellate review on the matter that is the subject of the notice;

(d) State that any higher authority required or permitted under these Bylaws to act on the matter following a waiver is not bound by the adverse action or recommended action that the practitioner has accepted by virtue of the waiver but may take any action, whether more or less severe, it deems warranted by the circumstances;

(e) State that upon receipt of his/her hearing request, the practitioner will be notified of the date, time and place of the hearing; and

(f) Provide a summary of the practitioner's rights in a hearing.

7.3.2 REQUEST FOR HEARING

The member shall have thirty (30) days following receipt of the notice above to request a hearing. The request shall be in writing and delivered to the Chief Executive Officer. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and accepted to recommendation or action involved.

7.3.3 TIME AND PLACE FOR HEARING

Upon receipt of a request for hearing, the Medical Executive Committee shall schedule a hearing and shall give at least thirty (30) days' notice to the member of the time, place, and

date of the hearing. Unless extended by the hearing committee, the date of the commencement of the hearing shall be not less than thirty (30) days nor more than sixty (60) days from the date of receipt of the request by the Medical Executive Committee for a hearing. If the practitioner is under suspension, he or she may request that the hearing be held not later than twenty (20) days after the Chief Executive Officer has received the hearing request. The Chief Executive Officer may grant the practitioner's request after consultation with the Chief of Staff or Chair of the Board of Directors.

7.3.4 NOTICE OF HEARING; LIST OF WITNESSES

Together with the notice stating the place, time, and date of the hearing, the Medical Executive Committee shall provide a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body. The content of this list is subject to update. The notice of hearing shall also contain a concise statement of the practitioner's alleged acts or omissions, a list by number of the specific or representative patient records in question, and/or the other reasons or subject matter forming the basis for the adverse action which is the subject of the hearing.

7.3.5 APPOINTMENT OF HEARING COMMITTEE

(a) By Medical Executive Committee. A hearing occasioned by an adverse MEC recommendation shall be conducted by a hearing committee appointed by the Chief of Staff and composed of no less than three (3) Practitioners. The Chief of Staff shall designate one of the appointees as chair of the committee.

(b) By the Board of Directors. A hearing occasioned by an adverse action of the Board shall be conducted by a hearing committee appointed by the Chair of the Board of Directors and composed of no less than three (3) persons, including a Practitioner. The Board of Directors' Chair shall designate one appointee to serve as chairman of the committee.

(c) Appointment of Hearing Officer. The use of a hearing officer is optional. A hearing officer may or may not be an attorney at law but must be experienced in and recognized for conducting hearings (e.g., arbitration proceedings, employee labor disputes and/or grievance procedures, administrative proceedings, military courts martial or like proceedings, and so on) in an orderly, efficient and non-partisan manner. The hearing officer shall not be any individual who is in direct economic competition with the individual requesting the hearing and shall not act as a prosecuting officer or as an advocate to either side at the hearing.

(1) As Alternative to Hearing Committee. As an alternative to the hearing committee, the Chief of Staff may appoint a Hearing Officer to perform the functions that would otherwise be carried out by the hearing committee, including but not limited to making findings and recommendations. In the event a hearing officer is appointed instead of a

hearing committee, all references in this Article to the "Hearing Committee" will be deemed to refer instead to the Hearing Officer.

(2) As Presiding Officer of Hearing Committee. The Chief of Staff may appoint a Hearing Officer who may be an attorney to act as presiding officer of the Hearing Committee. The Hearing Officer shall not act as an advocate for either side at the hearing and shall not be entitled to vote. The Hearing Officer may participate in the private deliberations of the Hearing Committee and act as legal advisor to the Committee. If no Hearing Officer has been appointed, the Chair of the Hearing Committee shall serve as the presiding officer and shall be entitled to one vote. The presiding officer shall:

a. Allow the participants have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross examination;

b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay;

c. Maintain decorum throughout the hearing;

d. Determine the order of procedure;

e. Rule on all matters of procedure and the admissibility of evidence; and

f. Allow argument by counsel on procedural points outside the presence of the Hearing Committee unless the Committee wishes to be present.

(d) Service on the Hearing Committee. An individual shall not be disqualified from serving on a hearing committee merely because he or she has heard of the case or has knowledge of the facts involved or what he or she supposes the facts to be.

7.3.6 FAILURE TO APPEAR OR PROCEED

Failure without good cause of the member to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

7.3.7 POSTPONEMENTS AND EXTENSIONS

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted by the hearing officer on a showing of good cause, or upon agreement of the parties.

7.4 HEARING PROCEDURE

7.4.1 PREHEARING PROCEDURE

(a) The member and the Medical Executive Committee shall have the right to receive all evidence which will be made available to the Hearing Committee. The Member shall have the right to inspect and copy at its expense any documents or other evidence relevant to the charges which the Hospital or Medical Executive Committee has in its possession or control as soon as practical after receiving the notice of hearing. The member shall, at least ten (10) days prior to the hearing, provide the Medical Executive Committee with a list of witnesses, if any, expected to testify at the hearing on behalf of the practitioner. The Medical Executive Committee shall have the right to inspect and copy at its expense any documents or other evidence relevant to the charges which the member has in his or her possession or control as soon as practical after receiving the request.

(b) The failure by either party to provide access to this information in a timely manner shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable members, other than the member under review.

(c) The hearing officer shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the hearing officer shall consider:

(1) whether the information sought may be introduced to support or defend the charges;

(2) the exculpatory or inculpatory nature of the information sought, if any;

(3) the burden imposed on the party in possession of the information sought, if access is granted; and

(4) any previous requests for access to information submitted or resisted by the parties to the same proceeding.

(d) The member shall be entitled to a reasonable opportunity to question and challenge the impartiality of hearing committee members and the hearing officer. Challenges to the impartiality of any hearing committee member or the hearing officer shall be ruled on by the hearing officer.

(e) It shall be the duty of the member and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the chair of the hearing committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions may be succinctly made at the hearing.

7.4.2 REPRESENTATION

The practitioner may be represented at the hearing by a member of the Medical Staff in good standing, a member of his local professional society, an attorney, or any other person of the practitioner's choice. The Medical Executive Committee or Board, depending on whose recommendation or action prompted the hearing, shall designate a person to support its recommendation or action and in addition may appoint an attorney to represent it.

7.4.3 RECORD OF THE HEARING

A court reporter shall be present to make a record of the hearing proceedings, and the pre-hearing proceedings if deemed appropriate by the hearing officer. The cost of attendance of the court reporter shall be borne by the Hospital, but the cost of preparation of a copy of the transcript, if any, shall be borne by the party requesting it. The hearing committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

7.4.5 RIGHTS OF THE PARTIES

Within reasonable limitations, both sides at the hearing may be represented by counsel or other person of their choice, may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The member may be called by the Medical Executive Committee and examined as if under cross-examination. The parties may also submit a written statement at the close of the hearing. If a witness is unable to attend in person and if both parties agree, the witness may appear by telephone or videoconference.

7.4.6 MISCELLANEOUS RULES

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The hearing committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the hearing committee may request or permit both sides to file written arguments.

7.4.7 BURDENS OF PRESENTING EVIDENCE AND PROOF

(a) At the hearing the Medical Executive Committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The member shall not be obligated to present evidence in response.

(b) An applicant shall bear the burden of persuading the hearing committee, by a preponderance of the evidence, of his/her qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning his/her current qualifications for members and privileges. An applicant shall not be permitted to introduce information requested by the Medical Staff but not produced during the application process unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(c) Except as provided above for applicants, throughout the hearing, the Medical Executive Committee shall bear the burden of persuading the hearing committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.

7.4.8 ADJOURNMENT AND CONCLUSION

After consultation with the chair of the hearing committee, the hearing officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Both the Medical Executive Committee and the member may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

7.5 HEARING COMMITTEE REPORT

Within twenty (20) days after adjournment of the hearing, the hearing committee shall make a written report of its findings and recommendations with such reference to the hearing record and other documentation considered as it deems appropriate. The hearing committee shall forward the report to the body whose adverse recommended action or action occasioned the hearing. The practitioner shall also be given a copy of the report by certified mail or hand delivery.

7.6 ACTION ON HEARING COMMITTEE REPORT

Within thirty (30) days after receiving the hearing committee report, the body whose adverse action or recommended action occasioned the hearing shall consider said report and affirm, modify, or reverse its action or recommended action. It shall transmit the result along with the hearing committee report to the Chief Executive Officer.

7.7 NOTICE OF RESULT

As soon as is reasonably practicable, the Chief Executive Officer shall send a copy of the result to the practitioner by certified mail or hand delivery and to the Chief of Staff.

7.8 EFFECT OF FAVORABLE RESULT

7.8.1 ADOPTED BY THE BOARD

If the Board initiated the action and the Board result under Section 7.6 is favorable to the practitioner, it shall become effective immediately as the Board decision in the matter, unless reversed or modified by the Board of Directors.

7.8.2 ADOPTED BY THE MEC

If the Medical Executive Committee made the recommendation, and the MEC's result is favorable to the practitioner, the Chief Executive Officer shall, as soon as is reasonably practicable, forward it to the Board which may adopt or reject the result in whole or in part, or refer the matter back to the Medical Executive Committee for further reconsideration. Any referral back shall state the reasons, set a time limit within which a subsequent recommendation must be made, and may include a directive for an additional hearing. After receiving a subsequent recommendation and any new evidence, the Board shall take action. Favorable action by the Board shall be effective immediately as the decision of the Board unless reversed or modified by the Board of Directors. If the Board's action is adverse, the practitioner shall be entitled to appellate review.

7.9 EFFECT OF ADVERSE RESULT

If the hearing results in a final adverse recommendation or action, the practitioner shall receive notice of his or her right to request appellate review as provided in Section 7.10 below.

7.10 APPEAL

7.10.1 TIME FOR APPEAL

A practitioner shall have thirty (30) days after receiving notice of an adverse result pursuant to Section 7.9 to file a written request for an appellate review. The request must be in writing and delivered to the Chief Executive Officer by certified mail. A practitioner who fails to request an appellate review within the time and in the manner specified herein shall have waived any right to a review. The waiver has the same force and effect as provided in Section 7.3.2, if applicable.

7.10.2 TIME, PLACE AND NOTICE

The Chief Executive Officer shall deliver a timely and proper request for appellate review to the Chair of the Board. As soon as practicable, said Chair shall schedule an appellate review to commence not less than thirty (30) nor more than sixty (60) days from the date of such notice. If the practitioner is under suspension, he or she may request that the appellate review be held not later than twenty (20) days after the Chief Executive Officer has received the appellate review request. The Chief Executive Officer may grant the practitioner's request after consultation with the Chief of Staff or Chair of the Board. At least thirty (30) days prior to the appellate review, the Chief Executive Officer shall send the practitioner notice of the time, place and date of the review via certified mail or hand delivery. The time for appellate review may be extended by the Board Chair for good cause.

7.10.3 APPELLATE REVIEW BODY

The appellate review may be conducted by the Board as a whole or by a committee thereof appointed by the Chair of the Board. If a committee is appointed, the Chair shall designate one of the members to serve as chairman.

7.10.4 APPEAL PROCEDURE

The proceeding by the review body shall be in the nature of an appellate hearing based upon the record of the hearing before the hearing committee, provided that the review body may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the hearing committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the hearing; or the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, to present a written statement in support of his or her position on appeal and, to personally appear and make oral argument. The review body may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The review body shall present to the Board of Directors its written recommendations as to whether the Board of Directors should affirm, modify, or reverse the hearing committee decision, or remand the matter to the hearing committee for further review and decision.

7.10.5 DECISION

(a) Within fifteen (15) days after adjournment, the appellate review body, on behalf of the Board, shall make its decision, including a statement of the basis of the decision.

(b) The appellate review body may decide:

(1) That the adverse recommendation be affirmed;

(2) That the adverse recommendation be denied;

(3) That the matter be the subject of further hearing or other appropriate procedures within a specified time period; or

(4) That modification of the adverse recommendation be made so that it is no longer unreasonable, arbitrary, capricious, or discriminatory.

(c) If the appellate review body finds that the procedures were substantially complied with and that the adverse recommendation which is the subject of the appeal was not unreasonable, arbitrary, capricious, discriminatory or lacking in basis, it shall affirm the adverse recommendation in its decision.

(d) A majority vote of the members of the appellate review body authorized to vote is required for an adverse decision.

(e) The decision of the appellate review body on behalf of the Board shall be effective upon the date of such decision, unless reversed or modified by the Board as a whole.

(f) A copy of the appellate review body's decision shall be sent to the practitioner by certified mail or hand delivery within five (5) days following its decision.

7.10.6 RIGHT TO ONE HEARING

No member shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.

7.11 EXCEPTIONS TO HEARING RIGHTS

7.11.1 AUTOMATIC SUSPENSION OR REVOCATION

No hearing is required when an automatic suspension or revocation has occurred.

7.11.2 SERVICE FORMATION OR ELIMINATION

A Medical Staff service can be formed or eliminated only following a determination by the Medical Executive Committee of appropriateness of service elimination or formation. The Board of Directors' decision shall uphold the Medical Executive Committee's determination unless the Board of Directors makes specific written findings that the Medical Executive Committee's determination is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.

(a) The Medical Executive Committee shall determine the formation or elimination of service to be appropriate based upon consideration of its effect on

quality of care in the facility and/or community. A determination of appropriateness of formation or elimination of a service must be based upon the preponderance of the evidence, viewing the record as a whole, presented by any and all interested parties, following notice and opportunity for comment.

(b) The Medical Staff member(s) whose privileges may be adversely affected by a Medical Executive Committee's determination of appropriateness of service formation or elimination may request a hearing before the hearing committee. Such a hearing will be governed by the provisions of Article VII, except that

(1) the hearing shall be limited to the following issues:

(a) whether the Medical Executive Committee's determination of appropriateness is supported by the preponderance of the evidence;

(b) whether the Medical Executive Committee followed its requirements for notice and comment on the issue of appropriateness;

(2) all requests for such a hearing will be consolidated.

Should an affected Medical Staff member request a hearing under this subsection, the Medical Executive Committee's recommendation regarding the service elimination or formation will be deferred, pending the outcome of the hearing.

(c) Except as specified in this Section, the termination of privileges pursuant to formation or elimination of a service determined to be appropriate by the Medical Executive Committee shall not be subject to the procedural rights otherwise set forth in Article VII.

7.12 NATIONAL PRACTITIONER DATA BANK REPORTING

7.12.1 ADVERSE ACTIONS

The authorized representative shall report an adverse action to the National Practitioner Data Bank only upon its adoption as a final action and only using the description set forth in the final action as adopted by the Board of Directors. The authorized representative shall report any and all revisions of an adverse action, including, but not limited to, any expiration of the final action consistent with the terms of that final action.

7.12.2 DISPUTE PROCESS

If no hearing was requested, a member who was the subject of an adverse action report may request an informal meeting to dispute the report filed. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report filed is consistent with the final action issued. The meeting shall be attended by the subject of the report, the

chief of staff, and the Hospital's authorized representative, or their respective designee. If a hearing was held, the dispute process shall be deemed to have been completed.

ARTICLE VIII
OFFICERS

8.1 OFFICERS OF THE MEDICAL STAFF

8.1.1 IDENTIFICATION

The officers of the Medical Staff shall be the chief of staff and vice chief of staff.

8.1.2 QUALIFICATIONS

Officers must be members of the active or associate Medical Staff at the time of their nominations and election, and must remain members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

8.1.3 NOMINATIONS

Nominations may be made for any office by any voting member of the Medical Staff. Nominations from the floor will be recognized if the nominee consents.

8.1.4 ELECTIONS

Election of officers shall be held in January each year. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the Medical Executive Committee shall decide the election at its next meeting or a special meeting called for that purpose.

8.1.5 TERM OF ELECTED OFFICE

Each officer shall serve a one year term, commencing on the day following his or her election. Each officer shall serve in each office until the end of that officer's term, or until a successor is elected, unless that officer shall sooner resign or be removed from office.

8.1.6 RECALL OF OFFICERS

Any officer whose election is subject to these Bylaws may be removed from office for valid cause including, but not limited to, gross neglect or serious acts of moral turpitude. Recall of a Medical Staff officer may be initiated by any voting member of the Medical Staff. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds vote of the Medical Staff members eligible to vote at the special meeting.

8.1.7 VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the Medical Staff. Vacancies, other than that of the chief of staff, shall be filled by appointment by the Medical Executive Committee until the next regular election. If there is a vacancy in the office of chief of staff, then the vice chief of staff shall serve out the remaining term. If there is a vacancy in the office of vice chief of staff, that office need not be filled by election, but the Medical Executive Committee shall appoint an interim officer to fill this office until the next regular election, at which time the election shall also include the office of chief of staff.

8.2 DUTIES OF OFFICERS

8.2.1 CHIEF OF STAFF

The chief of staff shall serve as the chief officer of the Medical Staff. The duties of the chief of staff shall include, but not be limited to:

(a) enforcing the Medical Staff Bylaws, rules and regulations, and policies, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;

(b) calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;

(c) serving as chair of the executive committee;

(d) serving as an ex officio member of all other staff committees without vote, unless his or her membership in a particular committee is required by these Bylaws;

(e) interacting with CEO and Board of Directors in all matters of mutual concern within the Hospital;

(f) appointing, in consultation with the Medical Executive Committee, committee members for all standing and special Medical Staff, liaison, or multi-disciplinary committees, except where otherwise provided by these Bylaws and, except where otherwise indicated, designating the chairs of these committees;

(g) representing the views and policies of the Medical Staff to the Board of Directors and to the CEO;

(h) being a spokesperson for the Medical Staff in external professional and public relations;

(i) performing such other functions as may be assigned to the chief of staff by these Bylaws, the Medical Staff, or by the Medical Executive Committee;

(j) serving on liaison committees with the Board of Directors and administration, as well as outside licensing or accreditation agencies.

8.2.2 VICE CHIEF OF STAFF

The vice chief of staff shall assume all duties and authority of the chief of staff in the absence of the chief of staff. The vice chief of staff shall be a member of the Medical Executive Committee and of the joint conference committee, and shall perform such other duties as the chief of staff may assign or as may be delegated by these Bylaws, or by the Medical Executive Committee.

ARTICLE IX
COMMITTEES

9.1 DESIGNATION

Medical staff committees shall include but not be limited to, the Medical Staff meeting as a committee of the whole, meetings of committees established under Article IX, and meetings of special or ad hoc committees created by the MEC (pursuant to this Section). The committees described in this Article shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee to perform specified tasks. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the chief of staff, subject to consultation with and approval by the Medical Executive Committee. Medical staff committees shall be responsible to the Medical Staff.

9.2 GENERAL PROVISIONS

9.2.1 TERMS OF COMMITTEE MEMBERS

Unless otherwise specified, committee members shall be appointed for a term of one year, and shall serve until the end of this period or until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee.

9.2.2 REMOVAL

If a member of a committee ceases to be a member in good standing of the Medical Staff, or loses employment or a contract relationship with the Hospital, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed by the Medical Executive Committee.

9.2.3 VACANCIES

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided however, that if an individual who obtains membership by virtue of these Bylaws is removed for cause, a successor may be selected by the Medical Executive Committee.

9.3 MEDICAL EXECUTIVE COMMITTEE

9.3.1 COMPOSITION

The Medical Executive Committee shall consist of the following persons:

(a) the officers of the Medical Staff;

(b) the Chief Executive Officer serving in an ex officio capacity; and

(c) one or more additional Active or Associate Staff members appointed by the Medical Staff.

At least fifty percent (50%) of the Medical Executive Committee members shall be members of the Active Staff in a primary care specialty (e.g., family medicine, obstetrics/gynecology, etc.).

9.3.2 DUTIES

The duties of the Medical Executive Committee shall include, but not be limited to:

(a) representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;

(b) coordinating and implementing the professional and organizational activities and policies of the Medical Staff;

(c) receiving and acting upon reports and recommendations from Medical Staff committees, and assigned activity groups;

(d) recommending actions to the Medical Staff on matters of a medical-administrative nature; the structure of the Medical Staff, the mechanism to review credentials and delineate individual clinical privileges, the organization of quality assurance activities and mechanisms of the Medical Staff, termination of Medical Staff membership and fair hearing procedures, as well as other matters relevant to the operation of an organized Medical Staff;

(e) participating in the development of all Medical Staff and Hospital policy, practice and planning;

(f) reviewing the qualifications, credentials, performance and professional competence, and character of applicants and staff members, and making recommendations to the Medical Staff regarding staff appointments and reappointments, assignments of clinical privileges, and corrective action;

(g) taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of and participation in Medical Staff corrective or review measures when warranted;

(h) taking reasonable steps to develop continuing education activities and programs for the Medical Staff;

(i) designating such committees as may be appropriate or necessary in the rules and regulations to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the chief of staff;

(j) reporting to the Medical Staff at the annual meeting or any called meetings;

(k) assisting in the obtaining and maintenance of accreditation;

(l) appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff;

(m) reviewing and approving the designation of the Hospital's authorized representative for National Practitioner Data Bank purposes;

(n) acting as the Credentials Committee in conducting the following:

> (1) review and evaluate the qualifications of each practitioner applying for initial appointment, reappointment, or modification of clinical privileges, and, in connection therewith, obtain and consider recommendations from appropriate sources;
>
> (2) submit required reports and information on the qualifications of each practitioner applying for membership or particular clinical privileges including recommendations with respect to appointment, membership category, clinical privileges, and special conditions;
>
> (3) investigate, review and report on matters referred by the chief of staff or by any members of the Medical Staff regarding the qual¬ifications, conduct, professional character or competence of any applicant or Medical Staff members; and
>
> (4) submit periodic reports to the Medical Staff on its activities and the status of pending applications.

9.3.3 MEETINGS

The Medical Executive Committee shall meet as often as necessary but at least every other month. The MEC shall maintain a record of its proceedings and actions.

9.4 JOINT CONFERENCE COMMITTEE

9.4.1 COMPOSITION

The joint conference committee shall be composed of the executive committee members of the Board of Directors and of the Medical Executive Committee. The CEO shall be a non-voting ex-officio member.

9.4.2 DUTIES

The joint conference committee shall constitute a forum for the discussion of matters of Hospital and Medical Staff policy, practice, and planning, and a forum for interaction between the Board of Directors and the Medical Staff on such matters as may be referred by the Medical Executive Committee of the Board of Directors.

9.4.3 MEETINGS

The joint conference committee shall meet at least semi-annually, and shall transmit written reports of its activities to the Medical Staff and to the Board of Directors.

9.5 OTHER COMMITTEES

Other committees shall be established in the rules and regulations to carry out other duties and responsibilities of the Medical Staff.

ARTICLE X
MEETINGS

10.1 MEETINGS

10.1.1 ANNUAL MEETING

There shall be an annual meeting held during the month designated by the rules and regulations. The meeting will be held for the following purposes:

(a) election of officers;

(b) committee appointments;

(c) assign disaster appointments;

(d) address other issues of concern.

10.1.2 REGULAR MEETINGS

Regular meetings of the members shall be held as designated in the rules and regulations. The date, place and time of the regular meetings shall be determined by the executive committee, and adequate notice shall be given to the members.

10.1.3 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the chief of staff or the Medical Executive Committee, or shall be called upon the written request of a member of the active Medical Staff. The meeting shall be scheduled by the Medical Executive Committee within 15 days after receipt of such request. Notice shall be mailed or delivered to the members of the staff which includes the time, place and purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

10.2 QUORUM FOR STAFF MEETING

The presence of 50% of the total members of the active Medical Staff at any regular or special meeting in person or through written ballot shall constitute a quorum for all actions.

10.3 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these Bylaws. Committee action may be conducted by telephone conference which shall be deemed to constitute a meeting for the matters discussed in that telephone conference.

10.4 MINUTES

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters. A copy of the minutes shall be signed by the presiding officer of the meeting and forwarded to the executive committee.

10.5 ATTENDANCE REQUIREMENTS

10.5.1 REGULAR ATTENDANCE

Except as stated below, each member of the active staff, including members on provisional status, shall be required to attend:

(a) at least 50% of all general staff meetings duly convened pursuant to these Bylaws, rules and regulations; and

(b) at least 75% of all meetings of each committee of which he or she is a member.

Each member of the Affiliate Staff shall be required to attend such meetings as may be determined by the Medical Executive Committee.

10.5.2 ABSENCE FROM MEETINGS

Failure to meet the attendance requirements may be grounds for removal from such committee or for corrective action as determined by the Medical Executive Committee.

10.5.3 SPECIAL ATTENDANCE

At the discretion of the chair or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a member to appear at any meeting with respect to which he or she was given such notice, unless excused by the Medical Executive Committee upon a showing of good cause, may be a basis for corrective action.

10.6 EXECUTIVE SESSION

Executive session is a meeting of a Medical Staff committee which only voting Medical Staff committee members may attend, unless others are expressly requested by the committee to attend. Executive session may be called by the presiding officer at the request of any Medical Staff committee member, and shall be called by the presiding officer pursuant to a duly adopted motion. Executive session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring confidentiality.

ARTICLE XI
CONFIDENTIALITY, IMMUNITY AND RELEASES

11.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising clinical privileges within this Hospital, an applicant:

(a) authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;

(b) authorizes persons and organizations to provide information concerning such practitioner to the Medical Staff;

(c) agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the Hospital who acts in accordance with the provisions of this Article; and

(d) acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of clinical privileges at this Hospital.

11.2 CONFIDENTIALITY OF INFORMATION

11.2.1 GENERAL

Records and proceedings of all Medical Staff committees having the responsibility of evaluation and improvement of quality of care rendered in this Hospital, including, but not limited to, meetings of the Medical Staff meeting as a committee of the whole, meetings of committees established under Article IX and rules and regulations, and meetings of special or ad hoc committees created by the MEC (pursuant to Section 9.1) and including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential.

11.2.2 BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff committees, except in conjunction with other Hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

11.3 IMMUNITY FROM LIABILITY

11.3.1 FOR ACTION TAKEN

Each representative of the Medical Staff and Hospital shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief for any

action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or Hospital.

11.3.2 FOR PROVIDING INFORMATION

Each representative of the Medical Staff and Hospital and all third parties shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the Medical Staff or Hospital concerning such person who is, or has been, an applicant to or member of the staff or who did, or does, exercise clinical privileges or provide services at this Hospital.

11.4 ACTIVITIES AND INFORMATION COVERED

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

(a) application for appointment, reappointment, or clinical privileges;

(b) corrective action;

(c) hearings and appellate reviews;

(d) utilization reviews;

(e) other committee or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

(f) National Practitioner Data Bank queries and reports, peer review organizations, Texas Medical Board and similar reports.

11.5 RELEASES

Each applicant or member shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such release shall not be deemed a prerequisite to the effectiveness of this Article.

ARTICLE XII
GENERAL PROVISIONS

12.1 RULES AND REGULATIONS

The Medical Staff shall initiate and adopt such rules and regulations as it may deem necessary for the proper conduct of its work and shall periodically review and revise its rules and regulations to comply with current Medical Staff practice. Recommended changes to the rules and regulations shall

be submitted to the Medical Executive Committee for review and evaluation prior to presentation for consideration by the Medical Staff as a whole under such review or approval mechanism as the Medical Staff shall establish. Following adoption such rules and regulations shall become effective following approval of the Board of Directors, which approval shall not be withheld unreasonably. Applicants and members of the Medical Staff shall be governed by such rules and regulations as are properly initiated and adopted. If there is a conflict between the Bylaws and the rules and regulations, the Bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff rules and regulations.

12.2 DUES OR ASSESSMENTS

The Medical Executive Committee shall have power to recommend the amount of annual dues or assessments, if any, for each category of Medical Staff membership, subject to the approval of the Medical Staff, and to determine the manner of expenditure of such funds received.

12.3 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings of these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws. These Bylaws apply with equal force to both sexes wherever either term is used.

12.4 AUTHORITY TO ACT

Any member or members who act in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee may deem appropriate.

12.5 DIVISION OF FEES

Any division of fees by members of the Medical Staff is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff.

12.6 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests required or permitted to be mailed shall be in writing, properly sealed, and shall be sent through United States Postal Service, first-class postage prepaid. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained.

Mailed notices to a member, applicant or other party, shall be to the addressee at the address as it last appears in the official records of the Medical Staff or the Hospital.

12.7 DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff offices, committee chairships, or the Medical Executive Committee shall, at least 20 days prior to the date of election or appointment,

disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

12.8 NOMINATION OF MEDICAL STAFF REPRESENTATIVES

Candidates for positions as Medical Staff representatives to local, state, and national Hospital Medical Staff sections should be filled by such selection process as the Medical Staff may determine. Appointment of such positions shall be made by the Medical Staff executive committee.

12.9 MEDICAL STAFF CREDENTIALS FILES

12.9.1 INSERTION OF ADVERSE INFORMATION

The following applies to actions relating to requests for insertion of adverse information into the Medical Staff member's credentials file:

(a) As stated previously, in Section 6.1.1, any person may provide information to the Medical Staff about the conduct, performance, or competence of its members.

(b) When a request is made for insertion of adverse information into the Medical Staff member=s credentials file, the MEC shall review such a request.

(c) After such a review a decision will be made to:

(1) not insert the information;

(2) notify the member of the adverse information by a written summary and offer him/her the opportunity to rebut this assertion before it is entered into his/her file; or

(3) insert the information along with a notation that a request has been made for an investigation as outlined in Section 6.1.2 of these Bylaws.

12.9.2 REVIEW OF ADVERSE INFORMATION AT THE TIME OF REAPPRAISAL AND REAPPOINTMENT

The following applies to the review of adverse information in the Medical Staff member's credentials file at the time of reappraisal and reappointment.

(a) Prior to recommendation on reappointment, the Medical Executive Committee, as part of its reappraisal function, shall review any adverse information in the credentials file pertaining to a member.

(b) Following this review, the MEC shall determine whether documentation in the file warrants further action.

(c) No later than 60 days following final action on reappointment, the MEC shall, except as provided in (e):

(1) initiate a request for corrective action, based on such adverse information, or

(2) cause the substance of such adverse information to be summarized and disclosed to the member.

(d) The member shall have the right to respond thereto in writing, and the MEC may elect to remove such adverse information on the basis of such response.

(e) In the event that adverse information is not utilized as the basis for a request for corrective action, or disclosed to the member as provided herein, it shall be removed from the file and discarded, unless the MEC, by a majority vote, determines that such information is required for continuing evaluation of the member's:

(1) competence, or

(2) professional performance.

12.9.3 CONFIDENTIALITY

The following applies to records of the Medical Staff and its committees responsible for the evaluation and improvement of patient care:

(a) The records of the Medical Staff and its committees responsible for the evaluation and improvement of the quality of patient care rendered in the Hospital shall be maintained as confidential.

(b) Access to such records shall be limited to duly appointed officers and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.

(c) Information which is disclosed to the governing body of the Hospital or its appointed representatives -- in order that the governing body may discharge its lawful obligations and responsibilities -- shall be maintained by that body as confidential.

(d) Information contained in the credentials file of any member may be disclosed with the members consent, or to any Medical Staff or professional licensing board, or as required by law. However, any disclosure outside of the Medical Staff shall require the authorization of the MEC and notice to the member.

(e) A Medical Staff member shall be granted access to his/her own credentials file, subject to the following provisions:

(1) timely notice of such shall be made by the member to the chief of staff or his/her designee;

(2) the member may review, and receive a copy of, only those documents provided by or addressed personally to the member. A summary of all other information -- including peer review committee findings, letters of reference, proctoring reports, complaints, etc. -- shall be provided to the member, in writing, by the designated officer of the Medical Staff, within a reasonable period of time, as determined by the Medical Staff. Such summary shall disclose the substance, but not the source, of the information summarized;

(3) the review by the member shall take place in the Medical Staff office, during normal work hours, with an officer or designee of the Medical Staff present.

12.10 MEDICAL EXECUTIVE COMMITTEE ROLE IN EXCLUSIVE CONTRACTING

The Medical Executive Committee shall review and make recommendations to the Board of Directors regarding quality of care issues related to exclusive arrangements for physician and/or professional services, prior to any decision being made, in the following situations:

(a) the decision to execute an exclusive contract in a previously open service;

(b) the decision to renew or modify an exclusive contract in a particular service;

(c) the decision to terminate an exclusive contract in a particular service.

ARTICLE XIII
ADOPTION AND AMENDMENT OF BYLAWS

13.1 PROCEDURE

Consideration shall be given to the adoption, amendment, or repeal of these Bylaws upon the request of:

(1) the Medical Executive Committee, or the chief of staff or the Bylaws committee after approval by the MEC, or

(2) upon written request signed by a member of the Medical Staff in good standing who is entitled to vote.

Such action shall be taken at a regular or special meeting provided:

(1) Written notice of the proposed change was sent to all members before the meeting of the Medical Staff. Written notice may be provided by mail or electronic mail;; and

(2) Notice of the next regular or special meeting at which action is to be taken included notice that a bylaw change would be considered. The text of the proposed amendments shall be made available in at least one of the following formats at the discretion of the Hospital: (1) paper copy; (2) electronic mail, CD-ROM, or other available electronic or digital format; or (3) posting on a password-protected internet or intranet site accessible by all Medical Staff Members.

13.2 ACTION ON BYLAW CHANGE

If a quorum is present for the purpose of enacting a bylaw change, the change shall require an affirmative vote of 51% of the members voting in person or by written ballot.

13.3 APPROVAL

Bylaw changes adopted by the Medical Staff shall become effective following approval of the Board of Directors, which approval shall not be withheld unreasonably, or automatically within 60 days if no action is taken by the Board of Directors. If approval is withheld, the reasons for doing so shall be specified by the Board of Directors in writing, and shall be forwarded to the chief of staff, the medical executive and Bylaws committees.

13.4 EXCLUSIVITY

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws.

13.5 SUCCESSOR IN INTEREST

These Bylaws, and privileges of individual members of the Medical Staff accorded under these Bylaws, will be binding upon the Medical Staff, and the Board of Directors of any successor in interest in this Hospital, except where Hospital Medical Staffs are being combined.

13.6 SEVERABILITY

In the event that any clause or paragraph of these Bylaws or the Rules and Regulations is contrary to the laws or the applicable regulations, its invalidity shall not affect any other clause or section of these Bylaws, Rules and Regulations.