BYLAWS
OF THE MEDICAL STAFF
OF
BAYLOR MEDICAL CENTER AT GARLAND

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PREAMBLE

In recognition of the desire of the Medical Staff, Administration, and Board of Trustees of Baylor Medical Center at Garland to strive for high ideals of humanitarian service to the community through the provision of quality health care, education and research and in recognition of the need for a Medical Staff organization that can respond effectively to changing conditions in executing its responsibilities subject to the ultimate authority of the Board of Trustees of Baylor Medical Center at Garland, the Medical Staff of Baylor Medical Center at Garland hereby formulates these Bylaws, subject to the approval of the Board of Trustees of Baylor Medical Center at Garland.

DEFINITIONS

The words and phrases herein have the following meanings whenever used in these Bylaws, unless the context requires otherwise.

Administration refers to the President, the President's designee, Chief Executive Officer (CEO) or the CEO's designee, who is responsible for managing the day-to-day operations of the Hospital.

Adverse Action means a professional review activity resulting in the denial of Medical Staff membership, restriction, reduction, suspension or revocation of Medical Staff membership or the member's ability to exercise clinical privileges at the Hospital.

Appointment and Reappointment refers to the process specified herein by which a Practitioner acquires and retains Medical Staff membership and delineated clinical privileges.

Board of Trustees means the governing body of Baylor Medical Center at Garland.

Bylaws means the Medical Staff Bylaws of Baylor Medical Center at Garland.

Chief Executive Officer (CEO) means the individual designated by the Board of Trustees to manage the performance of Baylor Medical Center at Garland.

Chief of the Department, Department Chief, Chair of the Department or Department Chair means the head of a clinical department.

Clinical privileges means the permission granted to a physician, podiatrist or dentist as recommended by the Medical Staff and approved by the Board of Trustees to provide specific professional, diagnostic, therapeutic, medical, dental, or surgical services and procedures at the Hospital.

Day means calendar day.

Dentist means any Medical Staff member who is licensed to practice dentistry in the State of Texas by the state licensing authority.

Department or department means a division of the Medical Staff composed of members who practice a similar specialty.

Ex Officio means one who serves as a resource person by virtue of an office or position held, but

without voting privileges.

He or His as used in these Bylaws refers to both genders. The use of a masculine pronoun is not intended to express an opinion about the gender of the Practitioners governed by these Bylaws.

Hospital means Baylor Medical Center at Garland located in Garland, Texas.

Medical Staff Member or member means, unless otherwise stated, a fully licensed Practitioner who is appointed by the Board of Trustees as a member of the Medical Staff of Hospital.

Physician means any Medical Staff member licensed to practice medicine in the State of Texas by the state licensing authority.

Podiatrist means any Medical Staff member who is licensed to practice podiatry in the State of Texas by the state licensing authority.

Practitioner means any individual who is a graduate of an approved medical, dental or podiatry school and holds a current, valid license to practice medicine, podiatry or dentistry in the State of Texas.

President means the individual designated by the Board of Trustees to manage the performance of Baylor Medical Center at Garland.

Professional review action pertains to any good faith activity by a professional review body duly authorized by these Bylaws, in the furtherance of quality health care, which is taken based on the competence or professional conduct of a Practitioner that affects or may affect the Practitioner's Medical Staff membership or clinical privileges.

Professional review activity means activities undertaken in determining whether a Practitioner may be appointed and/or be granted clinical privileges in this Hospital, determining the scope or conditions of such clinical privileges or membership, or changing or modifying such clinical privileges or membership.

Professional review body means this Hospital and the Board of Trustees or any committee of the Hospital, which conducts professional review activities, and includes any committee of the Medical Staff when assisting the Board of Trustees in a professional review activity.

Rules and Regulations mean the Medical Staff Rules and Regulations of Baylor Medical Center at Garland.

Year means twelve (12) consecutive months.

Article I APPOINTMENT AND REAPPOINTMENT

1.1 General

Except as otherwise specified herein, no Practitioner (including those engaged by the Hospital in administrative positions) shall exercise clinical privileges in the Hospital unless and until the Practitioner applies for and receives appointment to the Medical Staff in accordance with these Bylaws. Appointment to the Medical Staff shall confer on the Practitioner only such clinical privileges as have been granted in accordance with these Bylaws.

1.2 Burden of Producing Information

Any application for appointment or reappointment, change in category, or change in clinical privileges shall be deemed complete only when the Hospital and Medical Staff, including any committees, have received all information required to be produced or otherwise requested from the Practitioner. The Practitioner has the burden of timely producing all information supporting the Practitioner's qualifications and suitability for the clinical privileges and Medical Staff category requested, and resolving any doubts about these matters. The Practitioner's failure to sustain this burden within the time frame specified by the Medical Staff Services office, Credentials Committee or Medical Executive Committee (MEC) shall result in the immediate withdrawal of the application without further processing or consideration.

Submitting any false information on the application for appointment or reappointment for Medical Staff membership and privileges may result in the immediate withdrawal of the application without further processing or consideration, and may thereafter disqualify the Practitioner from Medical Staff membership or reapplication at any time in the future. Submitting false information includes the omission of material true information or submission of untrue information.

1.3 Appointment Authority

The Board of Trustees retains the ultimate authority in deciding all Medical Staff appointments and reappointments based on the recommendations of the MEC and other committees involved in credentialing and privileging.

1.4 Term of Appointment

Appointment or reappointment to the Medical Staff shall be for any period of time up to two (2) years as determined by the Board of Trustees.

1.5 Application for Initial Appointment

The Practitioner shall receive an application packet with instructions for completing the application, notification of supporting documents needed, and copies of these Bylaws, Rules and Regulations and other applicable policies of the Medical Staff relating to clinical practice in the Hospital. The Practitioner shall submit a completed and signed application on the prescribed form (or accompanied by an explanation of why answers are unavailable) with a non-refundable application fee as specified by the Hospital.

1.5-1 Minimum Eligibility Criteria

(a) Each Practitioner must provide evidence that the Practitioner meets the following minimum eligibility criteria.

(1) Physician. A Practitioner seeking physician membership to the Medical Staff shall be a graduate of a medical school that was approved by a nationally or internationally recognized and accredited body at the time such degree was issued. The Practitioner shall be in the process of applying for or hold a current valid and unrestricted license to practice medicine in the State of Texas, which license has never been suspended for more than 30 days or revoked by a licensing agency of any state. At the time of the initial application, the Practitioner shall:

(A) Have satisfactorily completed a residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA),

AND

(B) Be either (i) a certified diplomate of a Member Board of the American Board of Medical Specialties (ABMS), the Bureau of Osteopathic Specialists (BOS) or any other specialty board recognized and accepted by JCAHO; or (ii) a registered active candidate with a Member Board of ABMS, BOS or any other specialty board recognized and accepted by JCAHO and currently in good standing in the process toward certification.

Section 1.5-1(a)(1)(B) shall not apply to a Member of the Hospital's active staff who has been continuously in good standing since before January 1, 2000.

(2) Dentist. A Practitioner seeking dental membership to the Medical Staff shall be a graduate of a dental school that was approved by a nationally or internationally recognized and accredited body at the time such degree was issued. The Practitioner shall be in the process of applying for or hold a current valid and unrestricted license to practice dentistry in the State of Texas, which license has never been suspended for more than 30 days or revoked by a licensing agency of any state. At the time of the initial application, the Practitioner shall:

(A) Have satisfactorily completed a residency program accredited by the Commission on Dental Accreditation of the American Dental Association,

AND

(B) Be either (i) a certified diplomate of the American Board of General Dentistry (ABGD), the American Board of Oral and Maxillofacial Surgery (ABOMS), or any other specialty board recognized and accepted by JCAHO; or (ii) a registered active candidate with the ABGD, ABOMS or any other specialty board recognized and accepted by JCAHO and currently in good standing in the process toward certification.

Section 1.5-1(a)(2)(B) shall not apply to a Member of the Hospital's active staff who has been continuously in good standing since before January 1, 2000.

(3) Podiatrist. A Practitioner seeking podiatric membership to the Medical Staff shall hold a DPM degree conferred by a school that was approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association at the time such degree was issued. The Practitioner shall be in the process of applying for or hold a current valid and unrestricted license to practice podiatry in the State of Texas, which license has never been suspended for more than 30 days or

revoked by a licensing agency of any state. At the time of the initial application, the Practitioner shall:

(A) Have satisfactorily completed a residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association,

AND

(B) Be either (i) a certified diplomate of the American Board of Podiatric Surgery (ABPS) or any other specialty board recognized and accepted by JCAHO; or (ii) a registered active candidate with the ABPS or any specialty board recognized and accepted by JCAHO and currently in good standing in the process toward certification.

Section 1.5-1(a)(3)(B) shall not apply to a Member of the Hospital's active staff who has been continuously in good standing since before January 1, 2000.

(4) All Practitioners. Each Practitioner seeking membership in the Medical Staff shall maintain a current valid and unrestricted controlled substances certificate with the Federal Drug Enforcement Administration (DEA) and registration with the Texas Department of Public Safety (DPS), if required for clinical practice, and professional medical liability insurance that is currently in force with a minimum limit of $200,000 per occurrence and $600,000 in the aggregate and that does not exclude from coverage any of the procedures for which the Practitioner is seeking clinical privileges.

(b) One or more of the eligibility requirements in Section 1.5-1(a)(1)(A) or (B), or 1.5-1(a)(2)(A) or (B), or 1.5-1(a)(3)(A) or (B) may be waived by the Board of Trustees when the best interests of the Medical Staff will be served by granting Medical Staff membership to a Practitioner whose ineligibility is due only to these requirements, and who is a leader in the medical specialty in which privileges are requested. The factors to consider in determining a "leader" include exceptional training and experience, previous positions held at clinical or teaching facilities, publications, and special honors and awards. It must be shown that a demonstrated need of the Hospital will not be met reasonably unless one or more of these eligibility requirements is waived. This exception does not apply to the granting of temporary privileges for a limited duration as provided in these Bylaws.

1.5-2 Initial Review of Applications

As a preliminary step, the Credentials Committee and/or its designee, which includes the Medical Staff Services office, shall determine whether the Practitioner satisfies all the minimum eligibility criteria for Medical Staff membership. If the Practitioner fails to meet the minimum eligibility criteria, the Practitioner shall be notified in writing within 30 days of the determination of ineligibility and the reasons for such ineligibility. The application shall be withdrawn immediately due to ineligibility without further processing or consideration. Failure to meet the minimum eligibility criteria does not entitle a Practitioner to the right to a hearing under these Bylaws.

1.5-3 Additional Criteria

In addition to the minimum eligibility criteria, the Practitioner shall disclose the following information as part of the application, each of which serves as a basis for determining suitability of the Practitioner for admission to the Medical Staff:

(a) Any voluntary or involuntary restriction, reduction, suspension, relinquishment, lapse, denial or revocation of the Practitioner's license to practice medicine in any jurisdiction;

(b) Any restriction, reduction, suspension, relinquishment, lapse, denial or revocation of the Practitioner's DEA certificate or DPS registration;

(c) Any voluntary or involuntary restriction, reduction, suspension, relinquishment, lapse, denial or revocation by a health care entity of the Practitioner's (1) Medical Staff membership or (2) clinical privileges at any facility that grants membership and privileges;

(d) Any disciplinary action by a health care entity;

(e) Any denied membership application or renewal, or any disciplinary action taken against the Practitioner, by any medical organization including, but not limited to, Physician-Hospital Organizations (PHOs), Independent Practice Associations (IPAs), etc.;

(f) Any sanctions, exclusions or limitations imposed by the Texas Medical Foundation (TMF) or any other professional review organization;

(g) Any sanctions, exclusions or limitations imposed by any state or federal health care program including Medicare or Medicaid;

(h) Any sanctions, exclusions or limitations imposed by any private health care program, including, but not limited to, private third party insurers, health maintenance organizations (HMOs), PHOs, IPAs, etc.;

(i) Any filing of criminal charges against the Practitioner;

(j) Any professional liability cases filed, currently pending or final judgments or settlements that have been made against, or entered by, the Practitioner;

(k) Requested membership category, department(s), and clinical privileges;

(l) Information confirming health status relevant to possible risk to patient health and safety, and to performing the requested clinical privileges;

(m) List of health care facilities or organizations where the Practitioner currently holds or has at any time held membership and clinical privileges;

(n) Three (3) peer references from individuals practicing in the same professional discipline as the Practitioner and who are familiar with the Practitioner's current professional competence and ethical character. Such references must come from peers who are neither related to nor associated in practice with the Practitioner.

(o) Any periods of time in excess of 30 days, except for voluntary resignation, that the Practitioner has not been in continuous active medical practice or residency; and

(p) Affirmation and evidence that the Practitioner has established or will establish an office within a reasonable distance of the Hospital as required by the Medical Staff Rules and Regulations or by the appropriate clinical Department to allow for a timely response to patient needs and to provide appropriate continuity of care.

1.6 Effect of Application

By applying for appointment to the Medical Staff, each Practitioner:

(a) Agrees to appear for interviews as requested;

(b) Agrees to attend an orientation session for new members if accepted for initial appointment;

(c) Authorizes the Credentials Committee and/or its designee, which includes the Medical Staff Services office, to contact and discuss with individuals and organizations who have been associated with the Practitioner and who may have information bearing on the Practitioner's current competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information in both oral and written forms;

(d) Consents to inspection by the Credentials Committee and/or its designee, which includes the Medical Staff Services office, of records and documents relevant to an evaluation of the Practitioner's qualifications and ability to perform the requested clinical privileges, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

(e) Releases from any liability, to the fullest extent permitted by law, all persons and entities involved in the credentialing process for their acts performed in connection with investigating and evaluating, determining, recommending, and/or deciding on the granting of Medical Staff membership and clinical privileges;

1. (f) Releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the Practitioner, including otherwise confidential information;

2. (g) Agrees to sign the appropriate releases authorizing the applicable specialty board to disclose the Practitioner's specialty board status to the Hospital; and

3. (h) Consents to the disclosure to other hospitals by the Credentials Committee and/or its designee, which includes the Medical Staff Services office, and others involved in the credentialing process at other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the Practitioner's professional or ethical standing that the Hospital, or Medical Staff may have, and releases all those involved in the gathering and release of such information from liability for so doing to the fullest extent permitted by law.

4.

1.7 Procedure for Approval of Application

1.7-1 Review and Verification of Information

The Credentials Committee and/or its designee, which includes the Medical Staff Services office, shall assess whether the Practitioner meets all the qualifications for Medical Staff membership by verifying, to the best of its ability, the accuracy and veracity of the information submitted by the Practitioner, as follows:

(a) Current licensure. Document and verify from primary sources the Practitioner's current licensure

status.

(b) Relevant education, training and experience. Document and verify from primary sources whenever feasible the veracity of the Practitioner's disclosures regarding relevant education, training and experience; query the National Practitioner Data Bank; confirm board certification or registered active candidate status from the applicable specialty board.

(c) Continuing professional competence. Review of at least three (3) written references from individuals in the same professional discipline as the Practitioner and who are knowledgeable about the Practitioner's professional performance within the past two (2) years to attest to and confirm the Practitioner's continuing professional competence and ability to perform the clinical privileges requested. For Practitioners finishing a residency and/or fellowship, or practicing for less than two (2) years, one (1) reference must be from the program director of the residency and/or fellowship program at the institution where the Practitioner received residency and/or fellowship training, and another reference from the Clinical Department Chairman at that same institution. Additional references may include peers who are neither related to nor associated in practice with the Practitioner, but who are personally acquainted with the Practitioner's professional qualifications and current professional competence.

(d) Health status. Confirm absence of any substance abuse or health conditions that may adversely affect the Practitioner's ability to perform the privileges requested from the director of the residency or fellowship program, or by the chief of service or staff at another hospital where the Practitioner has privileges, or by a currently licensed physician designated by the Credentials Committee. Such confirmation may include a physical and/or mental health examination conducted by a health care professional of the Credentials Committee's choosing.

(e) Litigation history. Verification of the existence of any prior or current lawsuits, settlements, or judgments, including malpractice claims.

Following receipt and verification of the foregoing information, the Department Chief in which the Practitioner is requesting clinical privileges, or his designee, acting on behalf of the Credentials Committee shall review the completed application and supporting documentation as described in 1.7-3 below. The Credentials Committee shall have up to four (4) months following receipt of an application to complete the verification and review functions described herein in order to determine whether or not the application is complete. If after four (4) months all necessary information has not been received from the Practitioner or other sources, and all questions regarding the Practitioner or other sources have not been satisfactorily answered, the application shall be deemed incomplete and immediately withdrawn without further processing or consideration. In such event, the Practitioner shall not be entitled to the right to a hearing under these Bylaws.

1.7-2 Hospital Department Needs and Resources

The Hospital may decline to offer particular clinical privileges in connection with appointment, reappointment or otherwise on the basis of:

(a) the Hospital's present inability to provide adequate facilities or support services for the Practitioner and such Practitioner's patients or requirements or limitations in the Hospital's medical staff development plan; or

(b) the existence of a contractual or other arrangement for the provision by Practitioners of

professional services of the type being requested.

A decline to offer clinical privileges under this Section shall not constitute a denial of clinical privileges and shall not entitle the Practitioner to the right to a hearing under these Bylaws.

1.7-3 Department Review

Upon a determination that an application is complete, the application and all supporting documentation will be forwarded to the appropriate Department Chief, acting on behalf of the Credentials Committee, for the purpose of reviewing the application. The appropriate Department Chief may personally or through a designee conduct a personal or telephone interview with the Practitioner. The Department Chief shall evaluate all matters that he deems relevant to arriving at a recommendation regarding clinical privileges. The Department Chief may contact other individuals with personal knowledge of the Practitioner's qualifications. After reviewing all pertinent information (but in no event later than 30 days after receiving the completed application), the Department Chief shall make a written recommendation to the Credentials Committee regarding department appointment and clinical privileges to be granted, if any, along with any special conditions.

1.7-4 Credentials Committee Recommendation

Not later than 90 days after receiving a completed application with recommendation from the Department Chief, the Credentials Committee shall make its recommendation. During such time, the Credentials Committee may interview the Practitioner, seek additional information from the Practitioner and/or request further review or input as it deems appropriate. The time frame for acting upon a completed application shall be extended by the number of days required to obtain such additional information. After reviewing all pertinent information, the Credentials Committee shall make a written recommendation to the MEC regarding department appointment and clinical privileges to be granted, along with any special conditions.

1.7-5 MEC Recommendation

Not later than 30 days after receiving the recommendation from the Credentials Committee, the MEC shall make its recommendation. During such time, the MEC may interview the Practitioner, seek additional information from the Practitioner, and/or request further review or input as it deems appropriate. The time frame for acting upon a completed application shall be extended by the number of days required to obtain such additional information. After reviewing all pertinent information, the MEC shall make a written recommendation to the Board of Trustees regarding department appointment and clinical privileges to be granted, along with any special conditions.

1.7-6 Board of Trustees Action

The Board of Trustees shall approve or deny the application not later than 30 days after receiving the MEC recommendation and in no event later than 60 days after receiving the Credentials Committee recommendation. During such time, the Board of Trustees may request further review or input as it deems appropriate before acting upon the application, as necessary. The Board of Trustees may appoint a subcommittee comprised of the Chairman of the Board or his designee and 1 voting Board member ("Board Subcommittee") to render a decision on behalf of the full Board in the case of (i) expedited processing under Section 1.8-3, or (ii) if the next regularly scheduled Board meeting would

not be held within the time frame specified above.

5. (a) If the action of the Board of Trustees is favorable to the Practitioner, written notice shall be sent to the Practitioner regarding: (1) the Medical Staff category to which the Practitioner is appointed; (2) the Department to which the Practitioner is assigned; (3) the clinical privileges granted; and (4) any special conditions attached to the appointment. Such notice shall be delivered not later than 20 days following the action of the Board of Trustees.

(b) If the action of the Board of Trustees is unfavorable to the Practitioner, written notice shall be sent to the Practitioner not later than 20 days following the action of the Board of Trustees. An unfavorable decision shall constitute a final professional review action if it is based on the Practitioner's clinical competence or professional conduct. In such event, the Practitioner may request a hearing under these Bylaws. The Practitioner shall be ineligible to reapply to the Medical Staff for the specific clinical privileges previously denied for a one (1) year period commencing upon the date of final resolution of the Practitioner's status (i.e. either the date of notice from Board of Trustees if no hearing is requested, or the date of resolution of any hearing or subsequent appeals). Any reapplication after one (1) year shall be processed as a request for an initial appointment.

1.8 Special Provisions

1.8-1 Retired Staff

To be eligible for the retired staff status, the member must have held active-clinical, courtesy, active-community, consulting or administrative Medical Staff membership at the Hospital for ten (10) years or more.

A retired staff member is not eligible to admit patients or to exercise clinical privileges in the Hospital. A retired staff member may, however, attend staff and department meetings and hospital educational meetings. A retired staff member shall not be eligible to vote or to hold office in the Medical Staff organization or to hold office in any departments or committees of which he is a member.

Members in the retired staff status who have provided outstanding and distinguished service to the Medical Staff and the Hospital may be recognized for such service by the additional designation as Honorary Staff.

1.8-2 Contracted Services

Practitioners applying for Medical Staff membership by virtue of a contractual relationship to provide clinical services in the Hospital are not entitled to the automatic granting of Medical Staff membership or clinical privileges by virtue of the contractual relationship. Such Practitioners shall follow the same procedures for requesting membership and clinical privileges as outlined in these Bylaws. Unless the contractual relationship between the Practitioner and the Hospital, or the Practitioner's group and the Hospital, states otherwise, the Practitioner's membership on the Medical Staff and any associated clinical privileges shall be deemed automatically terminated if the contractual relationship is terminated (either by termination of the contract, or termination of the Practitioner's association with the contracted group). In such event, the Practitioner shall have no right to a hearing under these Bylaws.

1.8-3 Expedited Process for Initial Appointment

In exceptional circumstances, an expedited processing of a particular application may be necessary to satisfy a demonstrated patient care or Hospital need. In such exceptional circumstances, the evaluation of an application on an expedited basis shall be performed pursuant to the following criteria. If the application is deemed incomplete, or if at any step of the approval process, a review is unfavorable to the Practitioner, the application may be sent through the customary application process and will no longer be eligible for expedited processing. All information on the application must be verified via facsimile and/or mail in accordance with these Bylaws before clinical privileges can be granted under expedited processing.

(a) The criteria for expedited processing include:

(1) Satisfaction of all the qualifications to be considered for Medical Staff membership as delineated in these Bylaws, the Rules and Regulations and any applicable Hospital and Department policy or procedure;

(2) Proof of acceptable malpractice claims history activity (including past and current malpractice claims, settlements or judgments) in light of the Practitioner's specialty;

(3) Demonstration of acceptable practice history (e.g. the Practitioner has not changed practice locations more than three (3) times in the past ten (10) years and has no unexplained gaps in chronological school, training or practice history);

(4) Receipt of unanimously favorable peer recommendations;

(5) Absence of any disciplinary actions or special conditions during medical school, residency and/or fellowship training;

(6) Absence of any investigations, denials, restrictions, lapses, probations, suspensions or limitations on the DEA Certificate or DPS registration;

(7) Absence of any investigations, denials, restrictions, lapses, probations, suspensions or limitations on any current or previous professional license in Texas or in any other jurisdiction;

(8) Absence of any probations, withdrawals, special conditions, restrictions, reductions, suspensions, relinquishments, lapses, denials or revocations of Medical Staff membership or clinical privileges by any hospital or health care entity;

(9) Absence of any sanctions, exclusions or limitations imposed by any medical organization or professional review organization;

(10) No criminal history or felony convictions;

(11)No past or pending sanctions, limitations or exclusions from participation in any governmental or private third party agency, insurance program, reimbursement program, including participation in the Medicare and Medicaid programs;

(12)No history of substance abuse or health conditions that may adversely affect the Practitioner's

ability to perform clinical privileges requested; and

(13)Recommendation by Department Chief for expedited review of Practitioner's request for membership and clinical privileges.

(b) The procedure for an expedited initial application shall be as follows:

(1) Email request for Dictation and patient registration system numbers from the Medical Staff Services office for the following:

a. Office address
b. Phone number
c. Fax number
d. License number
e. UPIN
f. DEA and DPS numbers (if required for clinical practice)
g. Date of Birth
h. Social Security Number

(2) On behalf of the Credentials Committee, the appropriate Department Chief(s) shall review the expedited application and supporting documentation and make a written recommendation to the Credentials Committee concerning Medical Staff membership and delineation of clinical privileges.

(3) The Chairman of the Credentials Committee or his designee shall review the Department Chief's recommendation and shall determine if the Practitioner has satisfied the minimum eligibility criteria for appointment to the Medical Staff and for the requested clinical privileges. The Chairman of the Credentials Committee or his designee shall forward a written recommendation to the MEC.

(4) The Chairman of the MEC or his designee shall make a written recommendation to the Hospital President and the Board Subcommittee regarding department appointment and clinical privileges to be granted. The Hospital President and the Board Subcommittee shall take action on the application and request for clinical privileges. To the extent membership on the Medical Staff and clinical privileges are so granted, such membership and privileges shall take effect immediately upon the signature of the Board Subcommittee.

(5) If the Board Subcommittee does not grant Medical Staff membership or clinical privileges based on the Practitioner's continuing professional competence and ability to perform the clinical privileges requested, then the Practitioner shall be entitled to a right to a hearing under these Bylaws.

1.9 Procedure for Reappointment

1.9-1 Application

At least six (6) months prior to the expiration date of a member's current Medical Staff appointment, a reapplication form shall be sent to the member. Each Medical Staff member must submit to the Medical Staff Services office a completed application at least 90 days prior to such expiration date. An application shall not be considered complete until all requested information has been received.

1.9-2 Department Review

The Medical Staff Services office shall forward the application and all pertinent information to the appropriate Department Chief. The completed application for reappointment submitted by the member must include all information necessary to update and evaluate the member's qualifications, including but not limited to, the items set forth in Sections 1.5, 1.6 and 1.7 of these Bylaws. The Chief shall review the application and may consider any additional information available including, but not limited to the following:

(a) Number of admissions;

(b) Timeliness in completing medical records;

(c) Citations from applicable Medical Staff committees;

(d) Results of quality assurance/performance improvement activities, including drug utilization review, relating to the member's clinical and/or technical competence using relevant Practitioner-specific data compared to aggregate data, when available and Performance Measurement Data including morbidity and mortality data, when available;

(e) Peer recommendations as to the member's current continuing clinical competence and suitability for continued Medical Staff membership;

(f) Fulfillment of Medical Staff responsibilities relating to the member's category of Staff membership;

(g) Board certification or registered active candidate status as required by these Bylaws.

(1) If at the time of a preceding appointment the member was board certified, but at the time of reappointment that board certification has lapsed or expired, the requirement of subsection 1.9-2(g) may be waived and the member's equivalent clinical experience and competence may be accepted in lieu thereof if adequately demonstrated during his appointment at the Hospital.

(2) If at the time of the preceding appointment the member was not board certified or a registered active candidate, and received a clinical appointment, the member must successfully pass the board examination within the time limit established by the Department, which may not exceed two (2) reappointment periods; and

(h) National Practitioner Data Bank query.

The Department Chief shall follow the process described in Section 1.7-3 of these Bylaws.

1.9-3 Credentials Committee Recommendation

The Credentials Committee shall follow the process described in Section 1.7-4 of these Bylaws.

1.9-4 MEC Recommendation

The MEC shall follow the process described in Section 1.7-5 of these Bylaws.

1.9-5 Board of Trustees Action

The Board of Trustees shall follow the process described in Section 1.7-6 of these Bylaws.

1.10 Failure to Submit a Completed Reappointment Application

If the member does not submit a completed application by 90 days prior to the reappointment expiration date, the application will be deemed incomplete and the member's clinical privileges will expire at the end of the current staff appointment. If a staff appointment expires because of an incomplete reappointment application, the member is not entitled to a right to a hearing under these Bylaws. Any application submitted after the expiration date shall be processed as a request for an initial appointment.

1.11 Leave of Absence

1.11-1 Leave Status

A Medical Staff member may obtain a voluntary leave of absence (not to exceed the earlier of one (1) year or the last day of the member's current term of appointment) from the Medical Staff by submitting a written request to the Department Chief and the Credentials Committee specifying the reasons and the approximate period of leave. During a leave of absence, the member shall not exercise clinical privileges at the Hospital, and membership rights and responsibilities shall be inactive. In exceptional circumstances and upon demonstrating good cause, a leave of absence may be extended beyond one (1) year upon approval of the MEC, based upon the recommendation from the Department Chief and Credentials Committee.

1.11-2 Reinstatement

(a) If the leave of absence is for any reason other than the Medical Staff member's illness, incapacity or impairment or other cause that could affect the member's ability to fully and competently exercise the clinical privileges granted to such member (e.g. to attend to an ailing family member; when called to active military duty), the leave of absence may be terminated prior to its expiration at the written request of the member and the Medical Staff member will be reinstated by the Chairman of the Credentials Committee or designee. To be reinstated, the member must submit a written request prior to expiration of the period specified in the member's request for leave.

(b) In circumstances when the leave of absence is due to illness, incapacity, or impairment or other causes that could affect the member's ability to fully and competently exercise the clinical privileges granted to such member, reinstatement is conditioned upon a showing that:

(1) The member has submitted to the Credentials Committee a written request for reinstatement at least 30 days prior to the expiration of the leave, and demonstrated that the reasons for the leave will no longer exist by the expiration of the leave or by the requested date for reinstatement;

(2) In case of impairment, the member must present a letter of release from the member's physician, and, as may be required by the Credentials Committee, an agreement for ongoing treatment or therapy, a treatment plan from a treating physician, and the member's agreement for random testing, if applicable;

(3) The member currently meets all of the qualifications for membership set forth in these Bylaws;

(4) The member currently meets the qualifications for the category of membership to which the member shall be reinstated; and

(5) The member has submitted such other information as requested by the Credentials Committee, the MEC, or the Board of Trustees.

No reinstatement of a leave granted under (b) above shall be effective until approved by the Board of Trustees upon the recommendation of the MEC.

1.11-3 Failure to Request Reinstatement

Failure to request reinstatement from a leave of absence in any event shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic revocation of Medical Staff membership and clinical privileges. A request for Medical Staff membership subsequently received from a member who fails to request timely reinstatement shall be submitted and processed in the manner specified for applications for initial appointments.

1.12 Continuing Duties after Appointment

By accepting an appointment to the Medical Staff and clinical privileges at the Hospital, the member affirmatively agrees to the following duties:

(a) Notify the Medical Staff Services office in writing within five (5) business days upon actual or constructive knowledge of any of the following:

6. (1) Any material change to information submitted as part of an initial or renewal application for Medical Staff membership including that information required by Sections 1.5-1, 1.5-3, 1.6 and 1.7-1 of these Bylaws;
7. (2) Taking any requested or mandatory leave of absence by the member at any health care facility;
8. (3) The cessation of medical practice by the member at any health care facility for any reason (except for a voluntary resignation) for a period exceeding 30 days; and
9. (4) The reduction of member's professional liability insurance coverage below the minimum limits set forth in these Bylaws, or exclusion from coverage for any procedures for which the member has or is seeking clinical privileges.
10. (b) Provide and/or secure continuous care of the member's patients and seek consultation whenever necessary or appropriate;
11. (c) Complete a medical history and physical examination in accordance with the requirements set forth in the Rules and Regulations;

12. (d) Maintain an ethical practice, including refraining from the following: offering, soliciting, providing or accepting illegal inducements for patient referrals, allowing patient care services to be provided by a physician-in-training without the direct supervision of the responsible attending physician, and delegating patient care responsibility to non-qualified or inadequately supervised Practitioners; and
13. (e) Notify the Medical Staff Services office immediately if at any time the member is no longer certified as a diplomate or a registered active candidate in good standing in the process toward certification by the applicable specialty board.

Article II CLINICAL PRIVILEGES

2.1 Exercise of Privileges

Except as otherwise provided in these Bylaws, a member of the Medical Staff shall be entitled to exercise only those clinical privileges specifically granted, consistent with any conditions placed on such practice, and subject to the Rules and Regulations of the Medical Staff, applicable Hospital or Department policies and procedures.

2.2 Granting of Privileges

2.2-1 Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the Practitioner. A Medical Staff member may request a change in Medical Staff status or modification of clinical privileges at any time by submitting relevant documentation of training and experience, except that such request may not be submitted for at least twelve (12) months after a substantially similar request was denied.

2.2-2 Basis for Determining Privileges

Requests for clinical privileges shall be evaluated on the basis of the Practitioner's demonstrated ability to exercise such privileges, including, but not limited to the following:

(a) relevant education, training and experience;

(b) satisfaction of the minimum eligibility criteria and qualifications described in Article I of these Bylaws and those criteria set forth in the Practitioner's privilege cards;

(c) documented patient care results, as well as the results of other quality review and monitoring that the Medical Staff or the Board of Trustees deem appropriate; and

(d) clinical performance results obtained from other institutions and health care settings where the Practitioner exercises or has exercised clinical privileges.

2.2-3 Additional Requirements

In the case of a new Medical Staff appointee or a member requesting the granting of new clinical privileges, the Medical Staff may recommend conditions that are appropriate to assess and confirm clinical competence. The requested privileges may be granted subject to such conditions (e.g. a

period of clinical observation; proctoring; or a period of clinical trial on any or all of the clinical privileges requested).

2.3 Modification of Clinical Privileges or Department Assignment

The Credentials Committee may recommend and initiate a change in the clinical privileges or Department assignment of a member pursuant to a request under Section 2.2-1. The Credentials Committee may also recommend that the granting of additional clinical privileges to a current Medical Staff member be made subject to a period of concurrent monitoring.

2.4 Lapse of Application

If a Medical Staff member requesting a change of clinical privileges or department assignment fails to furnish timely the information necessary to evaluate the request, the request shall be deemed to be immediately withdrawn, and the member shall not be entitled to a right to a hearing under these Bylaws.

2.5 Temporary Clinical Privileges

2.5-1 Circumstances

Temporary clinical privileges may be granted to a Practitioner who is not a member of the Medical Staff for the care and treatment of specific patients for the provision of specific procedures, or for a specific period of time where good cause exists, as determined by the Credentials Committee or its designee. Good cause includes:

(a) fulfillment of an urgent patient care, treatment, or service need;

(b) performance or demonstration of a medical or surgical procedure for educational purposes; or

(c) provision of consultative services by a non-staff physician needed because of the physician's clinical expertise or a patient request.

2.5-2 General Conditions

A Practitioner receiving temporary clinical privileges must be appropriately licensed to practice medicine and demonstrate the qualifications, ability and good judgment necessary to exercise the temporary clinical privileges requested consistent with these Bylaws. The Practitioner shall be bound by these Bylaws and the Rules and Regulations of the Medical Staff, and the Practitioner's clinical privileges shall be granted only for the duration of the urgent patient care, treatment or service need, the patient's stay, or the provision of specific procedure(s) for a specified time period (whichever is less), all of which shall not exceed 120 days. Such Practitioner shall exercise such privileges only under the supervision of a designated Medical Staff member.

2.5-3 Procedure to Obtain Temporary Clinical Privileges

Requests for temporary clinical privileges shall be submitted in writing to the appropriate Department Chief as the designee of the Credentials Committee. The Department Chief, or Chief or President of the Medical Staff if the Department Chief is unavailable, acting on behalf of the

Credentials Committee, shall evaluate the request and recommend whether to approve or deny the request. Following verification from primary sources of licensure, professional liability insurance coverage for the privileges, and continuing current competence, the request and the Committee's recommendation shall be forwarded to the Hospital President. The Hospital President shall notify the Practitioner and the Department Chief of the determination. If granted, temporary clinical privileges shall take effect immediately subject to ratification at the next Board of Trustees meeting. Denial of such request shall not entitle the Practitioner to a right to a hearing under these Bylaws.

2.5-4 Termination of Temporary Clinical Privileges

Temporary privileges shall expire as specified in Section 2.5-2. Additionally, temporary clinical privileges may be terminated at any time in the following manner:

(a) by the Hospital President, upon consultation with the Credentials Committee, or its designee, upon the discovery of any information, or the occurrence of any event that brings into question a Practitioner's qualifications or ability to exercise any or all of the temporary clinical privileges granted;

(b) by any person entitled to impose summary suspension pursuant to these Bylaws. Because of the nature of temporary privileges, the termination of same shall not entitle the Practitioner to the right to a hearing under these Bylaws in the event that continued treatment by the Practitioner is determined to be detrimental to patient safety or to the delivery of quality patient care within the Hospital; or

(c) by the Board of Trustees if it does not ratify the grant of temporary privileges.

In such cases, the respective Department Chief, or in the Chief's absence, the Chairman of the MEC, shall assign a member of the Medical Staff to assume responsibility for the care being provided by such Practitioner. The wishes of the patient shall be considered in selecting a replacement Medical Staff member. A Practitioner whose temporary clinical privileges are terminated shall not be entitled to a right to a hearing under these Bylaws.

2.6 Privileges in Patient Emergencies

In the case of an emergency, any member of the Medical Staff, within the scope of the member's license and regardless of department, staff status, or clinical privileges, is permitted to provide patient care, treatment and service necessary as a life-saving measure or to prevent serious harm to a patient. The Medical Staff member shall make every reasonable effort to communicate promptly with the patient's attending physician or, if the patient has no attending physician, with the appropriate Department Chief concerning the need for emergency care and assistance by members of the Medical Staff with appropriate clinical privileges. Once the emergency has passed or other assistance has been made available, the member shall defer to the patient's attending physician or the appropriate Department Chief.

2.7 Privileges in Disaster Situations

The Hospital may grant temporary emergency disaster privileges to volunteers eligible to be licensed independent practitioners. When the Hospital disaster plan has been implemented and the immediate needs of the patients cannot be met, the Hospital may implement a modified credentialing and privileging process for eligible volunteer Practitioners. The Hospital President, the Chief of the

Medical Staff, or the individuals designated in Hospital policy, may grant at their discretion and on a case-by-case basis, temporary emergency disaster privileges to volunteer Practitioners, who are not members of the Medical Staff and do not have clinical privileges at the Hospital, to address immediate patient care needs in accordance with the disaster plan. The granting of these privileges shall be based on the needs of the Hospital and its patients and the qualifications of the volunteer Practitioners. The Medical Staff Services office shall be notified as soon as practicable when privileges are granted.

While temporary emergency disaster privileges are granted on a case-by-case basis, volunteer Practitioners considered eligible to act as licensed independent practitioners in the Hospital must at a minimum present a valid government-issued photo identification by a state or federal agency (e.g. driver's license or passport) and one of the following:

(a) a current hospital photo identification card that clearly identifies professional designation;

(b) a current license to practice;

(c) primary source verification of the license;

(d) identification indicating that the volunteer Practitioner is a member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organizations of groups;

(e) identification indicating that the volunteer Practitioner has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal authority); or

(f) identification by a current hospital or Medical Staff member who possesses personal knowledge of the volunteer Practitioner's ability to act as a licensed independent practitioner during a disaster.

As soon as practicable, the volunteer Practitioner shall provide information regarding licensure, insurance coverage, and primary hospital affiliation to the Medical Staff Services office for verification. Refusal to provide such information will disqualify a volunteer Practitioner from eligibility for temporary emergency disaster privileges or, if privileges have already been granted, shall result in such privileges being withdrawn and the volunteer Practitioner removed from Hospital premises. In either event the volunteer Practitioner will not be entitled to a right to a hearing under these Bylaws.

The Medical Staff Services office shall verify licensure, liability insurance coverage and continuing current competence from primary sources as soon as the immediate situation is under control and within 72 hours from the time the volunteer Practitioner presents to the Hospital. In the extraordinary circumstance that primary source verification cannot be completed in 72 hours, it must completed as soon as practicable and there must be documentation of the following: why primary source verification could not be performed in the required time frame, evidence of a demonstrated ability to continue to provide adequate care, treatment and services, and an attempt to rectify the situation as soon as practicable.

Any volunteer Practitioner granted emergency disaster privileges under the disaster plan must be provided with appropriate identification before exercising temporary emergency disaster privileges to

permit ready identification. Such volunteer Practitioner may provide patient care only in the designated disaster plan treatment centers, and only under the direct supervision of the chief or alternate chief (or their designees) of the assigned disaster plan treatment center or a designated Medical Staff member. Upon the discovery of any information or the occurrence of any event that raises questions about the volunteer Practitioner's qualifications or abilities, the supervising chief or alternate chief of the assigned disaster plan treatment center or the Chief of the Medical Staff (or their designees) may terminate the volunteer Practitioner's temporary emergency disaster privileges. Temporary emergency disaster privileges otherwise will terminate when the emergency or disaster situation no longer exists without any right to a hearing under these Bylaws.

2.8 Categories of the Medical Staff

The Medical Staff appointment categories shall include active-clinical, courtesy, active-community, consulting, administrative, and medico-administrative Practitioners.

For any category of the Medical Staff that requires any number of contacts, a "contact" as used in this Section 2.8 means a Practitioner-to-patient encounter, or a consultant-to-Practitioner encounter, from which it is possible to make a meaningful evaluation of the member's clinical experience, competence and care of the patient. The contact must occur in the Hospital, or the member shall have the burden to present sufficient evidence of a contact that occurred in another clinical setting. The Hospital has the authority to review the activity levels (i.e. number of contacts) and make the appropriate category assignments or reassignments of its members at any time.

2.8-1 Active-Clinical Staff

(a) Qualifications

A member of the Medical Staff is eligible for the category of active-clinical staff by maintaining a minimum number (as determined by the Board of Trustees) of contacts per appointment period.

(b) Prerogatives

A member of the active-clinical staff may:

(1) Admit patients without limitation, subject to these Bylaws, the Rules and Regulations and applicable Hospital and Department policies and procedures;

(2) Exercise such clinical privileges as are granted to him pursuant to these Bylaws;

(3) Vote on all matters presented at general and special meetings of the Medical Staff and of the Departments and committees of which he is a member; and

(4) Hold any office that is voted on by all members of the Medical Staff and in the Departments and committees of which he is a member.

(c) Responsibilities

A member of the active-clinical staff shall:

(1) Participate in the emergency services call program as determined by the Department;

(2) Actively participate in the quality evaluation and monitoring activities required of Medical

Staff members;

(3) Discharge the basic responsibilities set forth in these Bylaws, Rules and Regulations and applicable Hospital and Department policies and procedures;

(4) Retain responsibility within his area of professional competence for the continuous care and supervision of each patient for whom he is responsible for providing services in the Hospital, or arrange a suitable alternative in accordance with these Bylaws, Rules and Regulations and applicable Hospital and Department policies and procedures;

(5) Have procedures in place to provide care to or assist in the provision of care to such staff member's patients who come or are brought to the hospital's emergency room;

(6) Report any changes in health status to the Credentials Committee immediately; and

(7) Discharge such other staff functions as may be required from time to time by the MEC or the Chief of the Department in which the member is assigned.

2.8-2 Courtesy Staff

(a) Qualifications

A member of the Medical Staff is eligible for the category of courtesy staff as follows:

(1) Maintain at least one (1) and up to a maximum number (as determined by the Board of Trustees) of contacts per appointment period. This maximum number shall not include patient contacts that occurred when the courtesy staff member is providing call coverage for an active-clinical staff member. A courtesy staff member will not be required to become an active-clinical staff member because of call-coverage contacts alone; and

(2) Is a member of the active staff of another hospital where he actively participates in quality review, evaluation and monitoring activities similar to those required of the active-clinical staff at this Hospital.

(b) Prerogatives

A courtesy staff member may:

(1) Admit patients to the hospital subject to these Bylaws, within the limitations provided in the Rules and Regulations and applicable Hospital and Department policies and procedures and under the same conditions as specified for active-clinical staff members;

(2) Exercise such clinical privileges as are granted to him;

(3) Vote on all matters presented at general and special meetings of the Medical Staff and of the Departments and committees of which he is a member;

(4) Hold office in the Departments and committees of which he is a member; and

(5) Not hold any office that is voted on by all members of the Medical Staff.

(c) Responsibilities

A member of the courtesy staff shall:

(1) Participate in the emergency services call program as determined by the Department;

(2) Discharge the basic responsibilities set forth in these Bylaws and Rules and Regulations and applicable Hospital and Department policies and procedures;

(3) Retain responsibility within his area of professional competence for the continuous care and supervision of each patient for whom he is responsible for providing services in the Hospital, or arrange a suitable alternative in accordance with these Bylaws, Rules and Regulations and applicable Hospital and Departmental policies and procedures;

(4) Have procedures in place to provide care to or assist in the provision of care to such staff member's patients who come or are brought to the hospital's emergency room;

(5) Report any changes in health status to the Credentials Committee immediately; and

(6) Discharge such other staff functions as may be required from time to time by the MEC or the Chief of the Department in which the member is assigned.

2.8-3 Active-Community Staff

(a) Qualifications

A member of the Medical Staff who does not have patient contacts at the Hospital may be eligible for the category of active-community staff.

(b) Prerogatives

An active-community staff member may:

(1) Not have clinical privileges;

(2) Not hold any office that is voted on by all members of the Medical Staff;

(3) Vote on all matters presented at general and special meetings of the Medical Staff and of the Departments and committees of which he is a member; and

(4) Hold office in the Departments and committees of which he is a member.

(c) Responsibilities

A member of the active-community staff shall:

(1) Discharge the responsibilities set forth in these Bylaws, Rules and Regulations and applicable Hospital and Departmental policies and procedures; and

(2) Report any changes in health status to the Credentials Committee immediately; and

(3) Discharge such other staff functions as may be required from time to time by the MEC or the Chief of the Department to which he is assigned.

An active-community staff member is not required to participate in the emergency services call program.

2.8-4 Consulting Staff

The Consulting Category is limited to the medical staffs of hospitals that operate under a partnership agreement or that offer only a limited line of clinical services to the community.

(a) Qualifications

A member of the Medical Staff is eligible for the category of consulting staff as follows:

(1) Receives recognition for outstanding attainments in medicine, dentistry, or podiatry; and

(2) Is a member of the active staff of another medical, dental or podiatric facility, where he actively participates in quality review, evaluation and monitoring activities similar to those required of the active-clinical staff of this Hospital.

(b) Prerogatives

A consulting staff member may:

(1) Not have admitting privileges;

(2) Not hold any office that is voted on by all members of the Medical Staff;

(3) Have clinical privileges;

(4) Vote on all matters presented at general and special meetings of the Medical Staff and of the department and committees of which he is a member;

(5) Hold office in the departments or committees of which he is a member;

(6) Provide consultation as requested by any member of the Medical Staff at the Hospital and subject to these Bylaws, Rules and Regulations and applicable Hospital and Department policies and procedures; and

(7) Participate in quality review, evaluation and monitoring activities similar to those required of the active-clinical staff of this Hospital.

(c) Responsibilities

A member of the consulting staff shall:

(1) Participate in the emergency services call program as determined by the Department;

(2) Discharge the basic responsibilities set forth in these Bylaws, Rules and Regulations, and applicable Hospital and Department policies and procedures;

(3) Report any change in health status to the Credentials Committee immediately; and

(4) Discharge such other staff functions as may be required from time to time by the MEC or the Chief of the Department to which he is assigned

2.8-5 Administrative and Medico-Administrative Officers

A Practitioner employed by the Hospital in a purely administrative capacity with no clinical duties or privileges shall be an administrative officer who is subject to the regular personnel policies of the Hospital and to the terms of his contract or other conditions of employment, and need not be a member of the Medical Staff.

A medico-administrative officer, who serves in an administrative capacity and has some clinical duties, must be a member of the Medical Staff, appointed and having clinical privileges granted in accordance with these Bylaws. The Board of Trustees shall appoint a medico-administrative officer to such position after receiving the recommendation of the MEC with respect to the clinical qualifications of the member.

2.9 Choice of Medical Staff Categories

The Medical Staff may consist of Medical Staff member categories that have the qualifications, prerogatives, and responsibilities only as provided in Section 2.8. The Board of Trustees and the MEC may choose not to offer every category as they determine will best serve and fulfill the Hospital's mission.

Article III CORRECTIVE ACTION

3.1 Actions Other Than Summary Restriction or Suspension

3.1-1 Basis for Corrective Action

An investigation of a member of the Medical Staff may be requested whenever information indicates that the member may have exhibited acts, demeanor, or conduct reasonably likely to (1) be detrimental to patient safety or to the delivery of quality patient care within the Hospital; (2) be unethical; (3) be contrary to the Bylaws, Rules and Regulations, or any Hospital or Department policies and procedures; (4) be below applicable professional standards; or (5) indicate impairment due to substance abuse or other medical ailment. The Department Chief, the Chairman of the MEC, the Hospital President, or the Board of Trustees may request an investigation of such member. The request shall identify the areas of concern and shall be submitted to the MEC.

3.1-2 Investigation

If the MEC determines that an investigation is warranted, the MEC shall conduct the investigation or assign the investigation to an appropriate Medical Staff committee or an ad hoc committee appointed to conduct such investigation. Practitioners who are not members of the Medical Staff may be invited to participate in any such investigations. If such investigation is assigned by the MEC, the investigating body shall submit a written report of the investigation to the MEC that may include recommendations on corrective action, if any. The investigation shall not constitute a "hearing" and the member shall not be entitled to a right to a hearing under these Bylaws.

3.1-3 MEC Action

Upon the conclusion of the investigation, the MEC may in its discretion recommend any of the following:

(a) Removal of any adverse information from the member's file if no corrective action is warranted by the investigation;

(b) Deferral of action;

(c) Issuance of letters of admonition, censure, reprimand, or warning. The affected member may respond to such letters and warnings, and any written responses shall be placed in the member's file;

(d) Imposition of special conditions that may include case review, continuing medical education, counseling or probation, which do not involve a restriction, reduction, suspension or revocation of Medical Staff membership or the member's ability to exercise clinical privileges;

(e) Restrictions on continued Medical Staff membership or exercise of clinical privileges that may include co-admissions, mandatory consultation, or case supervision;

(f) Reduction, suspension or revocation of clinical privileges;

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

(h) Other actions deemed appropriate in the sole discretion of the MEC under the circumstances.

3.1-4 Subsequent Action

(a) Any MEC action that does not involve denial of Medical Staff membership or restriction, reduction, suspension or revocation of Medical Staff membership or the member's ability to exercise clinical privileges may be implemented by the MEC without further review and shall be effective when notice is delivered to the affected member.

(b) The MEC shall promptly submit to the Board of Trustees and notify the affected member of any recommendation for corrective action that involves the denial of Medical Staff membership or the restriction, reduction, suspension, or revocation of Medical Staff membership or the member's ability to exercise clinical privileges. Any MEC recommendation that is an "adverse action" (meaning that it involves denial of Medical Staff membership, restriction, reduction, suspension or revocation of Medical Staff membership or the member's ability to exercise clinical privileges) shall entitle the member to a right to a hearing under these Bylaws effective as of the date of the MEC recommendation unless otherwise indicated in these Bylaws.

(c) If the MEC recommendation is supported by credible evidence, the Board of Trustees shall approve the MEC recommendation and shall notify the affected member.

3.1-5 Initiation by Board of Trustees

If the MEC fails to take corrective action, the Board of Trustees in its discretion may direct the MEC to initiate an investigation or to consider corrective action. If the MEC fails to act, the Board of Trustees may initiate corrective action consistent with these Bylaws.

3.2 Summary Restriction or Suspension

3.2-1 Criteria for Initiation

A summary restriction or suspension of Medical Staff membership or clinical privileges may be made by the appropriate Department Chief or the Chairman of the MEC whenever a member's conduct appears to require that immediate action be taken to protect the well-being of any person including patients, visitors, and Hospital personnel, or to reduce a substantial and imminent likelihood of injury or impairment to the life, health, or safety of any person including patients, visitors, and Hospital personnel. Unless otherwise stated, such summary restriction or suspension shall be effective immediately upon imposition, and the responsible person or body shall deliver written notice to the member, the Credentials Committee, the MEC, the Hospital President, and the Board of Trustees. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if not stated, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the affected member's patients shall be assigned to another Medical Staff member in accordance with these Bylaws, the Rules and Regulations, Hospital and Department policies and procedures.

3.2-2 Initiation of Summary Restriction or Suspension

A summary suspension may be initiated by the Chairman of the MEC or appropriate Department Chief. If neither the Chairman of the MEC nor the appropriate Department Chief is available, the Hospital President or the Board of Trustees may summarily restrict or suspend a member's Medical Staff membership or clinical privileges, provided that the Hospital President or Board of Trustees first made reasonable attempts to contact the Chairman of the MEC and the Department Chief.

3.2-3 MEC Action

Within 14 days after a summary restriction or suspension, the MEC shall conduct a meeting to review and consider the action. The affected member may request to attend and present a statement to the MEC; however, the member may not be represented by a lawyer at the meeting and the member shall not be entitled to a right to a hearing under these Bylaws. The MEC may conduct whatever review or investigation it deems appropriate. The MEC shall recommend to the Board of Trustees to modify, continue, or terminate the summary restriction or suspension, and shall deliver notice of its recommendation to the affected member.

If the MEC does not ratify the restriction or suspension, it shall terminate upon the earlier of (a) the 14th day after imposition or (b) the date the MEC votes not to ratify the action. Notice of any action taken under this Section shall be delivered to the affected member.

3.2-4 Procedural Rights

If the summary restriction or suspension is not terminated within 14 days, the affected member shall be entitled to a right to a hearing under these Bylaws.

3.3 Administrative Suspension and Revocation

14. An administrative suspension of Medical Staff membership or clinical privileges may be made by the MEC based on a member's conduct as described in this Section 3.3. Unless otherwise stated, such administrative suspension shall be effective immediately upon imposition, and the MEC shall deliver written notice to the affected member, the Department Chief, the Hospital President and the Board of Trustees. The administrative suspension shall be limited in duration and shall remain in effect for the period stated or, if not stated, until resolved as set forth herein.

3.3-1 Licensure

If a member's license to practice in Texas lapses, the member's clinical privileges shall be suspended until the deficiency is corrected. If, within 90 days following the lapse, the member does not demonstrate that the member's license to practice in Texas has been renewed, the member's Medical Staff membership and clinical privileges shall be automatically revoked.

3.3-2 DEA Certificate and DPS Registration

If a member's DEA certificate or DPS registration lapses, the member's clinical privileges may be suspended unless the member provides documentation from the DEA or DPS demonstrating that the expiration date of the DEA certificate or DPS registration has been extended. If, within 90 days following the lapse, the member does not demonstrate that the member's DEA certificate or DPS registration has been renewed, the member's Medical Staff membership and clinical privileges shall be automatically revoked.

3.3-3 Professional Liability Insurance

If a member fails to maintain professional liability insurance as set forth in these Bylaws, the member's clinical privileges may be suspended until the deficiency is corrected. If within 90 days following the deficiency, the member does not provide evidence of required professional liability insurance, the member's Medical Staff membership and clinical privileges may be revoked.

3.3-4 Medical Records

If a member fails to complete and sign medical records in accordance with Hospital policy, the member's clinical privileges may be suspended until the deficiency is corrected.

3.3-5 Failure to Respond to Request for Information

A member of the Medical Staff is expected and required to respond in writing within 14 days of delivery of a letter, or by the date specified in the letter, to a Hospital or Medical Staff committee or representative that requests information relating to the member's clinical competence, qualifications, professional conduct and/or quality affecting patient care. If a member fails to respond or provide the requested information in a timely manner, the member's clinical privileges may be suspended for a period of up to 10 days.

3.3-6 Disruptive Behavior

A member of the Medical Staff is expected and required to adhere to the ethics of the profession, to work cooperatively with others, and to discharge properly the responsibilities of the Medical Staff. If

a member fails to do so, or if member's behavior is disruptive to the reasonably expected functioning of the Hospital, the member's clinical privileges may be suspended for a period of up to 10 days.

3.3-7 Repetitious Infractions

If a member has been subject to at least three (3) administrative suspensions under this Section 3.3 within any consecutive twenty-four (24)-month period, the member's Medical Staff membership and clinical privileges may be revoked by the MEC.

3.3-8 Procedural Rights

Any revocation under this Section 3.3 shall entitle the affected member to a right to a hearing under these Bylaws.

3.4 Professional Health

Whenever the member's actions, demeanor, conduct, or physical or mental condition reasonably appears to be impaired, the member may be asked by the Department Chief, Chief of Staff, the Hospital President, Credentials Committee, MEC, or Board of Trustees to provide evidence of current health status through a physical or mental examination, and will be referred to the committee on professional health. An impairment due to substance abuse is deemed reasonably likely to be detrimental to patient safety or to the delivery of quality patient care within the Hospital and shall be grounds for immediate summary suspension of the member's clinical privileges as provided in these Bylaws. A member has a duty to self-report to the Department Chief, Chief of Staff, Hospital President, Credentials Committee, MEC, or Board of Trustees any professional health matter that may adversely affect the member's ability to exercise safely clinical privileges and may seek assistance from the committee on professional health. Management and resolution of professional health matters shall be the responsibility of the committee on professional health, which shall report to the MEC. Any physical or mental examination shall be at the expense of the affected member, shall be provided by a Practitioner selected by the committee on professional health and may include an appropriate drug screen testing program for an individual suspected of impairment due to substance abuse.

3.5 Automatic Adverse Action

In the following instances, a member's Medical Staff membership and clinical privileges shall be subject to automatic adverse action as stated below, without a right to hearing under these Bylaws.

3.5-1 Licensure

If a member's license to practice in Texas is restricted, reduced, suspended, revoked, or placed on probation, the member's Medical Staff membership and clinical privileges shall be subject to the same action under the same terms and conditions as of the date such action becomes effective and throughout its term.

3.5-2 DEA Certificate and DPS Registration

If a member's DEA certificate or DPS registration is placed on probation, restricted, reduced, suspended or revoked, the member's clinical privileges shall be subject to the same action under the

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

3.5-3 Felony

If a member is convicted of a felony, the member's Medical Staff membership and clinical privileges shall be automatically revoked upon the Hospital receiving actual notice of the conviction.

3.5-4 Professional Health Program

If a member violates the terms of a return to work agreement signed as part of the Hospital's professional health program, the member's Medical Staff membership and clinical privileges shall be automatically revoked.

3.5-5 Failure to Maintain Reasonable Proximity to Hospital

If a member does not maintain a professional office or personal residence in reasonable proximity to the Hospital such that making customary patient rounds is not possible, the member's Medical Staff membership and clinical privileges may be automatically revoked by the MEC upon making findings of fact.

3.5-6 Failure to Request Reinstatement from Leave of Absence

If a member fails to request reinstatement from a leave of absence after expiration of the stated period of the requested leave, Section 1.11-3 shall control.

3.5-7 False Information

If a member has falsified an application for appointment or reappointment, the member's Medical Staff membership and clinical privileges may be suspended. If upon investigation such falsification is confirmed, the MEC may declare an automatic revocation and the member shall not be entitled to a right to a hearing under these Bylaws.

Article IV HEARING AND APPEAL PROCEDURE

4.1 Grounds for Hearing

(a) This Section describes the exclusive circumstances that entitle a Practitioner to a right to a hearing on an adverse action. A Practitioner shall be entitled to a hearing only upon making a timely request for a hearing after any of the following actions:

15. (1) an MEC recommendation to deny an application, under Section 1.7-5 or Section 1.9-4;
16. (2) an MEC recommendation that is an adverse action under Section 3.1-4(b);

(3) a decision by the Board Subcommittee to not ratify an initial appointment under Section 1.8-3(b)(5);

17. (4) a summary restriction or suspension that exceeds 14 days under Section 3.2-4; or
18. (5) any administrative revocation under Section 3.3-7.

(b) A Practitioner does not have a right to a hearing or an appeal for circumstances or actions of any kind not expressly set forth in Section 4.1(a).

(c) A hearing shall be conducted in accordance with the provisions of these Bylaws.

4.2 Notice to Practitioner of Adverse Action

4.2-1 Notice

When an adverse action occurs that entitles a Practitioner to a hearing, notice shall be given to the affected Practitioner that shall include:

19. (1) a statement of the action or recommendation and fair notice of reasons for it;
20. (2) a statement that the Practitioner has the right to request a hearing within 30 days of delivery of this notice;
21. (3) a statement that the Practitioner may affirmatively waive the right to a hearing, and that the failure to submit a timely request for a hearing shall be deemed a waiver of the right to a hearing and acceptance of the final action; and
22. (4) a summary of the rights in the hearing as provided in these Bylaws, including the Practitioner's right to be represented by an attorney of the Practitioner's choice and at the Practitioner's sole expense.

23. Notice shall be deemed delivered when sent by (1) first-class mail, return receipt requested, to the Practitioner's professional office or personal residence, or (2) hand delivered to the Practitioner personally.

4.2-2 Request for Hearing

The Practitioner has 30 days following the date of delivery of such notice to submit a written request for a hearing to the Hospital President or Chairman of the MEC. Failure to timely request a hearing shall be deemed a waiver of all rights to a hearing under these Bylaws and acceptance of the action or recommended action, as applicable.

4.3 Practitioner's Request for Mediation

When a Practitioner is entitled to a right to a hearing, the Practitioner may require the MEC to participate in mediation. The Practitioner must request mediation in writing to the Hospital President within 10 days of delivery of notice of an adverse action. The mediation must be scheduled and completed as soon as practicable, and in no event shall mediation be held less than 14 days before the hearing is scheduled (if a hearing has been timely requested) unless the Practitioner and MEC agreed in writing to do so. The parties shall be required to share the cost of any mediation equally. The mediator shall be qualified according to state law and selected by the MEC.

4.4 Notice of Hearing

The Hospital President or designee thereof shall schedule the hearing and shall give written notice of its time, place and date. The hearing shall take place as soon as practicable, but no sooner than 30 days after the notice of hearing unless an earlier hearing date has been agreed to in writing by the parties. The notice shall include:

(a) a proposed list of witnesses, as known at the time, but which may be modified as changes are known, who may give testimony or evidence on behalf of the MEC recommendation; and

(b) a concise statement of the reasons for the action or recommendation as well as the list of records and documents that may be used in support of the action or recommendation. This statement, and list of records and documents, may be revised, supplemented or amended as necessary prior to the hearing.

4.5 The Hearing

4.5-1 Composition of the Hearing Panel

(a) The MEC shall appoint a Hearing Panel comprised of either one (1) or more physicians, as the MEC determines appropriate. A physician member of the Hearing Panel must not have been in direct economic competition with the Practitioner at any time during the previous 12 months, and must not have been a member of any Hospital committee that previously considered or acted upon the issue that is the subject matter of the Hearing. A physician is not disqualified from serving on the Hearing Panel by having previously considered matters related to the Practitioner that are not the subject of the Hearing.

(b) Physician members of the Hearing Panel need not be members of the Hospital's Medical Staff nor are they required to have training or expertise in the same clinical practice area as the Practitioner.

(c) Physician members of the Hearing Panel may be compensated for reasonable time in preparing for and conducting the Hearing. If compensation is proposed, the MEC shall deliver notice to the Practitioner of the proposed compensation and the opportunity for the Practitioner to pay one-half of such compensation.

4.5-2 Presiding Officer

(a) The MEC may appoint an attorney as Presiding Officer. General Counsel to the Hospital may not serve in this capacity. The Presiding Officer may not act as prosecuting officer or as an advocate for either side at the hearing. The Presiding Officer shall:

24. (1) afford all participants in the Hearing a reasonable opportunity to be heard and to present oral and documentary evidence, subject to reasonable limits on the nature and extent of the proposed evidence, the number of witnesses and duration of direct and cross examination as the Presiding Officer deems necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;
25. (2) prohibit conduct or presentation of evidence that is cumulative, excessive, abusive, irrelevant or that causes undue delay;
26. (3) maintain decorum throughout the Hearing;
27. (4) facilitate delivery of relevant information to the Hearing Panel;
28. (5) have the authority and discretion to rule on all questions pertaining to procedural matters and admissibility of evidence, including the exclusion of witnesses from the Hearing room during testimony of other witnesses or exclusion of any evidence; and
29. (6) conduct sidebar conferences with counsel and hear arguments by counsel on procedural points outside the presence of the Hearing Panel unless the Hearing Panel wishes to be present.

The Presiding Officer may participate as a legal advisor in the private deliberations of the Hearing Panel, but the Presiding Officer shall not be entitled to vote on the recommendations of the Hearing Panel. The Presiding Officer may thereafter continue to advise the Board of Trustees on the matter.

(b) If no Presiding Officer has been appointed, the Chairperson of the Hearing Panel shall be the Presiding Officer, and shall be entitled to one (1) vote.

(c) The Presiding Officer may be compensated for reasonable time in preparing for and conducting the Hearing. If compensation is proposed, the MEC shall deliver notice to the Practitioner of the proposed compensation and the opportunity for the Practitioner to pay one-half of such compensation.

4.5-3 Representation by Counsel

The Practitioner shall be entitled to representation by an attorney or other person of the Practitioner's choice and at the Practitioner's sole expense. The Practitioner shall notify the Hospital President in writing of the name and all contact information of the attorney or representative at least 21 days before the date of the Hearing. The MEC shall appoint a person, who may be an attorney, as its counsel. Representatives from the MEC and the Hospital Administration may attend the Hearing to observe and to testify; however, no other individuals may attend the Hearing.

4.5-4 Discovery

(a) There is no right to conduct discovery in connection with the Hearing. However, the Practitioner shall be entitled to request the following information, subject to a stipulation signed by both parties that such information shall be maintained as confidential and shall not be disclosed or used for any purpose outside the Hearing:

30. (1) copies of, or reasonable access to, all patient medical records referred to as a basis for the adverse recommendation, at the Practitioner's expense;
31. (2) reports of experts relied upon by the Credentials Committee, MEC or Board of Trustees; and
32. (3) copies of any other documents relied upon in reaching the adverse recommendation.

(b) At a mutually agreed time prior to the Hearing or as provided by the Presiding Officer, each party shall provide the other party with a list of proposed exhibits and witnesses. If the Practitioner intends to rely upon expert testimony, a written report from each such expert shall be provided at the same time as the list of exhibits and witnesses. All objections to documents or witnesses (to the extent then reasonably known) shall be submitted prior to the Hearing to the Presiding Officer for consideration and ruling.

(c) Neither the Practitioner nor the Practitioner's representative shall contact directly or indirectly Hospital employees appearing on the Hospital's witness list concerning the subject matter of the Hearing, unless agreed upon by counsel.

4.5-5 Pre-Hearing Conference

The Presiding Officer may require counsel for the parties to participate in a pre-hearing conference. The Presiding Officer may issue any rulings he deems appropriate for the orderly conduct of the Hearing, including:

(a) List of Witnesses

Each party shall provide a written list of the names and addresses of the witnesses expected to offer testimony and a short summary of the expected testimony. Failure to do so may be grounds for the Presiding Officer to refuse testimony from such witnesses at the Hearing. Either party may, in the discretion of the Presiding Officer, supplement or amend the witness list before the Hearing provided that notice is given to the other party. The Presiding Officer has the

authority to limit the number of witnesses, especially character witnesses or witnesses whose testimony is merely cumulative;

(b) Time for Presentation

33. The time available for each party's presentation of testimony and evidence and cross-examination shall be determined by the Presiding Officer; and

34. (c) Documentary Evidence

35. All documentary evidence must be exchanged on or before the pre-hearing conference. Any objections shall be made at that time and ruled upon by the Presiding Officer. Failure to disclose and provide such documentary evidence may be grounds for the Presiding Officer to exclude such evidence.

4.5-6 Rights of Both Parties

Both parties shall have the following rights, subject to reasonable limits determined by the Presiding Officer: to call and examine witnesses, to introduce exhibits, to cross-examine any witness; and to submit a closing statement including points of argument and citation of authorities at the end of the Hearing. If the Practitioner does not testify on his behalf, the Practitioner may be called adversely and examined as if under cross-examination.

4.5-7 Admissibility of Evidence

Formal rules of evidence and procedure shall not be strictly enforced. However, the Presiding Officer shall make rulings for the orderly conduct of the Hearing. Any relevant evidence shall be admitted if a reasonable person would rely on such evidence in the conduct of serious affairs, regardless of its admissibility in a court of law. The Hearing Panel may interrogate witnesses, call additional witnesses, and request additional documentary evidence.

4.5-8 Taking Official Notice of Matters

The Hearing Panel has the discretion to take official notice of any matter that was not submitted by the parties but that the Hearing Panel deems relevant to the issues under consideration. The parties shall be informed of the matters to be officially noticed, and such matters shall be noted in the Hearing record or Panel report. Either party shall have the opportunity to object and refute that a matter be officially noticed. Reasonable additional time shall be granted, if requested, to present written rebuttal to any evidence admitted by official notice.

4.5-9 Burden of Proof and Basis of Decision

At the Hearing, the MEC shall proceed first with its evidence; however, the MEC shall not have any burden of proof regarding the action or proposed recommendation. At the conclusion of the MEC's presentation of evidence, the Practitioner shall proceed with his presentation. The Presiding Officer may allow rebuttal witnesses or evidence.

The burden of proof shall rest solely on the Practitioner to prove by a standard of "clear and convincing evidence" (as routinely defined in law) that the adverse action, in light of the MEC

recommendation, was either (1) arbitrary and capricious, or (2) not supported by substantial evidence. Arbitrary and capricious means the absence of any rational connection between the known facts and the recommendation made. Not supported by substantial evidence means that no reasonable person could conclude that there was sufficient support for the recommendation based on the facts.

The Hearing Panel shall recommend in favor of the MEC recommendation unless the Practitioner has carried the burden of proof as to each one of the Practitioner's contentions.

4.5-10 Record of Hearing

A stenographic reporter shall make a record of the Hearing. The cost of such Record shall be borne by the Hospital, but copies of the Record may be provided to the Practitioner at his expense. Each witness shall testify only on oath or affirmation administered by the Presiding Officer, and all testimony shall be contained in the Record.

4.5-11 Adjournment and Conclusion

The Presiding Officer may adjourn and reconvene the Hearing for the convenience of the participants without special notice. The Hearing shall conclude when the Presiding Officer, after consultation with the Hearing Panel, finds that no more evidence need be presented or questions need be asked.

4.5-12 Postponements and Extensions

Requests for postponements or extensions of the Hearing shall be permitted by mutual agreement, or by the Presiding Officer on a showing of good cause.

4.5-13 Failure to Appear

Failure, without good cause, of the Practitioner to appear timely and proceed at the Hearing shall be deemed a waiver of the Hearing and a voluntary acceptance of the recommendations and adverse action.

4.5-14 Deliberations and Recommendation of the Hearing Panel

Within 20 days after final adjournment of the Hearing, the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer, and shall render a recommendation, in the form of a written report, which shall contain concise statements of the reasons for the recommendation.

4.5-15 Delivery of Hearing Panel Report

The Hearing Panel shall deliver its recommendation and report to the Hospital President who shall forward it, along with the Record, to the Board of Trustees for further action. The Hospital President shall also send a copy of the recommendation and report to the Practitioner.

4.5-16 Board of Trustees Action

At the next regularly scheduled meeting following receipt of the Hearing Panel's recommendation, the Board of Trustees shall review such recommendation and the earlier MEC recommendation. The Board of Trustees may appoint a subcommittee of Board members to review the matter and bring a recommendation to the Board within 90 days. The Board is not bound by the recommendation of the Hearing Panel, so it may affirm, reverse or modify the same. The Board shall notify the Practitioner of its decision, with a statement of the basis for the decision, within 10 days of its decision in writing by personal delivery to the Practitioner or by certified mail, return receipt requested.

4.6 Appellate Review

4.6-1 Request for Appeal

Within 14 days after receiving notice of the action of the Board of Trustees, the Practitioner may appeal. This request shall be made in writing, return receipt requested, to the Hospital President and shall specify the reasons justifying further review. Failure to make a timely request shall constitute a waiver of the right of appeal and an acceptance of the Board's ruling.

4.6-2 Grounds for Appeal

The grounds to be argued on appeal shall be limited to:

(a) There was substantial and material failure to comply with this Article of the Bylaws so as to deny due process or a fair hearing; or

(b) The Board action under Section 4.5-16, in light of the recommendation of the Hearing Panel, was (1) arbitrary and capricious, or (2) not supported by substantial evidence (as defined above).

4.6-3 Notice of Review

Upon receipt of a timely request for appeal, the Hospital President shall arrange for a Review to be held within 45 days of the receipt of the request. The Practitioner shall receive written notice, return receipt requested, of the date, time and place for the Review no later than 14 days prior to the scheduled appellate review. The time for Review may be extended for good cause by the Chairman of the Board of Trustees.

4.6-4 Composition of the Appellate Review Committee

The Chairman of the Board of Trustees shall appoint a committee to act as an appellate body with one (1) member being designated as Chairman. The Review Committee shall consist of not less than five (5) members and shall not contain any person that directly participated in the Hearing. The Review Committee shall contain three (3) members of the Board of Trustees and two (2) members of the Medical Staff. These Medical Staff members shall not be in direct

economic competition with the Practitioner, or a member of the Credentials Committee or the MEC. The Hospital President, the Chief or President of the Medical Staff and a representative of the Hospital Administration may attend the proceedings, but not as voting members of the Review Committee.

4.6-5 Presiding Officer

The Chairman of the Review Committee may appoint a Presiding Officer to assist in matters of argument and procedure during the review process. The Presiding Officer may be, but is not required to be, the same individual who served in that capacity during the Hearing.

4.6-6 Written Statement

Each party shall have the right to present a written statement in support of its position on appeal. Legal counsel may assist in the preparation of these statements. The written statement shall be delivered to the Chairman of the Review Committee and the other party at least seven (7) days before the date of the scheduled Review, return receipt requested. Each party shall have three (3) days to submit written objections to the form and/or content of the other party's statement to the Chairman of the Review Committee. The Chairman, in consultation with the Presiding Officer if one is appointed, shall rule on these objections.

4.6-7 Record on Appeal

Except as provided below, the Record on Appeal that may be reviewed and considered by the Review Committee shall be limited to (1) the written statements; (2) the evidence admitted in the Hearing consisting of (a) documents, (b) witness testimony, and (c) matters taken by official notice; (3) the Record of the Hearing; and (4) closing statements submitted at the end of the Hearing. New evidence shall be accepted or excluded at the sole discretion of the Review Committee and only upon a sufficient demonstration by the proponent that the new evidence was not reasonably available at the time of the Hearing.

The Review Committee has sole discretion whether to allow the parties and their counsel to appear in person to present oral argument subject to any limitations imposed by the Review Committee, or to review only the Record on Appeal as provided in this Section.

4.6-8 Recommendation to the Board of Trustees

The Review Committee shall review the Record on Appeal and statements of the parties, and shall deliberate in private. The Review Committee may adjourn and reconvene at any time if additional investigation or deliberation is needed.

The Review Committee may recommend that the Board of Trustees affirm, reverse or modify the previous decision. The decision of the Review Committee shall be by majority vote of its members and shall be communicated in writing to the Board of Trustees within 10 days after conclusion of the appellate review.

4.6-9 Board of Trustees Action

The Board of Trustees shall review the recommendation of the Review Committee and make its final decision not later than its next regularly scheduled meeting. The Board is not bound by the recommendation of the Review Committee, so it may affirm, reverse or modify the same. If the Board requests further investigation, such investigation shall take place and be reported to the Board of Trustees within 30 days, and final action shall be taken not later than the next regularly scheduled meeting after such report. The Board decision shall be communicated in writing, return receipt requested to the MEC and the Practitioner.

4.7 Right to One Hearing and One Appeal

The Practitioner shall have the right to only one (1) hearing and one (1) appellate review on any matter.

Article V CONFIDENTIALITY, IMMUNITY AND RELEASE

5.1 Confidentiality of Information

5.1-1 General

Confidentiality shall be accorded to the fullest extent permitted by law to all activities of the Medical Staff that occur pursuant to the Bylaws and the Rules and Regulations.

5.1-2 Breach of Confidentiality

Any breach of the confidentiality described in Section 5.1-1 is outside appropriate standards of conduct of 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 MEC may undertake such corrective action as it deems appropriate, and such conduct shall be considered in the granting or removal of clinical privileges or prerogatives of Medical Staff membership.

5.2 Immunity from Liability

5.2-1 For Action Taken

Each representative of the Medical Staff and Hospital shall be exempt, to the fullest extent permitted by law, from liability to a Practitioner 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.

5.2-2 From 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 a Practitioner 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, a Practitioner to or member of the Medical Staff or who did, or does, exercise clinical privileges or provides services at this Hospital.

5.3 Activities and Information Covered

The confidentiality and immunity provided by this Article shall apply to all acts, communications, investigations, 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 department, division, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and
(f) peer review organizations.

5.4 Release

Each Practitioner 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 releases shall not be deemed a prerequisite to the effectiveness of this Article.

Article VIOFFICERS, DEPARTMENTS AND COMMITTEES OF THE MEDICAL STAFF

6.1 Officers

The designation, duties and term of the officers of the Medical Staff shall be defined in the Rules and Regulations.

6.2 Departments

36.

37. The Medical Staff be divided into various clinical Departments described in the Rules and Regulations. Each Department shall be organized as a separate component of the Medical Staff and shall perform clinical services and certain functions under the direction of a Department Chief. The Department Chief shall be appointed and entrusted with the authority,

duties and responsibilities set forth in the Rules and Regulations.

6.3 Committees

Medical Staff committees shall be defined in the Rules and Regulations and include but are not limited to, general meetings of the Medical Staff as a committee of the whole, meetings of Departments, divisions or sections, meetings of standing committees established under the Rules and Regulations, and meetings of special or ad hoc committees created to perform specified tasks. Each Medical Staff committee shall have the authority to appoint subcommittees and special or ad hoc committees as needed, and shall be accountable to the MEC.

Each Medical Staff committee acts as a "medical peer review committee" and/or a "medical committee" pursuant to Texas Occupations Code Sections 151.002(a)(7), 151.002(a)(8), and 160.007 and the Texas Health and Safety Code Section 161.031. Accordingly, all activities, proceedings, documents, reports, information, records and all communications of any Medical Staff committee are privileged and confidential to the fullest extent permitted by law.

6.4 MEC

6.4-1 Composition

38.

39. The composition of the members of MEC shall be set forth in the Rules and Regulations.

40.

6.4-2 Officers of the MEC

41.

42. The officers of the MEC shall include a Chairman and Vice-Chairman who will be appointed as set forth in the Rules and Regulations. The terms of such officers, as with all officers of any Medical Staff standing committee, shall be set forth in the Rules and Regulations.

43.

6.4-3 Authority and Duties of the MEC

44.

45. The authority and duties of the MEC shall be to:

(a) Act on all matters on behalf of the self-governing, organized Medical Staff, without requirement of subsequent approval by the Medical Staff, subject to any limitations imposed by these Bylaws;

(b) Receive and act upon reports and recommendations from Medical Staff committees, and make recommendations to the Board of Trustees;

(c) Exercise final authority over the activities of and policies adopted by the Medical Staff, Departments and committees;

(d) Keep the Medical Staff abreast of JCAHO accreditation, regulatory and other professional standards or requirements;

(e) Enforce Hospital and Medical Staff policies, procedures, rules and regulations in the best interest of patient care and of the Hospital;

(f) Review the Bylaws, Rules and Regulations and all policies of the Medical Staff at least once a year and recommend any changes; and

(g) Review the clinical competency and qualifications of all Practitioners and make recommendations to the Board of Trustees on appointment and reappointment to the Medical Staff, assignment to Departments and delineation of clinical privileges.

6.4-4 Meetings of the MEC

The MEC shall meet as often as necessary at the call of the Chairman of the MEC, but at least bi-monthly. The MEC shall maintain a confidential record of its proceedings, and shall report to the Board of Trustees. Voting, quorum, and other meeting matters are set forth in the Rules and Regulations.

6.4-5 Executive Session of the MEC

An executive session is closed to non-members of the MEC with the exception of individuals invited to attend by the Chairman of the MEC and the Hospital President.

Article VII ADOPTION AND AMENDMENT OF BYLAWS

7.1 Medical Staff Authority

The Medical Staff shall have the authority, delegated from the Board of Trustees, to recommend and adopt all Bylaws.

7.2 Procedure

The Medical Staff may adopt any Bylaws or amendment by the affirmative vote of two-thirds (2/3) of the eligible voting members of the Medical Staff present at a called Medical Staff meeting following at least seven (7) days prior written notice. The proposed Bylaws and/or amendments shall be made available in electronic format, with a hard copy available for inspection in the Medical Staff Services office, at least seven (7) days prior to the meeting.

Notwithstanding the above, the Bylaws may be amended as necessary to comply with any state or federal laws or any requirements of JCAHO. Such proposed amendments, along with documentation indicating necessary compliance, shall be presented to the MEC and be approved by two-thirds (2/3) of the MEC members eligible to vote. Adoption of these amendments is subject to the final review and approval of the Board of Trustees.

7.3 Board of Trustees Action

The Bylaws, and any amendment to the Bylaws, that have been adopted by the Medical Staff shall become effective upon ratification by the Board of Trustees. The Board of Trustees shall take action on any Bylaws or amendment at its next regularly scheduled meeting following receipt from the Medical Staff.

7.4 Initiation of Amendment by Board of Trustees

46. In the event the Medical Staff fails to exercise its responsibility and authority reasonably and in the best interest of patient care or the effective operation of the Hospital, the Board of Trustees may give reasonable advance notice to the Medical Staff and may initiate any amendment to the Bylaws. In such event, the Board of Trustees shall carefully consider recommendations and opinions of the Medical Staff regarding its proposed action.

7.5 Rules and Regulations

7.5-1 Medical Staff Rules and Regulations

Subject to approval by the Board of Trustees, the MEC shall adopt Rules and Regulations to implement more specifically the general principles found in these Bylaws. These Rules and Regulations govern the proper conduct of Medical Staff organizational and administrative activities and the level of practice required of each Practitioner at the Hospital. Such Rules and Regulations shall be a part of the Bylaws, except that they may be amended or repealed at any regular meeting of the MEC with the approval of at least two-thirds (2/3) of the MEC members eligible to vote and without prior notice. Such amendments shall become effective when approved by the Board of Trustees.

7.5-2 Department Policies and Procedures

Subject to approval by the MEC, each Department shall formulate its policies and procedures for the conduct of its affairs and the discharge of its duties. Such policies and procedures shall be consistent with these Bylaws, Rules and Regulations of the Medical Staff and applicable Hospital and Department policies and procedures. The Medical Staff Services office will maintain a permanent file of the current policies and procedures of each Department.

7.6 Savings Clause

The provisions set forth in these Bylaws supersede all prior versions thereof contained in the Medical Staff Bylaws of Baylor Medical Center at Garland. Except as expressly superseded herein, the provisions of the existing Rules and Regulations and other applicable Hospital and Department policies and procedures shall remain in full force and effect unless and until replaced by a subsequently written document. To the extent the existing Rules and Regulations, or other applicable Hospital and Department policies and procedures conflict with the provisions set forth herein, the provisions of these Bylaws shall control.