BYLAWS OF THE MEDICAL STAFF

OF

THE METHODIST HOSPITAL

HOUSTON, TEXAS

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PREAMBLE

WHEREAS, The Methodist Hospital ("Hospital") is a non-profit corporation organized under the laws of the State of Texas; and

WHEREAS, no physician, podiatrist, or dentist shall be entitled to Medical Staff appointment and clinical privileges at this Hospital solely by reason of education, licensure, or appointment to the medical staff of another hospital; and

WHEREAS, the purpose of the Hospital is to serve as a general, tertiary care, and teaching hospital providing patient care, education, and research; and

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of medical care provided to patients in the Hospital and for the ethical conduct and professional practices of its members, and the Medical Staff must accept and discharge this responsibility, subject to the ultimate authority of the Board; and

WHEREAS, the cooperative efforts of the Medical Staff, the Chief Executive Officer, and the Board are necessary to fulfill the Hospital's obligations to its patients.

NOW, THEREFORE, BE IT RESOLVED that the physicians, podiatrists, and dentists practicing in the Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws.

DEFINITIONS

1. The term "adverse action" shall mean a final action by the Board of Directors of the Hospital that adversely affects the Medical Staff membership or clinical privileges of a Practitioner.
2. The term "adverse recommendation" shall mean a recommendation of the Executive Committee of the Medical Staff, that, if affirmed by the Board of Directors of the Hospital, will adversely affect the Medical Staff membership or clinical privileges of a Practitioner.
3. The term "Allied Health Professionals" or "AHPs" shall mean Medical Scientists or the office personnel or employees of a member of the Medical Staff who are credentialed and approved to assist the Staff member with the care and treatment of his patients at the Hospital.
4. The term "Board" shall mean the Board of Directors of the Hospital.
5. The term "Bylaws" shall mean these Bylaws of the Medical Staff of the Hospital and the Rules and Regulations adopted hereunder.
6. The term "Chief Executive Officer" or "CEO" shall mean the individual appointed by the Board to act on its behalf in the overall management of the Hospital.
7. The term "clean application" shall mean an application in which all aspects of the application are complete; all references have been returned with all questions fully answered as either superior or good; the applicant has not been a party to any malpractice cases, hospital actions, or licensing actions requiring further investigation; the privileges checklist has been reviewed and approved by the Chair of Department or his designee at the Hospital; and all training, licensure, National Practitioner Data Bank, and OIG database information has been verified, with the results of such verification found to be acceptable.
8. The term "clinical privileges" or "privileges" shall mean the permission granted by the Board to render specific diagnostic, therapeutic, medical, dental, or surgical services at the Hospital.
9. The term "completed application" shall mean an application in which all questions have been answered, all information and documentation have been provided, and all verifications solicited by the Hospital have been received and require no further investigation. A completed application may be determined to be incomplete, based upon the review of the Chair of Department, the Credentials Committee or the Executive Committee.
10. The term "corrective action" shall mean any action designed to improve deficiencies in a Staff member's practice or behavior or to remove risk to patients, peers, or staff, and may include any or all of the following actions: a letter of reprimand; concurrent or retrospective monitoring; mandatory continuing medical education; mandatory consultation requirements; mandatory medical/psychiatric treatment or

counseling; probation for a specified period of time; and/or reduction, modification, limitation, suspension, or revocation of clinical privileges or Staff membership.

11. The term "days" shall mean calendar days, unless otherwise specified herein. Notice periods specified herein mean calendar days. Days are counted beginning on the day following the transmittal or receipt of a notice or other required correspondence.
12. The term "dentist" shall mean an individual with a D.D.S. or D.M.D. degree currently licensed to practice dentistry by the State of Texas.
13. The term "designee" of the Chief Executive Officer shall mean the Director of the Medical Staff Services Department of the Hospital or an executive of the Hospital designated by the Chief Executive Officer to act on his behalf under these Bylaws.
14. The term "Executive Committee" shall mean the Executive Committee of the Medical Staff, unless specific reference is made to the Executive Committee of the Board.
15. The term "executives" shall mean those employees of the Hospital who serve in senior management positions and are designated by the CEO to act on his behalf.
16. The term "ex officio" shall mean service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, refers to a position without voting rights.
17. The term "Fair Hearing Plan" shall mean the document so entitled, attached hereto and duly approved by the Medical Staff and the Board.
18. For the purposes of the Allied Health Professional Manual, the term "full time equivalent" shall mean no more than 50 hours per week
19. The term "Grievance Panel" shall mean the panel designated and appointed as provided in these Bylaws to serve as a pool from which individuals are selected to serve as members of a committee pursuant to the grievance resolution procedure, as members of a Hearing Committee, or as the physician representatives of an Appeals Committee. The Hearing Committee and the Appeals Committee are defined and organized under the Fair Hearing Plan of the Medical Staff.
20. The term "High Risk Procedure" shall mean any operative, other invasive, and noninvasive procedures that place the patient at risk. At The Methodist Hospital, high risk procedures include, but are not limited to, invasive procedures where the patient is sedated, even moderately. For example, and not by way of limitation - catheterization procedures, endovascular radiology procedures, digestive disease procedures, and bronchoscopy.
21. The term "Hospital" shall mean The Methodist Hospital, a general, tertiary care and teaching hospital located in the Texas Medical Center, Houston, Texas.
22. The term "investigation" shall mean the activities of gathering information, interviews, reviews, evaluations, making decisions, and transmitting recommendations concerning the professional competence or professional conduct of a particular Practitioner by a special interview committee formed to evaluate significant concerns, an ad hoc committee formed to confirm a summary suspension, or the Credentials Committee convened to Investigate, all as defined in the Investigation Procedure. No similar activities by other Medical Staff or Performance Improvement committees constitute Investigations.
23. The term "majority" shall mean more than half; and when the term "majority vote" is used without qualification it shall mean more than half of the votes cast by persons legally entitled to vote, excluding blanks or abstentions, at a regular or properly called meeting at which a quorum is present.
24. The term "Medical Staff" or "Staff" shall mean those duly licensed physicians, podiatrists, and dentists who have been granted clinical privileges to work within and use the facilities of the Hospital for or in connection with the observation, care, diagnosis, or treatment of patients.
25. The term "Medical Staff Year" shall mean the calendar year.
26. The term "medico-administrative" shall refer to a position held by a Practitioner employed by the Hospital, either full or part-time, whose duties are medico-administrative in nature and include clinical responsibilities or functions with the Medical Staff involving his professional capability.
27. The term "Mid-Level Professional" shall mean a health care professional in a discipline approved by the Board or its delegated representative for Mid-Level Professional status at The Methodist Hospital, with Practitioner direction and/or supervision if required, to provide patient care, treatment, and services set forth in Article V. Mid-Level Professionals require a grant of clinical privileges, but are not eligible for membership on the Medical Staff. Examples of Mid-Level Professional are physician assistants, nurse practitioners, certified nurse midwives and certified registered nurse anesthetists.

28. The term "patient contacts" shall mean direct patient care including personal participation in admissions, discharges, inpatient procedures, consultations, or outpatient procedures. Referring patients to The Methodist Hospital does not constitute a patient contact.
29. The term "physician" shall mean an individual with an M.D. or D.O. degree currently licensed to practice medicine by the State of Texas.
30. The term "podiatrist" shall mean an individual with a D.P.M. degree currently licensed to practice podiatry by the State of Texas.
31. The term "Practitioner" shall mean, unless otherwise expressly limited, any physician, podiatrist, or dentist holding a current license to practice within the scope of his license.
32. The term "preceptor" shall mean a physician who functions as an educator and counselor on behalf of the Medical Staff. In general, a preceptor will be assigned to introduce a Practitioner to the expectations of the Medical Staff, to counsel the Practitioner on steps to take to meet those expectations, to monitor the progress of the Practitioner toward meeting the expectations, and to report on that progress. During the assignment, the preceptor shall:
    a. Counsel, teach, instruct, coach, or advise the Practitioner being educated;
    b. Be permitted (but not required) to have a physician-patient relationship and to be an active participant in the care rendered to patients of the Practitioner being educated;
    c. Be permitted (but not required) to receive compensation directly or indirectly from patients of the Practitioner being educated;
    d. Maintain the confidentiality of all reports of educational activities and the Practitioner's progress; and
    e. Promptly notify the chair of the department of the Practitioner being evaluated if the preceptor develops concerns about the Practitioner's competence that may be sufficient to warrant a departmental intervention or review.
33. The term "President of the Staff" shall mean the duly elected President of the Medical Staff of The Methodist Hospital, Houston, Texas.
34. The term "Procedural Progress Note" shall mean a brief statement of events, findings, and facts written to inform the patient's next provider of care or service.
35. The term "Procedural Report" shall mean a formal statement or official account of the procedure that may be written, dictated, or compiled for entry into the patient's medical record. The Procedural **Report** must contain, as applicable, a detailed account of the findings, the technical procedures used, the specimens removed, the postoperative diagnosis, and the name of the primary performing surgeon and any assistants.
36. The term "proctor" shall mean a physician who functions as an observer, evaluator, and reporter on behalf of the Medical Staff. In general, a proctor will be assigned to assess and report on the professional competence of a Practitioner. During the assignment, the proctor shall:
    a. Have no obligation to teach, instruct, coach, or advise the Practitioner being evaluated (this does not preclude the proctor from such educational activities, if the proctor is willing and the educational activities do not impair the evaluation and reporting);
    b. Have no physician-patient relationship with any patient of the Practitioner being evaluated;
    c. Have no obligation to intervene if the care provided by the Practitioner being evaluated appears to be or is deficient (this does not preclude the proctor from rendering emergency medical care, if appropriate);
    d. Receive no compensation directly or indirectly from any patient for the proctoring activities;
    e. Maintain the confidentiality of all reports of proctoring activities; and
    f. Promptly notify the chair of the department of the Practitioner being evaluated if the proctor develops concerns about the Practitioner's competence that may be sufficient to warrant a departmental intervention or review.
37. The term "professional graduate training program" shall mean a program which has received required approval or sponsorship from the Graduate Medical Education Committee (GMEC) of The Methodist Hospital.
38. The term "professional office address" shall mean the physical professional office location of an applicant or Practitioner. A professional office address cannot be a home address or post office box, unless the Practitioner is a member of the Honorary/Emeritus Staff.
39. The term "professional review action" shall mean a peer review action evaluating the competence, professional conduct, or quality of care of a Practitioner or Mid-Level Professional, which has or may

adversely affect patient care. A summary suspension or a restricted privilege plan that adversely affects the clinical privileges of a Practitioner or Mid Level Professional for a period longer than thirty (30) days becomes a professional review action if it is affirmed by the Credentials Committee.

40. The term "quorum" for Committee and Department Meetings, shall mean the presence of fifty percent (50%), but not less than two, of the Active Medical Staff members of a Committee or Department with voting rights. Action may be taken without a meeting by unanimous consent, in writing, signed by each member entitled to vote. For Medical Staff Meetings, the tern shall mean the presence of 50 members of the Active Staff, when duly assembled in person in official session at any regular or special meeting.
41. The term "Residents" shall mean those individuals, licensed as appropriate, who are graduates of medical, dental, osteopathic, or podiatric schools and who are appointed to the Hospital's professional graduate training program and who participate in patient care under the direction of Practitioners who have clinical privileges for the services provided by the Residents.
42. The term "Rules" shall mean the Rules and Regulations of the Medical Staff adopted pursuant to the terms of these Medical Staff Bylaws.
43. The term "Special Notice" shall mean written notification sent by certified or registered mail, return receipt requested, or by personal delivery with a receipt of delivery or attempted delivery obtained.
44. The term "State" shall mean the State of Texas.
45. The term "State Board" shall mean, as applicable, the Texas State Board of Medical Examiners, the State Board of Dental Examiners, the State Board of Podiatric Examiners, or such other licensing board that may review individuals who have clinical privileges at the Hospital.
46. The term "System" shall mean the Methodist Hospital System and its multiple hospitals and facilities.
47. The term "telemedicine" shall mean the use of interactive audio, video, or other electronic media to deliver health care. The term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. The term does not include services performed using a telephone or facsimile machine.
48. The term "written" or "in writing" can include "by pen, electronically, or digitally".
49. For the purposes of these Bylaws, as well as the policies and procedures and protocols of the Hospital, the terms attending, primary, primary attending, and responsible physician shall be synonymous. Unless otherwise indicated, the attending (*i.e.*, the responsible) physician shall also be the admitting physician. Responsibilities of the attending/ responsible/admitting physician shall include but not be limited to the following: providing for the overall care and treatment of the patient; coordinating the input and care of various consultants, Residents, and other health care providers; communicating with the patient and family; and complying with the medical record documentation requirements of the Medical Staff, including admitting and discharge orders.
50. Whenever the context requires, words of masculine gender used herein shall include the feminine and the neuter, and words used in the singular shall include the plural.

OVERVIEW

All medical staff activities will support the mission, vision and values of The Methodist Hospital (TMH).

Mission: To provide high quality, cost effective health care that delivers the best value to the people we serve in a spiritual environment of caring in association with internationally recognized teaching and research.

Vision: People will seek Methodist as a globally recognized leader of pioneering medical expertise and innovative, personalized care.

Values:

INTEGRITY: We are honest and ethical in all we say and do.

COMPASSION: We embrace the whole person and respond to emotional, ethical and spiritual concerns as well as physical needs.

ACCOUNTABILITY: We hold ourselves accountable for our actions.

RESPECT: We treat every individual as a person of worth, dignity and

value.

EXCELLENCE: We strive to be the best at what we do and a model for others to emulate.

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ARTICLE I
NAME

The name of this organization shall be the Medical Staff of The Methodist Hospital.

ARTICLE II
PURPOSES

2.1. The purposes of the Medical Staff are:

2.2. To provide a mechanism so that all patients admitted to or treated in any of the facilities, departments, or services of the Hospital shall receive appropriate medical care;

2.3. To promote the performance of a uniform standard of quality patient care, treatment and services by all Practitioners and Mid-Level Professionals authorized to practice in the Hospital through the delineation of clinical privileges that each Practitioner and Mid-Level Professional may exercise in the Hospital and through an ongoing review and evaluation of each Practitioner's and Mid-Level Professional's practice in the Hospital;

2.4. To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill;

2.5. To teach and train medical personnel and AHPs;

2.6. To advance medical knowledge through investigation and research;

2.7. To promote community health;

2.8. To initiate and maintain rules, regulations, and standards for the self-governance of the Medical Staff, subject to the approval of the Board; and

2.9. To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff through the President of the Staff with the Board and the Chief Executive Officer.

ARTICLE III
MEDICAL STAFF MEMBERSHIP

3.1. Nature of Medical Staff Membership. Membership on the Medical Staff of The Methodist Hospital is a privilege extended only to professionally competent Practitioners who continuously demonstrate that they meet the qualifications, standards, and requirements set forth in these Bylaws. The Practitioner must bring forward documentation or testimony that clearly persuades the Medical Staff and Board of Directors that the Practitioner can and does treat patients, professional peers, and employees in accordance with the mission, vision, and values of The Methodist Hospital, as well as the Bylaws, Rules and procedures of the Medical Staff.

3.2. Qualifications for Membership.

3.2.1 Basic Qualifications. Physicians must document their successful completion of a residency training program in the specialty to which applying recognized by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or the Licentiate of the Medical Council of Canada. Podiatrists and dentists must document their successful completion of an appropriately accredited podiatry or dental program. Only Practitioners who can also document their completion of any necessary continuing education and training requirements, their experience, their current licensure and competence, their adherence to the ethics of their profession, their good reputation, their physical and mental health status, their continual maintenance in force of professional liability insurance coverage which meets the established criteria and in not less than the minimum amounts, if any, as from time to time may be jointly determined by the Executive Committee and the Board, and their ability to work with others, with sufficient adequacy to assure the Medical Staff and the Board that any patient treated by them in the Hospital will be given a high quality of medical care, shall be qualified for membership on the Medical Staff. No Practitioner shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Hospital solely by reason of the fact that he is duly licensed to practice medicine, osteopathy, podiatry, or dentistry in the State or in any

other state, or that he had in the past or presently has, such privileges at this or another hospital. All members of the Medical Staff shall locate their homes and offices within a reasonable geographic distance from the Hospital, to meet the needs of their clinical privileges.

(a) In order to improve the quality of medical care provided at the Hospital, applicants for membership to the Medical Staff must also meet at least one of the following criteria:

(1) Board certification granted in the specialty area in which primary clinical privileges are requested by a board recognized by the American Board of Medical Specialties, the Bureau of Osteopathic Specialists, the American Board of Oral & Maxillofacial Surgery, the American Board of Podiatric Surgery, the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, or such other board as the Executive Committee may from time to time recognize; or

(2) Qualified to become board certified in the specialty area in which primary clinical privileges are requested by a board recognized by the American Board of Medical Specialties, the Bureau of Osteopathic Specialists, the American Board of Oral & Maxillofacial Surgery, the American Board of Podiatric Surgery, the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, or such other board as the Executive Committee may from time to time recognize, verified by submission of an approved application to take the appropriate board examination. In order to maintain membership on the Medical Staff, a Practitioner must obtain board certification within five (5) years of the date on which the Practitioner became eligible to sit for the examination of the applicable specialty board, unless additional time is granted by the Executive Committee.

(3) This requirement shall apply to all applicants for initial membership on the Medical Staff whose applications are submitted on or after November 30, 2001.

(b) Unusually qualified Practitioners who do not meet any of the above criteria in Subsection (a) may be given special consideration by recommendation of the Chair of the Department within which the applicant requests primary clinical privileges, subject to approval by the Credentials Committee, the Executive Committee, and the Board.

(c) A Practitioner who is not board certified as described in Section 3.2.1(a)(1) must, upon initial appointment, decide whether to obtain board certification pursuant to the requirements of Section 3.2.1(a)(2) or to request special consideration pursuant to Section 3.2.1(b). If a Practitioner chooses to obtain board certification pursuant to the requirements of Section 3.2.1(a)(2) and does not obtain certification within the applicable time period, he shall be ineligible to request special consideration under Section 3.2.1(b).

(d) A Practitioner who has allowed his board certification to lapse must be recertified by his specialty board before he will be eligible for membership on the Medical Staff.

(e) Under extraordinary circumstance, board certification or re-certification may be waived as a criterion for Medical Staff Membership, but only at the written request of the Practitioner and the written recommendation of the Department Chair and the elected Deputy Chair and in concurrence with the Credentials and the Executive Committees.

3.2.2 Application of Principles of Medical Ethics. Acceptance of membership on the Medical Staff shall constitute the Practitioner's ongoing agreement that he will strictly abide by the Principles of Medical Ethics of the American Medical Association or the American Osteopathic Association, or by the Code of Ethics of the American Podiatric Association or the American Dental Association, whichever is applicable.

3.3. Acceptance of Membership. Acceptance of membership on the Staff shall constitute the Practitioner's ongoing agreement that he will do the following: abide by the terms of "The Methodist Hospital and the Medical Staff of The Methodist Hospital Notice of Privacy Practices"; maintain the confidentiality of all privileged information obtained during his participation in peer review, quality management, or committee activities; accept emergency department call assignment as determined by

the Chair of Department in accordance with the policies of the Department; accept consultations requested by committee chairs or Chairs of Department; avail himself of the resources and training provided by the Hospital to assure that he is capable of utilizing computerized patient information system(s) to the extent required to provide appropriate patient care within the scope of his privileges; and immediately disclose to the Credentials Committee, through the Medical Staff Services Department, any loss of licensure, loss of liability insurance coverage, loss of registration to dispense controlled substances, adverse action by the State quality improvement organization, exclusion from participation in federal health care programs, corrective action by any other health care entity, or change of address (which must include a professional office address and email address). Any changes of contact email address will be provided to the Medical Staff Services Department within fifteen (15) days. Failure to comply with these requirements of membership may result in corrective action, as described in Article VIII of these Bylaws.

3.4. Conditions and Duration of Appointment.

3.4.1 Authority of the Board. Initial appointments and reappointments to the Medical Staff shall be made by the Board. The Board shall act on appointments, reappointments, or revocations of appointments only after there has been a recommendation from the Credentials Committee and the Executive Committee as provided in these Bylaws. Appointments to the Medical Staff shall be made without regard to considerations of race, color, creed, sex, national origin, competition among Practitioners or other health care professionals, or any other basis prohibited by law.

3.4.2 Duration of Staff Appointments.

(a) Initial appointments for an applicant seeking privileges shall be to the Provisional Staff and shall be for a period of no more than two (2) years. If a Practitioner is not elevated from the Provisional Staff to another staff category, the Practitioner shall be removed from the Medical Staff. If the member of the Provisional Staff does not apply for reappointment, such removal shall be automatic and will not give rise to a right of review under the Fair Hearing Plan.

(b) All reappointments for Practitioners shall be for a period of no more than two (2) years.

(c) All appointments and reappointments will follow the procedures outlined in Article VI.

3.4.3 Clinical Privileges. Appointment to the Medical Staff shall confer on the member only those clinical privileges that have been recommended by the Credentials Committee and the Executive Committee and have been granted by the Board in accordance with these Bylaws.

3.4.4 Applications for Medical Staff Membership. Every application for appointment to the Medical Staff shall contain an acknowledgment of the Practitioner's obligations to conduct an ethical professional practice, to abide by the Bylaws, the Rules, and all pertinent Hospital policies and procedures, including the Hospital's Compliance Plan, all as approved by the Board, to accept committee assignments, to accept consultation assignments as requested by committee chairs or Chairs of Department, and to participate, when appropriate, in staffing the Emergency Department. Every application for appointment or reappointment may request the information included in these Bylaws. Additionally, each Practitioner, by submitting an application, pledges to provide continuous care for his patients and acknowledges and agrees to abide by all provisions of these Bylaws providing for immunity and release from civil liability. Each Practitioner also acknowledges and agrees to utilize Hospital resources in a manner consistent with quality patient care and to comply with third party payor standards and requirements, including the requirements of the State's peer review organization and all federal health care programs.

3.4.5 Review for Reappointment. Review of the applications for reappointment shall follow the procedures outlined in Section 6.3 of these Bylaws.

3.4.6 Automatic Termination at Reappointment. Failure to utilize the Hospital may be grounds for modification of Staff category or denial of reappointment. Failure to meet the minimum patient contacts requirement as mandated by the Practitioner's applicable Staff category during the prior twenty-four (24) month term, unless waived, shall automatically terminate the Practitioner's membership and clinical privileges at the end of the Practitioner's current appointment period, and the Practitioner shall have no right to review under the Fair Hearing Plan.

3.4.7 Waiver of Patient Contacts Requirement. The Practitioner's Chair of Department and Elected Deputy Chair of Department may waive the patient contacts requirement by providing, in writing, their justification for waiving the requirement and their personal knowledge of the Practitioner's current competence. Members of the Medical Staff who are subject to deletion due to insufficient patient contacts may seek a waiver to remain on staff as only a member of the Courtesy Staff.

3.5. Exclusion from Membership

3.5.1 Graduate Staff. The Graduate Staff shall consist of Residents and/or Sub-specialty Residents who are currently enrolled in a professional graduate training program, which has received required approval or sponsorship from the Graduate Medical Education Committee (GMEC) of The Methodist Hospital. Members of the Graduate Staff are excluded from eligibility for Medical Staff membership. Residents may not admit patients and must practice under the supervision of a member of the Medical Staff. These practitioners are governed by teaching affiliations or by job descriptions established by authorized representatives of The Methodist Hospital Education Institute and shall comply with these Bylaws, the Rules, and the policies and procedures of the Hospital.

ARTICLE IV
THE MEDICAL STAFF

4.1. Categories. The Medical Staff shall be divided into the Provisional, Active, Courtesy, Consulting, and Honorary/Emeritus categories. All Staff members shall be appointed to a specific Department according to their primary area of practice and which most closely relates to their accredited education and training. Clinical privileges and/or limitations on clinical privileges shall be delineated in accordance with the procedures adopted by the Board. Staff members may be granted privileges that are considered to be within the domain of another Department with the approval of the Chair of Department to which the Staff member is appointed and the Chair(s) of Department in whose domain the privileges fall.

4.1.1 Provisional Medical Staff. The Provisional Staff shall consist of Practitioners who are serving their initial appointment period of no more than two (2) years and who meet the basic qualifications for Staff Membership. Practitioners on the Provisional Staff shall not be eligible to vote or hold elected office, but they may serve on Medical Staff committees, except for the Executive Committee, the Bylaws and Rules Committee, the Credentials Committee, and the Nominating Committee. Practitioners on the Provisional Staff shall be invited to attend meetings of the Staff and of their Department. In order to be eligible for advancement to the Active Staff, members of the Provisional Staff must have attended fifty percent (50%) of all Department meetings and regular general Staff meetings during each Medical Staff Year.

(a) Evaluation of Practitioners on the Provisional Staff. Each Practitioner initially appointed to the Provisional Staff shall be assigned to a Department so that the Practitioner's professional performance, clinical competence, and ethical character may be observed to determine his qualifications for advancement to the category requested.

(b) Review of Provisional Appointments.

(1) In connection with the provisional appointment of each Practitioner, the Chair of Department of the Department to which the Practitioner is assigned shall act as the Practitioner's preceptor or shall designate an independent preceptor to review the activities of the provisional appointee.

(2) During the term of provisional appointment, the Chair of Department of the Department to which the Practitioner is assigned (and/or such preceptor, as designated by the Chair of Department) shall from time to time monitor and observe the professional performance of the Practitioner, and the Practitioner shall use his best efforts to perform at the Hospital the privileges provisionally granted to him. The purposes of monitoring and observing are to provide the Practitioner with an opportunity to demonstrate (i) that he is able to perform each procedure specified for observation in his provisional appointment, (ii) that he appropriately exercises the privileges provisionally awarded to him, (iii) that he continually meets all of the qualifications of the Staff category to which he requests appointment, and (iv) that he consistently discharges the responsibilities of such Staff category.

(3) Prior to the end of each Practitioner's twenty-four (24) month term on the Provisional Staff, or sooner if warranted, the Practitioner's preceptor, if one shall have been designated, shall report to the Chair of Department concerning the Practitioner's performance. The preceptor shall specifically report any concerns about deviations from the standard of care that the preceptor may have observed in the Practitioner's exercise of clinical privileges. At the end of the twenty-four (24) month term on the Provisional Staff, the Chair of Department may report to the Credentials Committee concerning the Practitioner's performance, highlighting any significant deviations from expected standards that have been observed or that have otherwise come to the attention of the Chair of Department.

(4) At the expiration of this twenty-four (24) month period, the Chair of Department shall recommend either termination from the Medical Staff or elevation of the Practitioner to the Staff category for which he is qualified. The final recommendation regarding either termination or elevation shall be made by the Executive Committee.

(5) After serving their initial twenty-four (24) month appointment on the Provisional Staff, Provisional Staff members, in conjunction with their reappointment to the Medical Staff, shall be transferred to the appropriate Staff category or be automatically terminated from the Medical Staff. A Practitioner may not remain on the Provisional Staff beyond the initial twenty-four (24) month period of appointment.

(6) Failure to meet the requirements of the Staff category for which the member is eligible shall result in deletion from the Medical Staff. A Practitioner whose membership is so terminated shall not have the right to a hearing and appellate review in accordance with the Fair Hearing Plan.

(c) Exemption of Chairs of Department. Chairs of Department shall be exempt from appointment to the Provisional Staff and may be appointed directly to the Active Staff, with all the privileges and prerogatives related to Active Staff status.

4.1.2 Active Medical Staff. The Active Medical Staff shall consist of Practitioners who meet the basic qualifications for Staff membership and who have primary responsibility for the patient care services in the Hospital, including the admission of patients. Members of the Active Staff must maintain at least twenty-four (24) patient contacts at the Hospital during each reappointment cycle, unless the patient contacts requirement is waived pursuant to Section 3.4.7 of these Bylaws. Members of the Active Medical Staff shall also perform the primary administrative functions of the Medical Staff, including serving on Medical Staff committees, holding elected office, and voting at meetings of the Medical Staff. In order to maintain Active Staff status, Practitioners shall attend at least fifty percent (50%) of all regular general Staff meetings (unless this requirement is waived as described below) and fifty percent (50%) of all Department meetings (unless this requirement is waived as described below) during the Medical Staff Year. Practitioners on the Active Medical Staff with twenty-five (25) or more years of service at the Hospital are automatically exempt from the attendance requirement for Department and Staff meetings. Meeting attendance shall be considered at the time of reappointment.

(a) Waiver of attendance at 50% of regular general staff meetings. At the time of a practitioner's reappointment, the President of the Medical staff may waive the general staff meeting attendance requirement for a practitioner who has failed to meet the requirement, upon receipt of:

(1) The practitioner's written request for waiver of the attendance requirement, based upon reasons of the practitioner's required attendance at conflicting professional events of significance to the reputation of The Methodist Hospital and

(2) Written recommendation from the practitioner's Department Chair to grant the request.

(b) Waiver of attendance at 50% of Department meetings. At the time of a practitioner's reappointment, the practitioner's Department Chair and Elected Deputy Chair may jointly waive the Department meeting attendance requirement

for a practitioner who has failed to meet the requirement, upon receipt of the practitioner's written request and justification for waiver of the attendance requirement.

4.1.3 Courtesy Medical Staff. The Courtesy Medical Staff shall consist of Practitioners who meet the basic qualifications for Staff membership and who maintain at least six (6) patient contacts at the Hospital per reappointment cycle. At the time of reappointment, the patient contacts requirement may be waived pursuant to Section 3.4.7. Members of the Courtesy Staff shall be encouraged to attend their Department meetings and at least one regular general Staff meeting per year, but are not required to do so. They may not vote or hold office, but they may serve on Medical Staff committees. The number of patients that members of the Courtesy Staff may admit may be restricted on the basis of patient load and bed availability.

4.1.4 Consulting Medical Staff. The Consulting Medical Staff shall consist of Practitioners who meet the basic qualifications for Staff membership, and who provide consultations on inpatients or outpatients attended by other members of the Staff. Members of the Consulting Staff must maintain at least six (6) patient contacts during each reappointment cycle. At the time of reappointment, the patient contacts requirement may be waived pursuant to Section 3.4.7 of these Bylaws. Members of the Consulting Staff may attend, by invitation, any meeting of the Medical Staff or any committee thereof and are eligible to serve on all Staff committees, except the Nominating Committee. Members of the Consulting Staff shall not admit patients to the Hospital or be the physician of primary responsibility to any patient within the Hospital. Members of the Consulting Staff shall not hold office on the Medical Staff or be eligible to vote on Medical Staff matters.

4.1.5 Honorary/Emeritus Staff. The Honorary/Emeritus Staff shall consist of Staff members of outstanding reputation who have retired from active practice, but who, because of their service and contributions to the Hospital, the Staff wishes to honor and to maintain their affiliation with the Hospital. Members of the Honorary/Emeritus Staff may attend meetings of their Department and the Staff and may serve as consultants or ex officio members on Medical Staff committees, but they are not eligible to vote or hold elected office. Though they shall have no clinical privileges and may not admit or treat patients, they may provide the benefit of their knowledge and expertise to the Staff. Appointment to the Honorary/Emeritus Staff shall be for life and members are not subject to the reappointment procedure.

ARTICLE V
CLINICAL PRIVILEGES

5.1. Clinical Privileges Restricted.

5.1.1 Limitation on Hospital Practice. Every Practitioner practicing at the Hospital by virtue of Medical Staff membership or otherwise shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him by the Board.

5.1.2 Application for Clinical Privileges. Every initial application for Staff appointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such request shall be based upon the applicant's education, medical training, experience, current competence, references, judgment, and other relevant information, including an evaluation of the application information by the Chair of Department of the Department in which such privileges are sought. The applicant shall have the burden of establishing and documenting his qualifications and competency to be granted the clinical privileges requested.

5.1.3 Review of Clinical Privileges. Periodic redetermination of clinical privileges, including an increase or curtailment of such clinical privileges, shall be based upon a review of the records of patients treated in this or, if requested, other hospitals, a review of records that document and evaluate the Practitioner's participation in the delivery of medical care, and a review of data maintained by the Practitioner's Care Management and Performance Improvement Subcommittee and the Chair of Department to which the Practitioner is assigned.

(a) Periodic Review of Clinical Privileges. Periodic redetermination of clinical privileges shall be based upon a review of the records of patients treated in this or, if requested, other hospitals, a review of records that document and evaluate the Practitioner's participation in the delivery of medical care, and a review of data maintained by the Medical Staff

Quality Management Committee and the Chair of Department to which the Practitioner is assigned.

(b) Redelineation of Clinical Privileges.

(1) Curtailment of Clinical Privileges. Curtailment of clinical privileges shall be based upon a review of the records of patients treated in this or, if requested, other hospitals, a review of records that document and evaluate the Practitioner's participation in the delivery of medical care, and a review of data maintained by the Medical Staff Quality Management Committee, the Chair of Department to which the Practitioner is assigned, and any additional information presented.

(2) Addition of Clinical Privileges. Practitioners seeking additional clinical privileges must submit their written request to Medical Staff Services. The evaluation of such request shall be based upon the applicant's record of experience, current competence, judgment, and other relevant information, including a query of the practitioner's state licensure and the National Practitioner Data Bank, as well as an evaluation of the request and all applicable information by the Chair of Department of the Department in which such privileges are sought.

5.1.4 Privileges in More Than One Department. Practitioners may be awarded clinical privileges in one or more Departments in accordance with their education, training, experience, and demonstrated competence. They shall be subject to all of the Rules of such Departments and to the jurisdiction of each Chair of Department involved.

5.1.5 Clinical Privileges for Dentists. Clinical privileges for the members of the Oral & Maxillofacial Surgery and Hospital Dentistry Department shall be based upon their education, training, experience, current competence, references, judgment, and other relevant information. The scope and extent of surgical procedures that each dentist/oral surgeon may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Qualified oral surgeons who admit patients without medical problems may perform the history and physical examination on those patients if they have such privileges, and they may assess the medical risks of the proposed surgical procedures. A physician member of the Staff shall be responsible for performing a history and physical examination on those patients admitted for the care of any medical problem that may be present at the time of admission or that may arise during the hospitalization.

5.1.6 Clinical Privileges for Podiatrists. Clinical privileges granted to podiatrists shall be based upon their education, training, experience, current competence, references, judgment, and other relevant information. The surgical procedures that each podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. All podiatric patients shall receive the same basic medical appraisal as other surgical patients. A co-admitting physician shall be responsible for performing the overall history and physical examination for the care of any medical problems that may be present at the time of admission or that may arise during hospitalization, and for evaluating the risk and effect of the proposed podiatric surgery on the total health status of the patient. The podiatrist shall be responsible for that part of the history and physical examination relating to podiatry and may complete an updated medical history and physical examination as described in Rules C2 and E2(a).

5.1.7 Clinical Privileges for Mid-Level Professionals. Clinical privileges granted to Mid-Level Professional shall be based upon their education, training, experience, current competence, references, judgment and other relevant information. The patient care, treatment, and services provided by Mid-Level Professionals shall be reviewed through medical peer review and/or professional review activity as applicable. Any grant of clinical privileges to a Mid-Level Professional shall automatically terminate on termination of the employment of the individual by, or termination of a contractual relationship with The Methodist Hospital or a sponsoring Medical Staff member. If a Mid-Level Professional is transferred to another Department, the individual's clinical privileges in that Department shall automatically terminate and the individual shall be required to request clinical privileges in the newly assigned Department.

5.2. Allied Health Professionals. AHPs shall be governed by the Allied Health Professional Manual. Members of the Medical Staff who wish to utilize AHPs must do so in accordance with the provisions set out in the AHP Manual.

5.3. Temporary Privileges. Temporary privileges may be granted only to fulfill an important patient care need or during the pendency of the processing of some applications. Temporary privileges may be granted by the Chief Executive Officer or his designee, upon the recommendation of the President of the Medical Staff, or his authorized designee, which may be but shall not be limited to, the applicable Chair of Department or, in his absence, the Deputy Chair of Department.

5.3.1 Important Patient Care Need. Temporary privileges will be granted on a case-by-case basis to a Practitioner who is not an applicant for Medical Staff membership or to a Practitioner fulfilling a department need for hospital-based service(s). Temporary privileges may be granted following the submission of a written request for specific temporary privileges for the care of one or more specific patients and upon the determination that the Practitioner provides necessary skills that currently privileged Practitioners at the Hospital do not possess. Such temporary privileges may be granted only after verification of current licensure, current competence (which shall be provided as a written reference from another hospital or the appropriate Department Director/Chair of Department indicating that the applicant has equivalent clinical privileges at that hospital), and evidence of professional liability insurance coverage (except in the case of Disaster Privileges), which meets the established criteria. Once a request for temporary privileges is received and evidence of medical licensure, current competence, and professional liability insurance provided, the request for temporary privileges will be processed and will include a query to the National Practitioner Data Bank. Temporary privileges may be granted for a time frame not to exceed 120 days. If the Practitioner requires temporary privileges more than twice within a calendar year, he must apply for and be granted Staff membership. Special requirements of supervision and reporting, including a preceptor, may be imposed by the President of the Staff and/or the applicable Chair of Department upon any Practitioner granted temporary privileges for an important patient care need. Temporary privileges shall be immediately terminated upon failure of the Practitioner to comply with such special requirements.

Because of the Hospital's status as an international teaching institution, Practitioners may also be granted temporary privileges for educational purposes in accordance with the procedures outlined in this section. Such privileges will be directly supervised by the applicable Department Chair.

5.3.2 Pendency of a New and Completed Application. Temporary clinical privileges may be granted to a new applicant with a request for specifically delineated clinical privileges whose application is complete and clean, and a review and recommendation by the Credentials Committee and approval by the Board is pending. Temporary privileges pursuant to a new and completed application shall be limited and cannot exceed one hundred twenty (120) days. During the term of temporary privileges, the President of the Staff or the Chair of Department of the Department to which the Practitioner is assigned (and/or such preceptor, if any, as may be designated) may impose special requirements of supervision and reporting upon any Practitioner granted temporary privileges. Temporary privileges shall be immediately terminated upon the Practitioner's failure to comply with such special requirements.

5.3.3 Denial of Temporary Privileges. A denial of temporary privileges shall not constitute an adverse recommendation, and the applicant shall have no right of review under Section 8.2 of these Bylaws or under the Fair Hearing Plan.

5.3.4 Termination of Temporary Privileges. The President of the Staff or the Chief Executive Officer may, at any time, after consultation with the appropriate Chair of Department or his designee, terminate the temporary privileges of a Practitioner. Temporary privileges can also be terminated upon failure to satisfy the basic qualifications for Staff membership. A termination of temporary privileges shall be immediately effective. In the event that the temporary privileges of a Practitioner are terminated or expire, the appropriate Chair of Department or the President of the Staff shall assign a member of the Medical Staff to assume responsibilities for the care of the patients of the Practitioner, until the patients are discharged from the Hospital. The wishes of the patient, or the person legally responsible for the health, care, and welfare of the patient, shall be considered in the selection of the substitute Practitioner. No substitute Practitioner shall be appointed without the consent of the patient or the person legally responsible for the health, care, and welfare of the patient, unless the patient requires immediate care and treatment, and such consent cannot reasonably be obtained. Where consent

is sought and denied, the decision of the patient, or other legally responsible person, shall control. The termination of temporary privileges shall not constitute an adverse recommendation, and the affected Practitioner shall have no right of review under Section 8.2 of these Bylaws or under the Fair Hearing Plan.

5.4. Expedited Credentialing. A committee of the Board may approve the applications of Practitioners who meet the qualifications established for expedited credentialing.

5.5. Telemedicine Privileges. The Hospital is not a receiving facility for telemedicine. If the Hospital becomes a receiving facility for telemedicine services, a Practitioner who provides services through telemedicine shall be credentialed for such privileges.

5.6. Emergency Privileges. A Practitioner, to the extent permitted by his license, shall be permitted to do and assist in doing everything possible in the case of an emergency. (For the purposes of this section, an "emergency" is defined as a condition in which serious permanent harm could result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.)

5.7 Disaster Privileges. Upon activation of the Hospital's Emergency Management Plan and in accordance with the Medical Staff Services *Privileging of Licensed Independent Practitioners (LIP) During a Disaster* policy and procedure, Disaster privileges may be granted to a Licensed Independent Practitioner (LIP) by the CEO or his designee(s), or by the President of the Medical Staff or his designee(s). Practitioners holding a valid license to practice medicine may volunteer to provide services within their scope of practice as outlined by their respective state licensing agency.

5.7.1 Documentation of Volunteer LIPs

(a) In order for volunteers to be considered eligible to act as a LIP, the organization obtains for each volunteer practitioner at a minimum, a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

1) Current picture ID card from a health care organization that clearly identifies professional designation;

2) Current license to practice;

3) Primary source verification of licensure;

4) Identification stating that the individual is a member of a Disaster Medical Assistance Team (DMAT); the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group;

5) Identification that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state or municipal entity); or

6) Verification of the volunteer practitioner's identity and ability to provide emergency care by a current hospital and/or medical staff member.

(b) The determination to grant temporary Disaster privileges to a LIP, will be made on a case-by-case basis, dependent on the needs of the patient population and the facility during the time of the disaster. Prior to attending patients, each volunteer LIP will have a distinctive badge provided. All LIP's granted temporary Disaster privileges, have the right to refuse to perform any procedure for which, in their opinion, they are not proficient or competent to perform.

(c) The CEO or President of the Medical Staff or their respective designees will obtain and verify all information as required when requesting privileges for an important patient care need as defined in Section 5.3.1 of these bylaws.

(d) In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, 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 possible. Primary source verification of licensure

would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges.

(e) Medical Staff Services will maintain a listing of all LIP's granted temporary Disaster privileges on file for future reference.

(f) The Medical Staff oversees the professional practice of volunteer licensed independent practitioners.

ARTICLE VI
PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

6.1. Application for Appointment.

6.1.1 Contents of Application. All applications for appointment or reappointment to the Staff shall contain the following information:

(a) Identity. For the purposes of verifying that the practitioner requesting approval is the same practitioner identified in the credentialing documents, the applicant must present to the Medical Staff Services Department a valid picture I.D., issued by a state or federal agency (e.g., driver's license or passport).

(b) Acknowledgment. The application shall contain an acknowledgment by the applicant that he has received and familiarized himself with the Bylaws, the Rules, and other policies of the Hospital relating to professional practice.

(c) Pledge. The application shall contain an agreement by the applicant to abide by the Bylaws, the Rules, the Special Interview Procedure, the Fair Hearing Plan, the Hospital's Compliance Plan, other policies of the Hospital in effect from time to time, and the Bylaws of the Board of the Hospital, to maintain an ethical practice, to provide for continuous care of all of his patients, and to comply with the requirements of Article XIV with regard to confidentiality, immunity, and releases.

(d) Request for Clinical Privileges. The application shall contain the complete and specific request of the applicant concerning the clinical privileges for which he wishes to be considered. A copy of the privileges requested shall be sent to the references listed by the applicant.

(e) Qualifications. The application shall contain a complete listing of the qualifications of the applicant and the identity of the responsible persons able and willing to verify each such qualification and upon whose opinions the Hospital shall be entitled to rely.

(f) Health Status. The application shall contain information regarding whether the applicant can fully perform the essential functions of the professional medical services and clinical privileges that the Practitioner has requested. If specifically requested by the Credentials Committee, the Executive Committee, or by the Board, a report of an examination of the applicant's physical and/or mental health status conducted by a physician or physicians designated by the President of the Staff and paid for by the applicant shall be obtained to confirm that the applicant can fully perform the essential functions of the professional medical services and clinical privileges that the applicant has requested. The application must include impairing substance clearance from the Practitioner Health Committee.

(g) References.

(1) Peer. The application shall contain the names of at least three (3) peers practicing in the applicant's specialty area who (i) have extensive experience in observing and working with the applicant, (ii) are knowledgeable about and can access the applicant's proficiency in the following six areas of general competencies: Patient Care, Medical/Clinical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and System-based Practice, (iii) are willing to act as references for him and to comment on his qualifications, and (iv) upon whose opinions the Hospital shall be entitled to rely. In addition to the foregoing, any applicant who has completed a program of graduate medical education (*e.g.*, a residency or fellowship) may submit as a reference the name of a faculty member within such program who is willing to act as a

reference for him and upon whose opinion the Hospital shall be entitled to rely.

(2) Institutional. The application shall contain a listing, in chronological order, of the names and addresses of all other general or special hospitals or other health care entities where the applicant has heretofore made application for appointment and/or privileges, the approximate date of each such application, the disposition of each such application, and the applicant's current relationship with each such hospital. The applicant shall account for his activities in every year since graduation from medical or professional school. Upon request of the Credentials Committee, the applicant agrees to provide a request addressed to each hospital where he has applied indicating that all information contained in the applicant's staff file at such hospital be made fully available to representatives of this Staff and Hospital in the course of their evaluation of his application.

(h) Occurrences. The application shall require disclosure, either within the application or on separate pages, the details and circumstances surrounding any of the following occurrences:

(1) Whether the applicant's professional license in any jurisdiction has ever been denied, reduced, suspended, revoked, or otherwise diminished, or whether the applicant has ever voluntarily or involuntarily surrendered his license;

(2) Whether the applicant currently has pending any challenge to his license or any disciplinary action initiated against him by any licensure board;

(3) Whether the applicant's clinical privileges at any other hospital or health care entity have ever been voluntarily or involuntarily limited, lost, denied, reduced, suspended, revoked, relinquished, terminated, or otherwise diminished or whether the applicant has ever been placed on any type of probation;

(4) Whether the applicant has ever voluntarily or involuntarily terminated his medical staff membership at any other hospital or health care entity;

(5) Whether the applicant's membership in any local, state, or national professional society or managed care organization has ever been voluntarily or involuntarily denied, reduced, suspended, revoked, relinquished, terminated, or otherwise diminished or whether the applicant resigned his membership in lieu of an adverse recommendation;

(6) Whether the applicant has had any formal corrective action initiated against him by any hospital, health care entity, professional society, peer review organization, managed care organization, or other professional entity;

(7) Whether the applicant has ever been cautioned, reprimanded, or otherwise disciplined by any other hospital, health care entity, managed care organization, or by any local, state, or national professional society or regulatory agency;

(8) Whether the applicant has ever withdrawn his application for appointment, reappointment, or clinical privileges to the staff of any hospital, health care entity, managed care organization, or for membership in any local, state, or national professional society and whether such action was or was not taken in lieu of an adverse recommendation;

(9) Whether the applicant has ever voluntarily or involuntarily resigned his appointment to the staff of any hospital or health care entity or his membership in any local, state, or national professional society or managed care organization in lieu of an adverse recommendation or action;

(10) Whether the applicant has ever had any claims for professional negligence asserted against him or had any professional negligence lawsuits filed against him in the courts of Texas or any other state, and, if so, a report of the status, nature, and outcome of the claims and lawsuits;

(11) Whether the applicant has had any final judgments against him relating to professional negligence;

(12) Whether the applicant has ever been involved in any settlements of professional liability claims or lawsuits;

(13) Whether the applicant has had any previously successful or currently pending challenges to any licensure or registration to dispense controlled substances (state or district, Drug Enforcement Administration) or whether the applicant has ever voluntarily or involuntarily relinquished such licensure or registration;

(14) Whether the applicant has been terminated, suspended, or the subject of an adverse action by the Medicare, Medicaid, or other federal health care programs;

(15) Whether the applicant has ever been charged with a criminal offense other than minor traffic violations; or

(16) Whether the applicant has ever been sanctioned for unethical conduct, including sexual or other harassment.

(i) Professional Liability Insurance. The application shall contain a certificate of insurance issued by the applicant's current professional liability insurance carrier, which meets the established criteria and in not less than the minimum amounts, if any, as shall from time to time be jointly determined by the Executive Committee and the Board.

(j) Releases. The application shall be accompanied by written releases whereby the applicant (i) authorizes and requests the release of all information relevant to his application, including any occurrences to the Chief Executive Officer for use by the Staff and Hospital, (ii) waives all rights that he might have against any person, institution, or organization conveying such information to the Chief Executive Officer, and (iii) agrees to abide by all applicable provisions of Article XIV with respect to confidentiality, immunity, and releases.

(k) Application Processing Fee. Processing of the application shall require payment of the non-refundable application processing fee, which shall be established from time to time by the Executive Committee. An application submitted without the application processing fee shall be deemed an incomplete application and shall be subject to the provisions of Section 6.1.4.

(l) Additional Information. The applicant shall provide a physical professional office address and such additional information as may be deemed appropriate in light of the Staff Category, Department assignment, and privileges requested.

6.1.2 Submission of Application. After a thorough review of these Bylaws, the Rules, and other policies of the Hospital pertaining to professional practice, the applicant shall complete, sign, and submit his application to the Medical Staff Services Department. The burden of producing all information necessary to the evaluation of the application shall be upon the applicant.

6.1.3 Preliminary Review and Development of Application. The Medical Staff Services Department, as the agent of the Credentials Committee, shall undertake the initial processing of each application, including the review of its contents and the development of evidence with respect thereto. The Medical Staff Services Department shall review the application submitted and shall determine whether the applicant has completed the required informational elements and forwarded the required processing fee. If the Medical Staff Services Department determines that the informational elements have been satisfactorily completed, the Medical Staff Services Department shall seek to verify and develop evidence of licensure, competency, references, and other qualifications set forth in the application and any additional information referred to therein or relevant thereto. The Hospital may contract with a credentials verification organization or otherwise delegate all or any portion of the documentation and information gathering functions in connection with the processing of applications for appointment and reappointment. The Medical Staff Services Department will perform primary source verification of education and licensure by contacting the applicant's medical school, residency program, and states of licensure or by utilizing the American Medical Association master profile for American or Canadian trained applicants or a letter from the Educational Commission for Foreign Medical Graduates for all other applicants.

6.1.4 Incomplete Application. An application that is incomplete, deficient, or for which the Medical Staff Services Department is unable to develop the evidence initially required to support the qualifications and other informational elements contained therein shall not be processed. The Medical Staff Services Department shall notify the applicant of the deficiencies. The applicant's failure to respond or to furnish the information initially or subsequently requested in connection with an application within thirty (30) days of such request shall constitute a waiver of the applicant's rights, if any, to further processing of the application and to any subsequent review to which he might otherwise be entitled.

6.1.5 Notice and/or Forwarding of Completed Application. If the Medical Staff Services Department determines (a) that the application is complete and (b) that the evidence initially required to support the qualifications asserted by the applicant can be developed, the Medical Staff Services Department shall forward the completed application to the Chair of Department. The application shall be considered a completed application only when collection and verification of information is complete.

6.1.6 Communication with Applicants. In order to ensure a reliable and timely method of communicating with members of the Medical Staff, all applicants will be required to provide an individual/unique email address at the time of initial application and reappointment to which all documents and communication can be sent.

6.2. Appointment Process.

6.2.1 Department Recommendations. Upon receipt of the completed application, the Chair of Department of the Department in which the applicant requests primary clinical privileges shall review the application and the applicant's qualifications and, if deemed necessary by the Chair of Department, conduct a personal interview with the applicant. The Chair of Department may then submit to the Credentials Committee his recommendations based solely upon the individual qualifications of the applicant, as to (a) whether or not the applicant should be appointed to the Staff and, if so, what privileges the applicant should be awarded within the Department of the reporting Chair of Department, and whether special conditions, if any, should be made a part of the appointment, or (b) whether action on the application should be deferred pending the receipt of further information or evaluation. This action shall be completed within twenty-one (21) days of the submission of a completed application to the Chair of Department, unless the application is returned to the Medical Staff Services Department for additional information or clarification, during which time the time parameters for processing the application shall be suspended. If no recommendation is received from the Chair of Department within the twenty-one (21) day allotted time period, the Medical Staff Services Department shall forward the application directly to the Credentials Committee.

6.2.2 Credentials Committee Recommendations. The Credentials Committee shall review the application, the supporting documentation, the reports and recommendations of the Chair of Department, if provided, and such other information as it may deem appropriate. The Credentials Committee may directly seek, from the applicant or from others, additional information by telephone, letter, personal interview, or other informal means of inquiry. In such cases, a report of the additional information shall become a part of the application. The Credentials Committee shall submit a written report to the Executive Committee within thirty (30) days of the Credentials Committee's receipt of the completed application, unless there is a question regarding the accuracy of information, the need for additional information, the failure to receive information, the qualifications of the applicant or other similar circumstances necessitating further investigation. Upon the completion of its evaluation, the Credentials Committee shall submit a written report to the Executive Committee, recommending whether or not the applicant should be appointed to the Medical Staff, what privileges, if any, the applicant should be awarded, 1and what special conditions, if any, should be made a part of the appointment.

6.2.3 Executive Committee Recommendations. The Executive Committee shall review the application, the supporting documentation, and the recommendations of the Chair of Department, the Credentials Committee, and such other information as it may deem appropriate. The Executive Committee may directly seek, from the applicant or from others, additional information by telephone, letter, personal interview, or other informal means of inquiry. The Executive Committee may also refer the application back to the Chair of Department and/or to the Credentials Committee for additional consideration and a follow-up report. Upon the completion of its evaluation and within thirty (30) days of its receipt of the reports and recommendations of the Chair of Department and the Credentials Committee, the Executive

Committee shall submit a written report on each application to the Chief Executive Officer for transmittal to the Board; provided, however, that before submitting a report containing an adverse recommendation, the Executive Committee may in its discretion afford the applicant a Special Interview as provided in Section 8.1.2. The time parameters for processing the application shall be suspended until the completion of the Special Interview, if any. The report of the Executive Committee shall recommend whether or not the applicant should be appointed to the Staff, what privileges, if any, the applicant should be awarded, and what special conditions, if any, should be made a part of the appointment.

6.2.4 Board Action.

(a) Nature of Board Action. The Board, after considering the recommendations of the Executive Committee, and such other information as it may deem appropriate, shall in whole or in part adopt, reject, modify, or defer any of such recommendations or refer the recommendations back to the Executive Committee for further consideration and recommendation; provided, however, that before the Board adopts an adverse recommendation with respect to a Practitioner, the Practitioner shall have been afforded an opportunity for review to the extent provided in Section 8.2 and the Fair Hearing Plan, and the Board shall have received and considered such recommendations, if any, as shall have resulted from such review. The time parameters for processing the application shall be suspended until the completion of the hearing process and appellate review, if any.

(b) Expedited Approval. With respect to applications that meet predefined criteria, a Subcommittee of the Board may make initial appointment decisions pursuant to the Expedited Credentialing Policy of the Board.

(c) Elements of Appointment. If the Board appoints the applicant to the Staff, such appointment shall include (i) the Staff category to which the applicant is appointed, (ii) the Department in which the applicant is assigned, (iii) the privileges that the applicant is awarded, (iv) the term of the appointment, which is for a period of no more than two (2) years, (v) the provisional nature of the appointment, (vi) such specific procedures, if any, as are designated for observation during the term of the provisional appointment, and (vii) such special conditions, if any, as are to be made a part of the appointment.

(d) Notice of Final Action. The Board shall take final action within sixty (60) days of receipt of the recommendations of the Executive Committee. When the final action has been taken, the Chief Executive Officer shall give written notice of the decision to the applicant and to the appropriate Chair of Department within twenty (20) days.

6.3. Reappointments.

6.3.1 Issuance of Application. Prior to the expiration of the Practitioner's appointment, the Medical Staff Services Department shall, if the Practitioner is eligible for reappointment, give a reminder notice to the Practitioner of such expiration and provide the Practitioner with an application for reappointment upon which a Practitioner desiring renewal may so indicate and provide supplemental information in accordance with Section 6.3.2.

6.3.2 Contents of Application for Reappointment. By requesting reappointment, the Practitioner agrees to supplement promptly and correctly the information contained in his initial application. Such supplemental information to be contained in an application for reappointment shall include, without limitation, any occurrences described in Section 6.1.1(g) which have transpired since the Practitioner's last application to the Staff; information concerning the Practitioner's current professional liability insurance coverage, which is mandatory; information documenting that the Practitioner has obtained, on an annual basis, the continuing medical education hours required to maintain licensure in Texas; information concerning the Practitioner's current physical and mental health status; impairing substance clearance from the Practitioner Health Committee and information documenting the results of quality assessment and improvement activities in order to assess specifically the Practitioner's professional performance, judgment, and clinical and technical skills. If specifically requested by the President of the Staff, the Credentials Committee, the Executive Committee, or the Board, an examination of the Practitioner's physical or mental health status shall be conducted by a physician or physicians mutually acceptable to the Credentials Committee and the affected Practitioner and shall be paid for by the Practitioner. A report of such examination shall be submitted to the Credentials Committee.

6.3.3 Submission, Initial Processing, and Forwarding. Prior to the expiration of the Practitioner's appointment, each Practitioner eligible for reappointment and desiring reappointment shall submit a completed application for reappointment on the prescribed form and the appropriate processing fee, if any, to the Medical Staff Services Department. The Medical Staff Services Department shall review the application for completeness, verify and develop evidence with respect thereto, and forward a copy of the application and supporting documentation, including developed evidence, to the appropriate Chair(s) of Department.

6.3.4 Expiration of Appointment. The appointment of any Practitioner who fails to submit an application for reappointment shall automatically expire at the end of his appointment period. A Practitioner whose appointment has so expired must submit a new application, and such application shall be processed without preference as an application for initial appointment.

6.3.5 Department Recommendations. The Chair of Department of each Department in which the Practitioner requests privileges shall review the application, the applicant's file, and the applicant's practice. The application for reappointment shall be evaluated by criteria relating to the Practitioner's professional performance, judgment, clinical and technical skills, and specialty. Individual Practitioner data shall be compared to aggregate data of the applicable peer group. Thereafter, the Chair of Department shall report to the Credentials Committee through the Medical Staff Services Department. This action shall be completed within twenty-one (21) days of the submission of a completed application for reappointment to the Chair of Department, unless the application is returned to the Medical Staff Services Department for additional information or clarification, during which time the time parameters for processing the application shall be suspended. If no recommendation is received from the Chair of Department within the twenty-one (21) day allotted time period, the Medical Staff Services Department shall forward the application directly to the Credentials Committee.

6.3.6 Credentials Committee Recommendations. The Credentials Committee, after consideration of the recommendations of the Chairs of Department, if provided, and such other information as it may deem appropriate, shall report in writing to the Executive Committee within thirty (30) days of the Credentials Committee's receipt of the report, if any, from the Chair of Department, unless there is a question regarding the accuracy of information, the need for additional information, the qualifications of the applicant, or other similar circumstances necessitating further investigation. Upon completion of its evaluation, the Credentials Committee shall report in writing to the Executive Committee, recommending whether or not each appointment should be renewed, renewed with modification, or terminated. Recommendations for non-renewals of appointment or clinical privileges shall be documented with recommendations and reasons.

6.3.7 Executive Committee Recommendations. The Executive Committee, after consideration of the recommendation of the Credentials Committee and such other information as it may deem appropriate, shall report to the Chief Executive Officer, within thirty (30) days of its receipt of the reports of the Chair of Department and the Credentials Committee, for transmittal to the Board. The report of the Executive Committee shall recommend whether or not each appointment should be renewed, renewed with modification, or terminated. Before submitting to the Board a report containing an adverse recommendation, however, the Executive Committee may, in its discretion, afford the applicant a Special Interview as provided in Section 8.1.2 or proceed directly to the Fair Hearing Plan.

6.3.8 Board Action.

(a) Nature of Board Action. The Board, after considering the recommendations of the Executive Committee and such other information as it may deem appropriate, shall in whole or in part, adopt, reject, modify, or defer any of such recommendations, or refer the recommendations back to the Executive Committee for further consideration and recommendation; provided, however that if the Board refers the recommendation back to the Executive Committee, the Board must explain the reasons for its referral. Before the Board adopts an adverse recommendation with respect to a Practitioner, the Practitioner shall have been afforded an opportunity for review to the extent provided in Section 8.2 and the Fair Hearing Plan, and the Board shall have received and considered such recommendations, if any, as shall have resulted from such review.

(b) Elements of Appointment. If the Board re-appoints the Practitioner to the Staff, such reappointment shall include (i) the Staff category to which the Practitioner is

appointed, (ii) the Department in which the Practitioner is assigned, (iii) the privileges which the Practitioner is awarded, (iv) the term of the appointment, and (v) such special conditions, if any, as are to be made a part of the appointment.

(c) Expedited Approval. With respect to applications that meet predefined criteria, a Subcommittee of the Board may make reappointment and renewal or modification of Medical Staff memberships and clinical privileges decisions pursuant to the Expedited Credentialing Policy of the Board.

(d) Notice of Final Action. When the final action has been taken, the Chief Executive Officer shall give written notice of the reappointment decision to the Practitioner.

6.4. Modification of Appointments. Each Practitioner who desires a modification of his appointment (*e.g.*, a modification of his Staff category, Department assignment, or privileges) shall submit a written request to his Chair of Department. The request shall be processed in accordance with procedures substantially the same as those specified in Section 6.3 for a reappointment but may be submitted at any time.

6.5. Time Parameters for Processing Applications. All committees, Departments, and representatives of the Staff and Hospital shall make good faith efforts to process applications for reappointment expeditiously. All general time parameters referenced in these Bylaws shall be measured from the time at which the Practitioner furnishes all information that was reasonably requested in accordance with these Bylaws through the submission of a completed application. Such time parameters may, however, be suspended as provided in these Bylaws. The time parameters specified shall be for the guidance of the committee or Department concerned and shall not be deemed to create any right for a Practitioner to require the processing of his application within such parameters, except that (subject to appropriate suspensions) the Credentials Committee must make a recommendation within ninety (90) days after receipt of a completed application, the Board must then take final action within sixty (60) days after the Credentials Committee's recommendation, and the Hospital must notify the applicant within twenty (20) days after the Board has made its final decision.

6.6. Leave of Absence. The Board may grant leaves of absence to members of the Staff. The Staff member must submit a written request for a leave of absence to his Chair of Department, specifying the duration of the leave, which may not exceed a period of twelve (12) months. The Chair of Department will forward the request and his recommendation to the Credentials Committee. At least forty-five (45) days prior to the end of the leave of absence, the Practitioner shall submit a written summary of his relevant activities during the leave, if the Chair of Department or the Board so requests, and a physician's report if the Practitioner's leave of absence was for medical reasons. Failure to return from a leave of absence and resume professional activities shall be considered voluntary resignation from the Medical Staff and shall not give rise to the right to a hearing pursuant to the Fair Hearing Plan. If a Practitioner's appointment expires during a leave of absence, the Practitioner, prior to his return, is responsible for completing an application for reappointment to the Medical Staff and for providing information in conjunction with his activities in the reappointment application.

6.7. Application after Deletion or Automatic Termination. A Practitioner who has been deleted from Medical Staff status after confirmation of an automatic suspension by the Board or who has been automatically terminated for failure to utilize the hospital or maintain the minimum patient contacts required shall not be eligible to apply for Staff membership or clinical privileges for at least twelve (12) months from the effective date of the confirmation by the Board of the suspension or termination, unless his Medical Staff status was reinstated pursuant to Section 6.8.

6.8. Reinstatement after Deletion. A Practitioner who was deleted from Medical Staff status after confirmation of an automatic suspension by the Board may have his Medical Staff membership and clinical privileges reinstated by the Chief Executive Officer or his designee so long as the issue(s) prompting the automatic suspension have been resolved within one hundred twenty (120) days of the date of the Special Notice of the automatic suspension. Reinstatement of Medical Staff status shall be limited and shall be available only if the automatic suspension related to a failure to provide proof of professional liability insurance, proof of current licensure, or proof of current registration to dispense controlled substances and only so long as the reinstatement does not extend a Practitioner's appointment period beyond two (2) years.

6.9. Application after Adverse Action. A Practitioner who has been terminated from the Staff following an adverse action shall not be eligible to apply for Medical Staff membership or clinical privileges for two (2) years from the effective date of the adverse action. Further, an application from a Practitioner who has been the subject of adverse action after requesting and being afforded the

opportunity for review shall include clear and convincing written evidence demonstrating that the basis for any adverse action no longer exists.

6.10. Denial for Hospital's Inability to Accommodate Applicant. A decision by the Board to deny staff appointment, a department or staff category assignment, or particular clinical privileges on the basis of any of the following shall not be considered an adverse decision and shall not entitle the applicant to a hearing and appellate review in accordance with Section 8.2 of these Bylaws and the Fair Hearing Plan:

6.10.1 The Hospital's present inability, as supported by documented evidence, to provide adequate facilities or supportive services for the applicant and his patients

6.10.2 Inconsistency with the Hospital's current provisions of patient care services; or

Professional contracts that the Hospital has entered into for the rendition of services within various sections of the Hospital or for hospital-based services. Unless otherwise specified in the contract, termination of an exclusive contract or termination of a practitioner's relationship with the holder of an exclusive contract shall result in the automatic termination of an affected Practitioner's membership on the Medical Staff and clinical privileges at the Hospital without application of the hearing and appeals provisions of the Fair Hearing Plan. In the case of a terminated contract, if a Practitioner with the outgoing group is also a member of the incoming group, that Practitioner's membership and privileges shall continue uninterrupted.

6.11. Licensure Verification. The Medical Staff Services Office shall verify the renewal of each Practitioner's license, not only at the time of granting, renewal and revision of privileges, but also when such license expires.

6.12. System Applications. The Hospital, with the approval of the Credentials Committee, the Executive Committee, and the Board, may approve and utilize the same application through the hospitals and healthcare entities in the System.

6.13. Core Credentials Data. Upon the implementation of a standardized credentials verification program by the State Board, the Hospital will obtain core credentials data from the State Board.

ARTICLE VII
THE RESPONSIBLE PHYSICIAN

7.1. Definition. The responsible physician embraces any or all of the following terms: attending physician; primary attending physician; primary physician; and admitting physician. The responsible physician is identified as the physician of record by the addressograph plate and is responsible for the daily care and supervision for each patient in the Hospital for whom he is providing services. During a temporary absence, the responsible physician may designate a surrogate member of the Medical Staff with comparable clinical privileges to act on his behalf to carry out the appropriate responsibilities. Thus, on occasion, the admitting physician may be a surrogate physician admitting a patient on behalf of another physician for whom he is temporarily taking call. The surrogate physician will correctly designate the primary attending physician for the purpose of the addressograph plate, but will assume primary responsibility for patient care until the attending physician returns.

7.2. Transfer of Patient Responsibilities. The official transfer of a patient who consents to be transferred to the care of another physician willing to accept the responsibility of attending physician must be documented by a transfer order on the order sheet to the accepting physician, a transfer note on the progress sheet indicating to whom the transfer is being made and acceptance of the transfer by the patient, and an acceptance note on the progress sheet by the receiving physician. An order to change the addressograph plate should be written on the order sheet to reflect this transfer.

7.3. Surgery Department Transfer. A major operative procedure will result in a transfer to the surgeon's Department. It will be the responsibility of the attending physician to confer and verify with the surgeon if this transfer is not to take place.

7.4. Coordination of Care. The coordination of care for a patient with a complicated medical and surgical condition requiring multiple consultants remains the responsibility of the attending physician until or unless the patient is formally transferred to the Department of another physician. For purposes of biomedical ethics discussions, the responsible physician will remain central to patient care discussions and decisions in conjunction with consulting physicians and biomedical ethics committee members.

7.5. Responsibilities of the Responsible Physician. The responsibilities of the responsible physician are directed to the following:

7.5.1 The patient;

7.5.2 The Hospital;

7.5.3 The payor;

7.5.4 Society;

7.5.5 The patient's family;

7.5.6 The Medical Staff;

7.5.7 The physician's employer; and

7.5.8 The laws of the State.

7.6. Specific Responsibilities of the Responsible Physician. Responsibilities of the Responsible Physician with respect to the hospitalized patient include, but are not limited to, the following, each of which should be documented in the patient's hospital record by the Responsible Physician:

7.6.1 Determining the propriety, necessity, and urgency of admission as well as type of unit or facility to which the patient should be admitted;

7.6.2 Providing an admission history and physical examination, admission note, admission orders, and, if the admitting physician is a surrogate physician, documentation of who will be the primary attending physician;

7.6.3 Promoting care that is medically appropriate and scientifically based;

7.6.4 Respecting human dignity in the care of the patient;

7.6.5 Providing for the stewardship of expensive medical services;

7.6.6 Coordinating the input of various consultants and explaining each consultant's role to the patient;

7.6.7 Explaining the diagnosis or differential diagnoses to the patient;

7.6.8 Establishing and executing treatment plans, including the explanation of treatment options, risks and benefits of proposed treatment, and treatment alternatives, in conjunction with the consultants, when appropriate;

7.6.9 Obtaining informed consent, when appropriate;

7.6.10 Assuming responsibility for triage decisions;

7.6.11 Assuming responsibility for appropriate implementation of a patient's living will or other request to forego life-sustaining treatment;

7.6.12 Transferring the responsibility for patient care outside his expertise or training to another more appropriate physician;

7.6.13 Communicating with family members and surrogates, where appropriate, concerning a patient's illness and care;

7.6.14 Ordering and coordinating paramedical services such as physical therapy, occupational therapy, dietary, social service, and home health services;

7.6.15 Assuming responsibility for on-call coverage when personally not available;

7.6.16 Performing discharge planning such as patient education, medication and diet orders, follow-up arrangements, and home health;

7.6.17 Providing orders for discharge;

7.6.18 Providing the discharge summary and completing other chart documentation such as progress notes;

7.6.19 Coordinating, delegating and supervising the Residents and Mid-level Professionals, when appropriate; and

ARTICLE VIII
INFORMATION GATHERING AND CORRECTIVE ACTION PROCEDURES

8.1. Functions of the Information-Gathering Procedures. Information-gathering procedures are utilized by the Medical Staff in connection with the evaluation of the qualifications, professional practice, professional conduct, or any other matters relevant to the administrative or clinical aspects of patient care within the Hospital. The information-gathering procedures of an Interview and a Special Interview afford a Practitioner ("Subject Practitioner") the opportunity to more fully explain or provide evidence to address concerns regarding his qualifications, professional practice, or professional conduct. At least three (3) persons appointed by the President of the Staff shall be present during all information-gathering procedures. The Subject Practitioner must also be asked to appear. While the information-gathering procedures are non-adverse, the results of an Interview and/or a Special Interview could lead to some form of corrective action.

8.1.1 Interviews. The President of the Staff may, in his discretion, direct the holding of one or more Interviews of a Subject Practitioner and shall appoint at least three (3) persons, other than the Subject Practitioner, to serve as interviewers ("Interview Committee") at the Interview. An officer of the Medical Staff, a chair of a standing committee, a Chair of Department, or the Chief Executive Officer may also ask the President of the Staff to schedule an Interview with a Subject Practitioner. The Interview shall be informal, and no court reporter shall be present. Minutes of the Interview shall be kept. The President of the Staff shall furnish the Subject Practitioner and the interviewers with Special Notice of the time, date, place, and general subject(s) of the Interview. The notice may include directions for the production of evidence relevant to the subject(s) of the Interview and may describe the specific procedures, if any, under which the Interview is to be conducted. The Subject Practitioner must appear, produce evidence, and cooperate in the Interview process as a condition for appointment to or continued membership on the Staff. A written report of the findings and recommendations of the Interview Committee shall be forwarded to the person or entity requesting the Interview, the President of the Staff, and the Subject Practitioner.

8.1.2 Special Interviews. The President of the Staff may, upon becoming aware of matters of significant medical, behavioral, or professional concern, initiate a Special Interview in accordance with the "Special Interview Procedure" adopted by the Medical Staff and approved by the Board. Any officer of the Medical Staff, the Chair of the Medical Staff Quality Management Committee, the chairs of other Medical Staff committees, the Chairs of Department, or the Chief Executive Officer may also ask the President of the Staff to schedule a Special Interview with a Subject Practitioner. Minutes of the Special Interview shall be kept. The Subject Practitioner must appear, produce any requested information, and cooperate in the Special Interview process as a condition for appointment to or continued membership on the Staff. A written report of the findings and recommendations of the Special Interview Committee shall be forwarded to the person or entity requesting the Special Interview, the President of the Staff, the Chief Executive Officer, and the Subject Practitioner.

8.1.3 Grievance Resolution Procedure.

(a) With the exception of actions or policies which would otherwise give rise to the right to a hearing as defined in the Fair Hearing Plan and the Medical Staff Bylaws, whenever a Practitioner believes he has been adversely affected by the actions or policies of his Chair of Department, he shall have the right to initiate the Grievance Resolution Procedure by notifying the Elected Deputy Chair of Department of his grievance and requesting a meeting to discuss the matter.

(b) The Elected Deputy Chair shall meet with the Practitioner regarding the grievance. Should a satisfactory resolution to the matter be reached, no further action shall be necessary. Should a resolution acceptable to the parties not be reached, the Elected Deputy Chair shall schedule a meeting of the Practitioner, the Chair of Department, and the Elected Deputy Chair.

(c) The Elected Deputy Chair and the Chair of Department shall meet with the Practitioner regarding the grievance. Should a satisfactory resolution to the matter be reached, no further action shall be necessary. Should a resolution acceptable to the parties not be reached, the Elected Deputy Chair shall notify the President of the Medical Staff who, at his discretion, will proceed under Section 8.1.1 or Section 8.1.2. In this specific circumstance, the requesting Practitioner and the President of the Medical Staff shall agree on the composition of the three (3) members of the

Interview Committee and these three (3) members shall be selected from the Grievance Panel.

8.2. Functions of Corrective Action. Corrective action is the mechanism to assure that members of the Medical Staff maintain appropriate standards of medical care and professional conduct and achieve continuing compliance with these Bylaws and other policies and procedures of the Hospital. Certain forms of corrective action do not adversely affect the privileges, Staff category, or appointment of a Practitioner and are referred to herein as non-adverse corrective action. Other forms of corrective action that may affect clinical privileges, Staff category, or involve a termination of appointment are referred to herein as adverse corrective action.

8.2.1 Non-Adverse Corrective Action.

(a) Letter of Reprimand. A letter of reprimand may be issued to a Practitioner by the President of the Staff, with the approval of either the Practitioner's Chair of Department or the Chair of the Credentials Committee, whenever it is determined that:

(1) Such Practitioner has failed to provide appropriate care or has otherwise failed to discharge his responsibilities under these Bylaws or other policies and procedures of the Hospital; but

(2) Such failure of itself need not currently require the institution of adverse action against the Practitioner pursuant to Section 8.2.2 of these Bylaws; provided, however, that when the President of the Staff issues a letter of reprimand, such letter becomes a permanent part of a Practitioner's file.

(3) Examples of behavior that may give rise to a letter of reprimand include, but shall not be limited to, failure to respond to emergency call or failure to respond to inquiries from the Practitioner's Quality Management Subcommittee.

(4) Letters of reprimand shall be considered at the time of reappointment, may be considered at any other time, and may give rise to adverse corrective action.

(b) Practice Improvement Plan ("PIP"). When a Quality Management Subcommittee identifies concerns or trends regarding a Practitioner's practice and there is no potential threat to patient outcomes, a plan to provide education, promote collaboration, and enhance improvement may be recommended without restricting a Practitioner's practice. A PIP may consist of:

(1) Concurrent monitoring of the Practitioner's practice;

(2) Education (both internal and external); and/or

(3) Retrospective monitoring.

(c) Administrative, Precautionary, and Automatic Suspensions.

(1) Administrative Suspension. The Chief Executive Officer or the President of the Staff may suspend a Practitioner at any time for administrative reasons, including inappropriately disclosing privileged peer review information. Such action shall not constitute a professional review action and shall not give rise to a hearing. The administrative suspension shall remain in effect until the issue is resolved, utilizing appropriate mechanisms described in the Bylaws.

(2) Precautionary Suspension. If, at any time, the Chief Executive Officer, or the President of the Staff, or the Practitioner's Chair of Department has serious but unconfirmed concerns about the qualifications or quality of care of a Practitioner, the Practitioner may be suspended for up to twenty-nine (29) days, during which time an investigation and appropriate corrective action, if necessary, may be initiated. The Medical Staff Services Department shall provide for immediate personal notice and Special Notice of the precautionary suspension.

(d) Approval of Precautionary Suspension. Within twenty-four (24) hours of the affected Practitioner's receipt of verbal notice of a precautionary suspension, the person imposing the precautionary suspension shall confer with and obtain approval from a second person empowered to impose a precautionary suspension. If such approval

for the precautionary suspension is not obtained, the suspension shall be lifted and the Staff member's clinical privileges shall be restored immediately. No further action shall be taken.

(e) Ad Hoc Committee. Within five (5) days of the affected Practitioner's receipt of verbal notice of the precautionary suspension, an ad hoc committee appointed by the Chair of the Credentials Committee shall meet with the persons approving the suspension and the Practitioner in an effort to resolve the concerns that prompted the precautionary suspension. If the matter is not resolved, the ad hoc committee shall so inform the Chair of the Credentials Committee within seven (7) days of the affected Practitioner's receipt of verbal notice of the precautionary suspension and the matter shall be investigated by the Credentials Committee or a subcommittee thereof utilizing the Special Interview Procedure.

(f) Automatic Suspensions. Any Practitioner who meets one or more of the following criteria shall be automatically suspended from the Medical Staff:

(1) The licensure of a Practitioner has been terminated or suspended (taking into account any grace period allowed by law);

(2) The Practitioner has failed to maintain adequate medical records in a timely fashion as specified in the Rules;

(3) The Practitioner has failed to maintain or provide proof of professional liability insurance as required herein;

(4) The Practitioner has failed to provide proof of current licensure;

(5) The Practitioner has failed to maintain or provide proof of current registration to dispense controlled substances; or

(6) The Practitioner has been terminated, suspended, or been the subject of adverse action by the Medicare, Medicaid, or other federal health care programs or the State peer review organization relating to quality of care.

(g) In these circumstances, the CEO or his designee shall promptly give personal and Special Notice of the automatic suspension to the affected Practitioner. An automatic suspension does not give rise to a right of review under the Fair Hearing Plan. If such suspension continues in effect for thirty (30) days, it shall be submitted to the Credentials Committee, the Executive Committee, and the Board for termination of Medical Staff membership and clinical privileges; provided, however, the suspension may be extended for just cause with the approval of the CEO or his designee. Prior to confirmation by the Board, an automatic suspension may be terminated by the Chief Executive Officer or his designee, upon a finding that the specified event(s) that were the basis for the automatic suspension no longer persist.

(1) Notice and Enforcement. It shall be the duty of every Practitioner, as a condition of securing and maintaining his Medical Staff status, to immediately disclose to the Credentials Committee, through the Medical Staff Services Department, any loss of licensure, loss of liability insurance coverage, loss of registration to dispense controlled substances, adverse action by the State professional review organization, exclusion from participation in federal health care programs, or changes in his address or professional office address. A Practitioner's failure to disclose such information may result in corrective action as described in Article VIII of these Bylaws. The President of the Staff shall cooperate with the Chief Executive Officer in enforcing all corrective actions.

(2) Patient Medical Coverage. Immediately upon the imposition of a suspension, the President of the Staff or the Practitioner's Chair of Department shall have the authority to provide for alternate medical coverage for patients of the suspended Practitioner still in the Hospital at the time of the suspension. The wishes of the patients shall be considered in the selection of such alternate Practitioner.

(3) Effect of Suspensions. It shall be the responsibility of the suspended Practitioner not to admit or treat patients during the period of the

suspension. A Practitioner's failure to abide by the terms of the suspension may result in permanent loss of membership on the Staff.

8.2.2 Adverse Corrective Action.

(a) Executive Committee Recommendations. The Executive Committee may, in its discretion, submit an adverse recommendation with respect to a Practitioner to the Chief Executive Officer for transmittal to the Board upon receipt of:

(1) An adverse recommendation resulting from a Special Interview Procedure; or

(2) Any adverse recommendation from the Credentials Committee, including, but not limited to:

(i) A Restricted Privilege Plan ("RPP"), which is originally generated through the quality management procedures of the Medical Staff and designed to improve deficiencies in a Practitioner's behavior or practice or to remove risk to patients, peers, or staff. A RPP may include any or all of the following: mandatory medical/psychiatric treatment or counseling; probation for a specified period of time; and/or reduction, modification, limitation, suspension, revocation, or monitoring of clinical privileges; or

(ii) A behavioral issue that was reported to the Human Resources Department, a Chair of Department, or a Medical Staff Officer.

(b) Summary Suspension. A summary suspension of all or any portion of a Practitioner's privileges may be imposed by the Practitioner's Chair of Department, or the President of the Staff, or the Chief Executive Officer, upon the determination of an immediate, serious, and direct threat to the life or safety of a patient, prospective patient, employee, or other person present in the Hospital or to the operations of the Hospital. Such suspension shall become effective immediately. Within twenty-four (24) hours of the affected Practitioner's receipt of verbal notice of a summary suspension, the person imposing the summary suspension shall confer with and obtain approval from a second person empowered to impose a summary suspension. If such approval for the summary suspension is not obtained, the suspension shall be lifted and the Staff member's clinical privileges shall be restored immediately. No further action shall be taken.

(1) Notice to the Practitioner. The Practitioner's Chair of Department shall immediately and personally notify the Practitioner that a summary suspension has been imposed, that an investigation will be conducted, and that the Practitioner will have an opportunity to provide information relevant to the investigation to the Credentials Committee. Within twenty-four (24) hours of the affected Practitioner's receipt of verbal notice of the summary suspension, the CEO shall provide Special Notice confirming the summary suspension to the affected Practitioner and written notice to the Chair of Department, the President of the Staff, the Chief Executive Officer, and the Chair of the Credentials Committee.

(2) Ad Hoc Committee. Within five (5) days of the affected Practitioner's receipt of verbal notice of the summary suspension, an ad hoc committee consisting of the Chair of the Credentials Committee, the Practitioner's Chair of Department, the elected Deputy Chair of the Practitioner's Department, the Chair of the Practitioner's Quality Management Subcommittee, the Chief Executive Officer, and other persons approving the summary suspension or their respective designees shall meet with the Practitioner. The ad hoc committee shall render a decision within seven (7) days of the affected Practitioner's receipt of verbal notice regarding the necessity of proceeding with an investigation by the Credentials Committee.

(3) Investigation by the Credentials Committee. If the ad hoc committee determines that an investigation by the Credentials Committee is necessary, the Credentials Committee shall conduct an investigation to determine if the corrective action is warranted. The Credentials Committee shall complete its investigation and report the results of its investigation to the Executive

Committee within twenty-nine (29) days of the affected Practitioner's receipt of the verbal notice of summary suspension. In conducting its investigation, the Credentials Committee may delegate investigative duties to individual members or to a subcommittee of its members and may utilize appropriate consultants from the Medical Staff or outside the Hospital. The Credentials Committee may also interview individuals involved or solicit information, including written statements from individuals believed to have knowledge relevant to the investigation. The Credentials Committee must offer an interview to the affected Practitioner.

(4) Findings and Recommendations of the Credentials Committee. If the findings and recommendations of the Credentials Committee are not adverse, the summary suspension shall be lifted. If at the conclusion of the investigation, the Credentials Committee determines that corrective action is warranted, it shall make its recommendations regarding the type of corrective action necessary to the Executive Committee at the next regularly scheduled meeting.

(5) Review by the Executive Committee. The Executive Committee shall review all materials in connection with the recommendation of the Credentials Committee. An adverse recommendation by the Executive Committee initiates the procedures set forth in the Fair Hearing Plan.

(c) Rights of Review. Before the Board confirms an adverse recommendation with respect to a Practitioner, the CEO shall cause Special Notice of such adverse recommendation to be sent to the affected Practitioner, who shall be afforded an opportunity for an evidentiary hearing and an appeal in accordance with the Fair Hearing Plan. Except as may be otherwise provided by the Board in an individual case, this section and the Fair Hearing Plan constitute a complete and exclusive statement of all rights of review afforded to Practitioners under these Bylaws. An adverse recommendation or final adverse action by the Board relating in any way to temporary privileges of any Practitioner shall not give rise to any right of review. An adverse recommendation or final adverse action by the Board relating to an application of an AHP or an individual who has received AHP designation shall be governed by the fair hearing policy for individuals who are not eligible for Medical Staff membership.

(d) Grievance Panel. A Grievance Panel composed of at least twenty-five (25) members of the Active Medical Staff shall be appointed by the President of the Staff at the beginning of each Medical Staff Year. As many Departments as possible shall be represented on the Grievance Panel. The members of the Grievance Panel shall serve as a pool of individuals from which Hearing Committees and physician representatives of Appellate Review Committees are selected for hearings and appellate reviews conducted under the Fair Hearing Plan.

8.3. Initiation of Information-Gathering or Corrective Action Procedures. The initiation of one form of information-gathering or corrective action procedures shall not preclude the contemporaneous or subsequent initiation of one or more additional forms of information-gathering or corrective action procedures.

8.4. Rights of a Practitioner. If the Credentials Committee fails to take action on a Practitioner's completed application or if the Practitioner is subject to a professional review action that may adversely affect his membership on the Medical Staff or his clinical privileges, and the Practitioner believes that mediation of the dispute is desirable, the Practitioner may require the Hospital to participate in mediation in accordance with Chapter 154 of the Texas Civil Practice and Remedies Code. The mediation shall be conducted by a person meeting the qualifications of Section 154.052, and within a reasonable period of time. The procedures of such mediation should be held in accordance with the mediation provisions of the Fair Hearing Plan.

8.5. Records and Proceedings. The records and proceedings of all procedures conducted under Article VIII are confidential and privileged, are not subject to court subpoena, and will not be disclosed to the Subject or affected Practitioner, but may be maintained in the Practitioner's credentials file or in the minutes of the applicable committee or Department.

ARTICLE IX
OFFICERS AND ELECTED OFFICIALS

9.1. Officers and Other Elected Officials of the Medical Staff.

9.1.1 Identification of Officers. The officers of the Medical Staff shall include the:

(a) President;

(b) President-Elect; and

(c) Secretary.

9.1.2 Identification of Other Elected Officials. Other elected officials on the Medical Staff include:

(a) Members-at-large of the Executive Committee; and

(b) Two (2) members of the Nominating Committee.

9.2. Qualifications of Officers and Elected Officials

9.2.1 Qualifications. Officers must be members of the Active Medical Staff who have been on the Medical Staff for ten (10) years, have served on Medical Staff committees, possess leadership and administrative skills, and center their practices at the Hospital. The officers of the Staff may not concurrently serve as a Chair of Department. Officers must remain members in good standing during their term of office and failure to do so shall result in their removal and immediately create a vacancy.

9.3. Election of Officers and Other Officials.

9.3.1 Annual Meeting. The officers of the Medical Staff and the elected members-at-large of the Executive Committee with expiring terms, as well as the elected members of the Nominating Committee, shall be elected at the annual meeting of the Medical Staff. At the Annual Meeting, the President will offer each candidate equal time to address the assembly.

9.3.2 Development of Slate of Candidates. By September 1 of each year, the Nominating Committee shall announce its proposed slate of candidates (officers and elected officials) to the Active Medical Staff. The purpose of this announcement is to allow sufficient time to consider proposed nominations from the floor at the September General Staff meeting. Combined nominations shall be announced as the final slate at the September General Staff meeting.

9.3.3 Notice of Nominations. At least twenty-one (21) days prior to the date of the annual meeting, the Nominating Committee shall distribute to the Active Staff the final slate of all qualified nominees who agree to run for Medical Staff officer positions, at-large members of the Executive Committee, and elected members of the Nominating Committee. The final slate of nominees shall include the candidates who have been nominated by the Nominating Committee and/or from the floor at the general Staff meeting prior to the annual meeting.

9.3.4 Election Procedure. Voting will be by secret ballot with ballot box(es) as the collection repository. All members of the Active Staff who have voting rights shall be entitled to vote for officers, elected members-at-large of the Executive Committee, and elected members of the Nominating Committee.

(a) The Nominating Committee will be solely responsible for counting the votes. Election results, if not communicated the night of the election, will be posted in the Medical Staff Office within 24 hours of adjournment of the annual Meeting and effective communication for all members of the Medical Staff will be made within three working days of the election.

9.3.5 Voting. A majority vote of the qualified members of the Active Staff who are present and voting at the annual meeting at which a quorum is present shall determine the election. Should the votes be divided between more than two candidates and thereby prevent any candidate from receiving a majority, the candidate receiving the fewest votes shall be eliminated, and the voting then continued until one candidate receives a majority vote as required. Should two minority candidates receive an equal number of votes, a vote shall then be taken to determine which of them shall continue in nomination. In the event of the vote remaining equally divided between two final candidates, the President shall refer that election to the Executive Committee.

9.4. Term of Office.

9.4.1 Officers. The term for each officer shall commence on the first day of the Medical Staff Year and continue for a period of two (2) Medical Staff Years or until a successor is elected, unless the officer shall resign sooner or be removed.

9.4.2 Elected Members-at-Large of the Executive Committee. The term of each elected member-at-large of the Executive Committee shall commence on the first day of the Medical Staff Year following his election and shall continue for a period of three (3) Medical Staff Years or until a successor is elected, unless the elected member-at-large shall resign sooner or be removed.

(a) Elected members-at-large shall serve staggered terms of three (3) years, with approximately one third of the at large members elected each year;

(b) Members-at-large may be re-elected following a period of at least one year between terms;

(c) Members-at-large elected to serve less than a full three-year term shall be eligible for re- election immediately following the end of their partial term; and

(d) Qualified members-at-large are eligible to become officers of the Staff at any time.

9.4.3 Elected Nominating Committee Members. The term of each elected member of the Nominating Committee shall commence on the first day of the next year and shall continue until a successor is elected, unless the member shall resign sooner or be removed.

9.4.4 Resignations. An officer or other elected official may resign at any time by notifying the Executive Committee in writing. Such resignation shall take effect on the date of receipt or at any later time specified in the notice of resignation.

9.5. Vacancies and Removal of Officers and Elected Officials.

9.5.1 Vacancies. If the office of President should become vacant, the President-Elect shall assume the office of President and serve the remainder of the unexpired term and his regular term as President. He will instruct the Nominating Committee to nominate a candidate for President-Elect to be elected by the Staff at the next regular meeting held after the vacancy occurred. Nominations may be made from the floor at that meeting. The same nomination and election procedures shall be followed in case the offices of President-Elect and Secretary should become vacant or if vacancies occur among the elected members-at-large of the Executive Committee.

9.5.2 Removal. Any officer, elected member-at-large of the Executive Committee, or elected member of the Nominating Committee may be removed from office on the basis of an appropriate finding of cause by the Executive Committee. The recommendation for removal may come from the Chief Executive Officer, a chair of any Medical Staff committee, a Chair of Department, or a petition signed and verified by two hundred (200) members of the Active Staff and submitted to the Executive Committee. If a petition is utilized to recommend the removal of an officer or other elected official, the names of the petitioners must be identified on the petition in printed or typed form in addition to their signatures. The removal of an officer or other elected official shall not constitute a diminution of his Staff appointment or otherwise give rise to any right of review. Conditions for removal may include but shall not be limited to the following:

(a) Failure to perform the duties of the position held in a timely and appropriate manner;

(b) Failure to continuously meet the qualifications for the position;

(c) Being the subject of a final adverse action;

(d) Conduct or statements that are damaging to the best interests of the Hospital, the Medical Staff, or their goals, programs, or public image;

(e) Malfeasance in office;

(f) Mental or physical impairment that renders the officer, elected member-at-large, or elected member of the Nominating Committee incapable of fulfilling the duties of the position; or

(g) Flagrant disregard for the rights of members of the Medical Staff or the Board.

9.5.3 Procedure for Removal. A recommendation for the removal of an officer, elected member-at-large or elected member of the Nominating Committee shall be submitted to the Medical Staff Services Department and automatically placed on the agenda of the next regularly scheduled meeting of the Executive Committee. The immediate Past President of

the Staff or his designee shall present the reasons for the request for removal. An officer, elected member-at-large, or elected member of the Nominating Committee may be removed by a two-thirds (2/3) vote of the Executive Committee at which a quorum is present.

9.6. Duties of Officers.

9.6.1 President of the Staff. The President of the Staff shall serve as the chief administrative officer of the Medical Staff and shall:

(a) Act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern within the Hospital;

(b) Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;

(c) Serve as the Chair of the Executive Committee of the Medical Staff;

(d) Serve as an ex officio member of all other committees of the Medical Staff;

(e) Be responsible for the enforcement of the Bylaws and Rules, for the implementation of sanctions when indicated, and for the Medical Staff's compliance with procedural safeguards in all instances in which corrective action has been requested against a Practitioner;

(f) Appoint committee members and chairs to all Medical Staff committees, except the Executive Committee;

(g) Represent the views, policies, needs, and grievances of the Medical Staff to the Board and to the Chief Executive Officer;

(h) Receive and interpret the policies of the Board regarding the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;

(i) Be the spokesperson for the Medical Staff in its external professional and public relations;

(j) Serve as a voting member of the Board and represent the Medical Staff at all meetings of the Board and the Executive Committee of the Board; and

(k) Perform such other duties as may be assigned to him by the Board.

9.6.2 President-Elect. In the absence of the President of the Staff, the President-Elect shall assume all the duties and have the authority of the President of the Staff. The President-Elect shall be a member of the Executive Committee of the Medical Staff. If the President of the Staff fails to serve for any reason, the President-Elect shall automatically succeed to the office of President of the Staff, and a new President-Elect shall be elected as provided herein.

9.6.3 Secretary. The Secretary shall be a member of the Executive Committee of the Medical Staff. The Secretary, or his designee, shall keep accurate and complete minutes of all Medical Staff meetings, call and give proper notice for all Medical Staff meetings on the order of the President of the Staff, attend to all correspondence, submit reports, as requested, to the Executive Committee and to the Staff of receipts and disbursements, and perform such other duties as ordinarily pertain to his office.

9.6.4 Elected Members-at-Large of the Executive Committee. Elected members-at-large of the Executive Committee shall be voting members of the Executive Committee of the Medical Staff and shall perform the functions of such members as set forth in Section 11.2 of these Bylaws.

9.6.5 Elected Members of the Nominating Committee. Elected Members of the Nominating Committee shall be voting members of the Nominating Committee of the Medical Staff and shall perform the functions of such members as set forth in Section 11.8 of these Bylaws.

9.7. Termination from Medico-Administrative Position. Except as otherwise required by contract, any Practitioner appointed to a medico-administrative position by the Chief Executive Officer or the Board may be terminated from such position upon thirty (30) days written notice from the Chief Executive Officer, who may, with the consent of the Board, appoint a replacement. Such termination shall not be considered an adverse recommendation, shall not result in the loss of clinical privileges, and shall not give rise to a right of review. This provision is not applicable to officers or officials of the Medical Staff who are elected to serve by the Medical Staff.

ARTICLE X
DEPARTMENTS

10.1. Organization of Departments.

10.1.1 Areas of Departments. Clinical services at the Hospital include the following: Anesthesiology, Cardiology, Cardiovascular Surgery, Medicine, Neurology, Neurosurgery, Obstetrics and Gynecology, Ophthalmology, Oral and Maxillofacial Surgery and Hospital Dentistry, Orthopedic Surgery, Otolaryngology – Head & Neck Surgery, Pathology, Pediatrics, Psychiatry, Radiology, Surgery, and Urology. These Departments may be grouped by the Executive Committee in any manner in which the Executive Committee deems best for the benefit of the Hospital and its teaching programs.

10.1.2 Changes in Departments. Any of the Departments enumerated in Section 10.1.1 may be deleted and other Departments and Sections of Departments may be added by the Executive Committee.

10.1.3 Meetings. All Departments shall document separate or joint meetings on a regularly scheduled basis. Any Active Staff member with clinical privileges shall attend at least fifty percent (50%) of the meetings held in that Practitioner's designated Department.

10.1.4 Chair. Each Department shall have a Chair. If a vacancy occurs for any reason, a Chair of Department or Acting Chair of Department may be appointed according to the following procedure:

(a) A Chair of Department shall be appointed for a period of three years and may be reappointed. An Acting Chair of Department may be appointed by the Chief Executive Officer of the Hospital to serve whenever the appointed Chair of Department is unable to serve, has resigned or has been removed from the position, and/or until a permanent Chair of Department is appointed to fill the vacancy.

(b) The appointment of a Chair of Department shall be initiated by the Chief Executive Officer of the Hospital. The recommendations for a Chair of Department shall then be reviewed by the Executive Committee. If approved by the Executive Committee, the recommendation will be presented for final action to the Board by the Chief Executive Officer of the Hospital.

10.2. Qualifications and Tenure of Chairs of Department.

10.2.1 Qualifications. Each Chair of Department shall be a member of the Active Medical Staff and qualified by training, experience, and demonstrated ability for the position. Each Chair of Department must be certified by an appropriate specialty board recognized by the American Board of Medical Specialists or shall affirmatively establish comparable competence through the credentialing process. A Chair of Department may not concurrently serve as an officer of the Staff.

10.2.2 Evaluation. Approximately every three years according to a schedule established by the Hospital, prior to considering the Chair of Department for reappointment, his performance will be evaluated by an ad hoc committee appointed to review the Chairs of Department. The ad hoc committee will evaluate the Chair's performance during his current term of appointment in accordance with the Hospital's *Guidelines for Review of Chair of Department*. Following its review, the ad hoc committee shall submit its written report to the Chief Executive Officer of the Hospital, who after consultation with the President of the institution with which Methodist has a teaching affiliation agreement, as appropriate, and the Executive Committee of the Medical Staff, shall submit his recommendation to the Board. The Chief Executive Officer of the Hospital may, at his discretion, provide a copy of the applicable portion of the report of the ad hoc committee to the Chair of Department.

10.2.3 Removal. A Chair of Department may be removed from that position by the Chief Executive Officer of the Hospital with the approval of the Board, after an appropriate finding of cause and consultation with the Executive Committee and the President of the institution with which Methodist has a teaching affiliation agreement. The recommendation for removal may come from the Chief Executive Officer of the Hospital or the Executive Committee. After being notified in writing of his removal, a former Chair of Department may appeal in turn to the Executive Committee and the Board. Said appeal must be requested within ten (10) days from the date he receives notification of his removal. The appeal shall not be in accordance with the Fair Hearing Plan. When a request for appeal has been duly received by one of the above stated bodies, the matter in question will be considered at its next regularly scheduled meeting

or within thirty (30) calendar days, whichever occurs sooner, and a decision will be reached within sixty (60) calendar days from the date of said meeting. If such appeal is not requested within the specified time period, the former Chair of Department shall be deemed to have waived his right to said appeal and to have accepted his removal.

10.3. Responsibilities of Chairs of Department.

10.3.1 Overseeing. Each Chair of Department shall be generally responsible for overseeing all professional and administrative activities within his Department.

10.3.2 Review of Professional Performance. Each Chair of Department shall maintain continuing review and surveillance of the professional performance of all Practitioners and Allied Health Professionals with clinical privileges in his Department and report regularly thereon to the Executive Committee.

10.3.3 Enforcement of Rules. Each Chair of Department shall be responsible within his Department for enforcement of the Hospital Bylaws, these Bylaws, and the Rules and be further responsible for supervising the review and evaluation of the quality and appropriateness of patient care provided within the Department.

10.3.4 Implementation of Bylaws and Rules. Each Chair of Department shall be responsible for implementation and enforcement within his Department of the Bylaws and actions taken by the Executive Committee and the Medical Staff.

10.3.5 Recommendations for Staff Membership and Clinical Privileges. Each Chair of Department shall transmit, in accordance with established time frames, to the Credentials Committee of the Medical Staff recommendations concerning clinical privileges, corrective action, appointment to the Department, Staff classification, reappointment, and the delineation of clinical privileges for all Practitioners in his Department. The recommendations shall include those of the Deputy Chairs. The Chair of Department shall ensure that there are a sufficient number of qualified and competent Practitioners in his Department to provide care to patients of the Hospital.

10.3.6 Teaching, Education, and Research. Each Chair of Department shall be responsible for the teaching, education, and research program in his Department.

10.3.7 Administration of Department. Each Chair of Department shall participate in administration of his Department through cooperation with the Nursing Service and the Hospital Administration in matters affecting patient care, including space, personnel, supplies, special regulations, standing orders, techniques, and any other resources required by the Department. The Chair of Department shall be responsible for and report to the Executive Committee and the Chief Executive Officer regarding all professional and administrative activities within his Department.

10.3.8 Annual Reports. Each Chair of Department shall assist in the preparation of such annual reports, including budgetary planning and recommendations for space and other resources required by his Department, as may be requested by the Executive Committee, the Chief Executive Officer, or the Board.

10.3.9 Participation of Members. Each Chair of Department shall monitor the participation of Department members in continuing education programs and attendance at meetings and shall appoint committees, as needed, to conduct Department functions. The Chair of Department shall ensure that members of his Department participate in measuring, assessing, and improving the education of patients and families.

10.3.10 Presiding Officer. Each Chair of Department shall preside at all Department meetings and assure that a record is maintained that includes results, recommendations, conclusions, and actions instituted at the Department meetings.

10.3.11 Off-Site Services. Each Chair of Department shall be responsible for assessing and recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by his Department or the Hospital.

10.3.12 Criteria for Clinical Privileges. Each Chair of Department shall transmit to the Procedures & Criteria Committee his recommendations and that of the Elected Deputy Chair concerning the criteria for the delineation of clinical privileges within the Department.

10.3.13 Quality of Care. With the Deputy Chair(s) of Department, each Chair of Department shall assure that the quality and appropriateness of patient care provided within the Department is monitored and evaluated continuously. With the Elected Deputy Chair of

Department, the Chair of Department shall develop and implement procedures for the ongoing monitoring of practice, credentialing review and privileges delineation, medical education, utilization review, and quality assurance.

10.3.14 Monitoring and Corrective Action. Each Chair of Department shall transmit to the appropriate committee his recommendations, and that of the Deputy Chair(s), for the monitoring of patient care services and corrective action with respect to Practitioners and AHPs in his Department.

10.3.15 Coordination and Integration. Each Chair of Department shall be responsible for integrating his Department into the primary functions of the Hospital. The Chair of Department shall also be responsible for coordinating and integrating interdepartment and intradepartment services.

10.3.16 Miscellaneous. Each Chair of Department shall perform such additional duties as may be assigned to him by the President of the Staff or the Executive Committee.

10.4. Deputy Chairs of Department. Each Department shall have at least one, but no more than three Deputy Chair(s) of Department. The Deputy Chair(s) of Department shall act, as designated, for the Chair of Department in his absence and may perform such other duties as may be assigned by the Chair of Department.

10.4.1 Elected Deputy Chair of Department. At least one of the Deputy Chair(s) must be elected from among qualified nominees who are proposed by the Active Staff members of the Department. The elected Deputy Chair, as an advocate, is responsible for representing the interests of members of his Department. The Elected Deputy Chair's responsibility to represent the interests of the members of his Department does not include any responsibility to represent an individual practitioner during corrective action procedures or during any hearing under the Fair Hearing Plan. The elected Deputy Chair shall be elected by a simple majority vote of the Active Staff members. The ballots will be distributed and counted by the Medical Staff Services Department. Upon unanimous consent from all members, departments with fewer than ten (10) members are not required to elect a Deputy Chair.

10.4.2 Concurrence of the Executive Committee. The Deputy Chair(s) of Department (both elected and appointed) shall be approved by the President of the Hospital, with the concurrence of the Executive Committee.

10.4.3 Term of the Deputy Chair(s). The Deputy Chair(s) of Department (both elected and appointed) shall serve a three-year term, with such term to run concurrently with that of the Chair of Department. The term of the Deputy Chair(s) of Department shall automatically expire upon the resignation, retirement, or termination of the Chair of Department from the Medical Staff, unless that the Chief Executive Officer of the Hospital, in consultation with the Executive Committee, requests their continued appointment.

10.4.4 Interim Deputy Chair(s). Deputy Chair(s) of Departments who continue their appointment at the request of the Chief Executive Officer of the Hospital shall be designated as Interim Deputy Chair(s) of Department. The term of the Interim Deputy Chair(s) of Department shall continue until the appointment of a full-time Chair of Department.

10.4.5 Qualifications of the Deputy Chairs. The Deputy Chair(s) of Department (both elected and appointed) must: (a) be a member of the Active Staff; (b) have leadership and administrative ability; (c) be a respected member of the Department; (d) center his practice at the Hospital; (e) understand and fully support the uniqueness of the relationship between the Hospital and the institution(s) with which Methodist has a teaching affiliation agreement as reflected within the mission statement and goals of the Hospital; (f) actively support, with the Chair of Department and the Hospital executives assigned to the Department, the mission and strategic plan of the Hospital; and (g) support the Chair of Department, the Medical Staff, and the organizational structure of the Department to ensure optimal patient care, research, and teaching.

10.4.6 Duties of the Deputy Chairs. The Deputy Chair(s) of Department (both elected and appointed) shall:

(a) In the absence of the Chair of Department, provide continuity in the monitoring and evaluation of the quality and appropriateness of the care provided by members of the Department.

(b) In the absence of the Chair of Department, the Elected Deputy Chair, or in his absence another Deputy Chair, shall preside at Department meetings and make recommendations to the Chief Executive Officer regarding the granting of temporary privileges.

(c) Perform such other duties as may be assigned by the Chair of Department.

(d) Perform other duties specific to the Elected Deputy Chair, unless delegated to another Deputy Chair or member of the Department by mutual agreement of the Chair of Department and the Elected Deputy Chair, including the following:

(1) Recommend to the Chair of Department the criteria for delineation of clinical privileges within the Department;

(2) Recommend to the Chair of Department the delineation of clinical privileges, as well as appointment, reappointment, and staff category, if applicable, for members of the Department;

(3) Determine, with the Chair of Department, that the quality and appropriateness of patient care provided within the Department is monitored and evaluated;

(4) Generally monitor the quality of patient care and professional performance rendered by members of the Department through a planned and systematic process;

(5) Oversee the effective provision of patient care by members of the Department;

(6) Report the results of his monitoring and overseeing functions to the Chair of Department;

(7) Develop and implement, with the Chair of Department, departmental procedures for the following: the ongoing monitoring of practice; the allocation of resources, including operating room time, where appropriate; credentials review; medical education; and utilization review and quality monitoring in accordance with accreditation, utilization review and quality management requirements; and

(8) Recommend to the Chair of Department the monitoring of specified services and corrective action with respect to persons with clinical privileges within his Department.

10.4.7 Removal. A Deputy Chair of Department (either elected and appointed) may be removed from that position for cause by the Chief Executive Officer or the Chair of Department, with the approval of the Executive Committee.

ARTICLE XI
COMMITTEES

11.1. Committees. Committees of the Medical Staff include the following: Ad Hoc or Special Committees; the Bylaws and Rules Committee; the Credentials Committee; the Executive Committee;; the Medical Staff Committee Council; the Medical Staff Quality Management Committee; the Nominating Committee; the Operating Room Committee; the Pharmacy and Therapeutics Committee; the Practitioner Health Committee; the Procedures and Criteria Committee; and the Record Committee.

11.1.1 Appointment and Meetings. Unless otherwise specified, the President of the Staff shall appoint the chair and members of each committee. The chair must be a member of the Active Staff. The officers of the Medical Staff shall serve as ex officio members of all standing Medical Staff committees.

11.1.2 Terms. The terms of office for all appointed committee members shall begin on the first day of January following their appointment by the President of the Staff and shall terminate on the thirty-first day of December one year hence, unless the President of the Staff fails to appoint new members. In such case, the committee members shall serve until new members are appointed.

11.1.3 Reports to the Executive Committee. Unless otherwise specified, each committee of the Medical Staff shall report to the Executive Committee at least annually or at the request of the President of the Staff.

11.2. Executive Committee.

11.2.1 Composition The Executive Committee will consist of the following members:

1. The officers of the medical staff;
2. The immediate past president of the medical staff;
3. The chief executive officer of The Methodist Hospital or his designee;
4. Four Chairs of Department, selected by the Chairs of Department; and
5. Four members-at-large of the active category of the medical staff, each with at least five years of continuous active category status at the time of nomination, elected by the members of the active category of the medical staff. Chairs of Department are qualified to hold any of these elected members-at-large positions.
6. Either of the following (but not both) may be appointed or removed by the President of the Medical Staff, with the advice and consent of the Executive Committee: Chief Medical Officer of The Methodist Hospital or Chief Medical Officer of The Methodist Hospital System.
7. The Committee may include other licensed independent practitioners.

11.2.2 Terms. The terms of office for all Members-at-Large and Chairs of Department of the Executive Committee shall begin on the first day of January following their election, and the members shall serve until their successors have been duly elected and take office. Members-at-large and Chairs of Department will serve staggered three (3) year terms.

11.2.3 Meetings. The Executive Committee shall meet regularly and on call of the Chair. The President of the Staff shall be the Chair, and the Chief Executive Officer shall act as the Secretary.

11.2.4 Functions. The functions of Executive Committee shall include the following:

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

(b) Coordinating the activities and general policies of the various Departments;

(c) Receiving and acting upon committee and Department reports;

(d) Implementing policies of the Medical Staff not otherwise the responsibility of the Departments;

(e) Serving as a liaison between and among the Medical Staff, the Chief Executive Officer, and the Board;

(f) Recommending action to the Chief Executive Officer on matters of a medico-administrative nature;

(g) Approving or disapproving recommendations concerning the appointment of a Chair of Department;

(h) Making recommendations regarding the proposed dismissal of Chairs of Department;

(i) Making recommendations on management matters to the Board through the Chief Executive Officer;

(j) Fulfilling the Medical Staff's responsibility to the Board for the medical care rendered to patients in the Hospital;

(k) Reviewing the credentials of all applicants and making recommendations to the Board for staff membership, assignments to Departments, and delineation of clinical privileges;

(l) Reviewing periodically all information available regarding the performance and clinical competence of Staff members and Mid-Level Professionals with clinical privileges and, as a result of such reviews, making recommendations for reappointment and renewal or modification in clinical privileges;

(m) Taking all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in corrective action or review mechanisms, when warranted;

(n) Evaluating and reviewing appropriate Hospital contracts for clinical scope and ability to meet the needs of patients;

(o) Reporting at each general Staff meeting;

(p) Acting for the Staff in the intervals between Medical Staff meetings;

(q) Maintaining a permanent record of its proceedings and actions;

(r) Requiring any Practitioner to appear before it when appropriate in accordance with the Bylaws;

(s) Informing the Medical Staff of the standards of the Joint Commission on Accreditation of Healthcare Organizations and the accreditation status of the Hospital and to encourage active participation by the Medical Staff in the accreditation process;

(t) Meeting within thirty (30) days of the initiation of an investigation of a summary suspension by the Credentials Committee or a Subcommittee thereof; and

(u) Reviewing all recommendations from the Procedures and Criteria Committee, approving or disapproving such recommendations on the basis of such reviews, and transmitting approved criteria to the Credentials Committee for use in the delineation of clinical privileges.

11.3. Ad Hoc or Special Committees.

11.3.1 Composition. Except as otherwise provided herein, the number and members of Ad Hoc or Special Committees shall be determined by the President of the Staff. The chairs of these committees shall be chosen from the membership of the Executive Committee, unless otherwise specified in these Bylaws.

11.3.2 Meetings. Ad Hoc or Special Committees shall meet on the call of the Chair or the President of the Staff.

11.3.3 Functions. The functions of Ad Hoc or Special Committees shall, unless otherwise specified in these Bylaws, be determined by the President of the Staff.

11.4. Bylaws and Rules Committee.

11.4.1 Composition. The Bylaws and Rules Committee shall be composed of at least seven (7) Medical Staff members. The Chair of the Credentials Committee shall serve as a voting member.

11.4.2 Meetings. The Bylaws and Rules Committee shall meet at least annually or on call of the President of the Staff.

11.4.3 Functions. The functions of Bylaws and Rules Committee shall include the following:

(a) Reviewing the Bylaws and the Rules;

(b) Determining whether the Bylaws and Rules comply with applicable laws and provide for the functions of the Staff; and

(c) Making recommendations to the Executive Committee regarding amendments to and improvement of the Bylaws and the Rules.

11.5. Credentials Committee.

11.5.1 Composition. The Credentials Committee shall consist of at least nine (9) members of the Medical Staff selected from past members of either the Executive or Medical Staff Quality Management Committees who are not Chairs of Department and are not currently serving on the Executive Committee. At least one member from the two largest Departments shall be included, and as many Departments as possible shall be represented on the Credentials Committee.

11.5.2 Meetings. The Credentials Committee will meet at least ten times per year and on call of the Chair.

11.5.3 Functions. The Credentials Committee shall perform the following specific functions:

(a) Reviewing and evaluating the qualifications of each Practitioner or Mid-Level Professional seeking initial appointment, renewal of appointment, or modification of appointment to the Staff, including the recommendations from each Department in which privileges are sought;

(b) Making recommendations to the Executive Committee concerning the qualifications of each Practitioner and Mid-Level Professional applicant for appointment to the Staff;

(c) Reviewing and recommending action to the Executive Committee on any change in status of any member, as recommended by the relevant Department;

(d) Investigating, reviewing, and reporting on the clinical performance and conduct of any Practitioner when so requested by the Executive Committee, a Chair of Department, or the Board;

(e) Developing criteria for appointment and reappointment to the Medical Staff;

(f) Seeking additional information, through its Chair, from Practitioners and others by telephone, letter, or voluntary personal interview and seeking the assistance of the President of the Staff pursuant to Section 8.1.1 or 8.1.2, if further information is considered essential, in order to perform a complete review of the application or the applicant's credentials or to address concerns regarding a Practitioner's qualifications, professional practice or professional conduct; and

(g) Treating confidentially all matters brought before the Credentials Committee insofar as possible without interfering with the duty of the committee to report its recommendations through the official channels.

11.6. Medical Staff Committee Council.

11.6.1 Composition. The Medical Staff Committee Council shall be composed of the officers of the Medical Staff and the chairs of Medical Staff Committees.

11.6.2 Meetings. The Council shall meet on call of the President of the Staff, who shall serve as Chair.

11.6.3 Functions. The functions of the Medical Staff Committee Council shall include the following:

(a) Reviewing the activities of Medical Staff Committees; and

(b) Providing a mechanism for interaction among Committees and with the Medical Staff Officers.

11.7. Medical Staff Quality Management Committee.

11.7.1 Composition. The Medical Staff Quality Management Committee shall consist of the Chairs of the multi-specialty Quality Management Subcommittees and other members of the Medical Staff who are necessary to accomplish the functions of the Medical Staff Quality Management Committee. Hospital personnel involved in Hospital management and performance improvement may serve as members, without authority to vote. The following guidelines shall also apply to the composition of the Medical Staff Quality Management Committee and the multi-specialty Quality Management Subcommittees:

(a) Meetings or portions of meetings conducted for the purpose of discussing Practitioner peer review activities shall involve Committee or Subcommittee members of the Medical Staff, with support from authorized Hospital management and performance improvement staff.

(b) A member or agent of a Medical Staff Quality Management Committee or multi-specialty Quality Management Subcommittee, an affected Practitioner, or a person participating in peer review or furnishing records, information, or assistance may attend meetings of the Committee or a Subcommittee, at the discretion of the Chair.

(c) Meetings or portions of meetings conducted for the purpose of voting on Practitioner peer review activities shall include only Committee and Subcommittee members of the Medical Staff.

11.7.2 Meetings. The Medical Staff Quality Management Committee shall meet at least four (4) times annually and on the call of the Chair.

11.7.3 Functions. As part of the Hospital's care management and performance improvement efforts, the Medical Staff Quality Management Committee shall work to assure that Practitioner and clinical quality of care issues are addressed effectively. The functions of the Medical Staff Quality Management Committee shall include the following:

(a) Developing policies and procedures, including those designed to assure fair and consistent peer review processes by the multi-specialty Quality Management Subcommittees;

(b) Providing pertinent quality of care information to each Chair of Department on an as-needed basis and at the time of each Practitioner's application for reappointment;

(c) Directing the quality management activities of the Residents during their rotation at the Hospital;

(d) Referring any non-Practitioner specific care management, performance improvement, or utilization review issues to the appropriate hospital or professional review committee;

(e) Regularly reviewing the following statistics and data developed by the multi-specialty Quality Management Subcommittees:

- Results of surgical and invasive procedures, including complications, morbidity, and mortality;
- Blood usage evaluations and reports;
- Medication usage reports from the Pharmacy and Therapeutics Committee;
- Information related to autopsy results;
- Information related to risk management activities; and
- Information related to the documentation of clinically pertinent information in medical records;

(f) Assisting in the formulation, enforcement, and evaluation of Practice Improvement Plans developed by the multi-specialty Quality Management Subcommittees;

(g) Assisting in the formulation, enforcement, and evaluation of Restricted Privilege Plans developed by the multi-specialty Quality Management Subcommittees and referring such plans to the Credentials Committee for appropriate action;

(h) Confirming that the multi-specialty Quality Management Subcommittees receive input and feedback from an affected Practitioner prior to the implementation of a Practice Improvement Plan or a Restricted Privilege Plan; and

(i) Forming additional multi-specialty Quality Management Subcommittees or special committees appointed by the Chair of the Medical Staff Quality Management Committee, to address specific quality issues that may arise from time to time.

11.8. Nominating Committee.

11.8.1 Composition. The Nominating Committee shall consist of five (5) members of the Active Staff constituted at each annual meeting of the Staff. The President of the Staff, with the advice and consent of the Executive Committee, shall appoint the Chair and one additional member. The immediate past President shall be a member and two (2) members shall be elected by the Active Staff at the annual meeting by nominations taken from the floor at the quarterly Staff meeting immediately preceding the annual meeting. Any vacancies on the Nominating Committee that might occur before it has fulfilled its functions will be filled by the Executive Committee. No member may serve for more than two (2) consecutive years. A member of the Nominating Committee may not be nominated to be an officer or other elected official of the Staff by the Nominating Committee but is eligible to be nominated from the floor at the quarterly Medical Staff meeting immediately preceding the annual meeting.

11.8.2 Meetings. The Nominating Committee shall meet at least annually and at the direction of the Chair.

11.8.3 Functions. The functions of the Nominating Committee shall include the following:

(a) Every year, the Nominating Committee will develop its slate of candidates for elected officers and other elected officials. In considering its nominees for the at-large

members of the Executive Committee, the Nominating Committee will use its discretion to name those Staff members who are actively engaged in the affairs of the Hospital and who can assure adequate representation of the Departments on the Executive Committee. The Nominating Committee shall announce its initial slate of candidates at the quarterly meeting of the Staff immediately preceding the annual meeting.

(b) At the quarterly meeting of the Staff immediately preceding the annual meeting, the Nominating Committee shall solicit and receive nominations from the floor for the positions of the Executive Committee members-at-large whose three-year terms are expiring and for the elected members of the Nominating Committee.

(c) Every other year at the quarterly Staff meeting immediately preceding the annual meeting, the Nominating Committee will solicit and receive nominations from the floor for the positions of Secretary and President-Elect.

(d) Following the quarterly meeting of the Staff at which nominations are made from the floor, the Nominating Committee will prepare a final slate of candidates that lists the names of all nominees who meet the qualifications of the office for which they are nominated and who have accepted the nominations made by the Nominating Committee or from the floor. The slate will include the names of candidates for Medical Staff officers, if applicable, elected members-at-large of the Executive Committee, and elected members of the Nominating Committee.

(e) At least twenty-one (21) days before the annual meeting of the Medical Staff, the Nominating Committee shall mail the final slate of candidates to the Active Staff members.

(f) At the annual meeting of the Medical Staff, the Nominating Committee will conduct the election by the procedure designated by the President of the Staff.

11.9. Operating Room Committee.

11.9.1 Composition. The Operating Room Committee shall include physicians representing each of the surgical Departments and at least one non-physician representative from Administration and nursing.

11.9.2 Meetings. The Operating Room Committee shall meet at least quarterly, and on call of the Chair.

11.9.3 Functions. The functions of the Operating Room Committee shall include the following:

(a) Developing, reviewing, implementing, and overseeing policies and procedures for the effective and efficient operation of the operating rooms;

(b) Taking the appropriate actions necessary to enforce the policies and procedures of the operating rooms, so long as they do not adversely affect the membership and/or clinical privileges of members of the Medical Staff;

(c) Ensuring that policies and procedures or any amendments thereto developed by the Operating Room Committee which affect the Medical Staff shall be approved by the Executive Committee;

(d) Reporting on its activities and accomplishments at least annually to the Executive Committee; and

(e) Making specific reports as required.

11.10. Pharmacy and Therapeutics Committee.

11.10.1 Composition. The Pharmacy and Therapeutics Committee shall consist of at least three (3) members of the Medical Staff, along with the Director of the Pharmacy Service, at least two (2) registered nurse representatives from the Nursing Service, and a representative from Purchasing. The President of the Staff shall designate one Medical Staff member to serve as Chair.

11.10.2 Meetings. The Pharmacy and Therapeutics Committee will meet ten (10) times per year.

11.10.3 Functions. The functions of the Pharmacy and Therapeutics Committee shall include the following:

(a) Formulating broad professional policies and procedures regarding the evaluation, appraisal, selection, procurement, storage, distribution, handling, use, safety procedures, and all other matters relating to drugs in the Hospital;

(b) Binding all Practitioners at the Hospital to such policies and procedures upon approval by the Executive Committee and written notification to the Staff;

(c) Reviewing all untoward drug reactions and developing and monitoring all drug utilization policies and practices within the Hospital in order to promote optimal clinical results with minimal potential for hazard;

(d) Serving as an advisory group to the Medical Staff and pharmacists on matters pertaining to the choice of available drugs;

(e) Making recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

(f) Developing and reviewing periodically a formulary or drug list for use in the Hospital;

(g) Preventing unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients;

(h) Evaluating clinical data concerning new drugs or preparations requested for use in the Hospital;

(i) Establishing standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;

(j) Reporting on its activities and accomplishments to the Executive Committee at least annually; and

(k) Making specific reports and recommendations as required.

11.11. Practitioner Health Committee.

11.11.1 Composition. The Practitioner Health Committee shall consist of five members of the Active Staff who are appointed by the President of the Staff. One of the members shall be designated as the Chair. An attempt shall be made to include a distinguished senior member of the Medical Staff, a Practitioner knowledgeable in the treatment of addiction, a psychiatrist, a representative from anesthesiology, surgery, or emergency medicine, and a physician with personal recovery experience.

11.11.2 Meetings. The Practitioner Health Committee shall meet as needed to address issues related to a Practitioner's health. All physician information discussed at the meeting shall be confidential, unless limited by law, ethical obligation, or when the safety of a patient is threatened.

11.11.3 Functions. The functions of the Practitioner Health Committee shall include the following:

(a) Addressing physician health as it relates to patient safety;

(b) Educating the Staff regarding illness and impairment recognition issues specific to Practitioners;

(c) Encouraging self-referral by Practitioners and referral by other members of the Medical Staff and Administration;

(d) Evaluating the credibility of a complaint, allegation, or concern;

(e) Determining whether a physician problem is best addressed through a disciplinary measure or via the physician-health route;

(f) Working confidentially with the Harris County Medical Society and the State Board of Medical Examiners without the procedural deadlines and reporting obligations set forth in the Corrective Action Procedures provided for in these Bylaws;

(g) Monitoring the affected Practitioner and the safety of patients until the rehabilitation or any disciplinary process is complete; and

(h) Reporting to the medical staff leadership when the Practitioner fails to complete the required rehabilitation program or is providing unsafe treatment.

(i) Contracting with various Texas Medical Association-approved laboratories (that are independent from The Methodist Hospital) to provide the results of tests of

applicants for medical staff membership, evaluating those results, and determining whether to provide impairing substance clearance to the Medical Staff (through the Medical Staff Services Department).

11.12. Procedures and Criteria Committee.

11.12.1 Composition. The Procedures and Criteria Committee shall be composed of at least eight (8) members of the Medical Staff from the various Departments of the Medical Staff.

11.12.2 Meetings. The Procedures and Criteria Committee shall meet on call of the Chair.

11.12.3 Functions. The functions of the Procedures and Criteria Committee shall include the following:

(a) Identifying current procedures that are performed by different Departments within the Hospital and ensuring that the criteria required for the performance of such procedures are consistent;

(b) Reviewing a request and supporting literature for the performance of a new procedure proposed by a member of the Medical Staff;

(c) Inviting, receiving, and reviewing input from consultants and experts, including members of the Medical Staff, regarding the equipment, staffing, training, and experience necessary to perform the proposed procedure and the safety of the procedure;

(d) Requesting input from the appropriate Chair(s) of Department;

(e) Receiving and reviewing the input, if any, received from the applicable Chair(s) of Department;

(f) Obtaining and reviewing comments from appropriate Hospital executives regarding the feasibility of performing the proposed procedure at the Hospital (i.e., with documented evidence to include information on staffing, costs, equipment, volume, etc.);

(g) Making recommendations to the Executive Committee regarding unresolved jurisdictional disputes involving clinical privileges;

(h) Developing criteria regarding the education, training, and experience necessary to perform any proposed procedure (i.e., with documented evidence to include the number of procedures completed within a designated time, length of stay, complications, morbidity and mortality, etc.); and

(i) Forwarding the information gathered and the criteria developed to the Executive Committee for review, comment, and final approval.

11.13. Record Committee.

11.13.1 Composition. The Record Committee shall consist of at least eight (8) members.

11.13.2 Meetings. The Record Committee will meet at least ten (10) times per year and on the call of the Chair.

11.13.3 Functions. The functions of the Record Committee shall include the following:

(a) Reviewing and evaluating medical records to ensure their maintenance at the required standard in the health care industry;

(b) Recommending and enacting punitive measures for delinquent medical records and ensuring compliance with the Medical Record Rules and Regulations;

(c) Inviting a Practitioner with delinquent medical records to the Medical Record Committee meeting to explain the reason for delinquent records;

(d) Making recommendations to the Executive Committee regarding policies and procedures for the completion of records that affect the Staff; and

(e) Making recommendations to the Executive Committee regarding the transition of medical records to electronic format.

ARTICLE XII
MEDICAL STAFF MEETINGS

12.1. Annual Staff Meeting.

12.1.1 Meeting Time. The annual meeting of the Medical Staff shall be held in November of each Medical Staff Year and shall be designated as the annual business meeting.

12.2. Regular General Staff Meetings. Regular meetings of the Medical Staff shall be held at least four (4) times per year to accomplish the purposes of the Medical Staff.

12.3. Special Meetings.

12.3.1 Request. The President of the Staff, the Executive Committee, or not less than twelve members of the Active Staff may at any time file a written petition, requesting a special meeting of the Medical Staff. Within seven (7) days of the filing of such petition, the Executive Committee shall designate the date, time, and place of any such special meeting.

12.3.2 Notice. Written or printed notice stating the place, date, and hour of any special meeting of the Medical Staff shall be delivered, either personally or by mail, to each member of the Active Staff not less than three (3) days before the date of such meeting by written or electronic notice or by personal delivery. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each Staff member at his address as it appears on the records of the Hospital. Notice may also be sent to members of other Medical Staff groups who have so requested. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

12.4. Attendance Requirements. In order to transfer to or maintain Active Staff status, Practitioners shall be required to attend fifty percent (50%) of all regular general Staff meetings. Practitioners with twenty-five (25) or more years of service at the Hospital are exempt from the Medical Staff meeting attendance requirements and will maintain their Active Staff Status without such attendance. These meeting are essential for effective communication. Other staff categories are welcome to attend Medical Staff meetings. Meeting attendance shall be considered at the time of reappointment.

12.5. Agenda. The President of the Staff may establish the agenda for regular and special meetings.

ARTICLE XIII
COMMITTEE AND DEPARTMENT MEETINGS

13.1. Regular Meetings. Committees and Departments may, by resolution, provide the date and time for holding regular meetings without notice.

13.2. Special Meetings. A special meeting of any Committee or Department may be called by or at the request of the Chair of the committee, by the Chair of Department, by the President of the Staff, or by one-third (1/3) of the group's then members but not less than two (2) members.

13.3. Notice of Meetings. Written or oral notice stating the place, date, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the committee or Department not less than five (5) days before the time of such meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at his address as it appears on the records of the Hospital with postage thereon prepaid. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

13.4. Manner of Action. The action of a majority of the members present at a meeting at which a quorum is present shall constitute the action of the committee or Department. Action may be taken without a meeting by unanimous consent in writing signed or returned through secure electronic mail by each member entitled to vote.

13.5. Minutes. Minutes of each regular and special meeting of a committee or Department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer and after such signature is obtained, the minutes shall be forwarded to the Executive Committee. Only the Executive Committee or its designee shall maintain a permanent file of the minutes of all such meetings. Minutes shall be maintained in such a manner as to protect their confidentiality under State and federal law.

13.6. Attendance Requirements.

13.6.1 Committee Meetings. The chair of each Medical Staff committee shall have the discretion to determine attendance requirements for his committee.

13.6.2 Department Meetings. During the Medical Staff Year, members of the Active Staff are required to attend at least fifty percent (50%) of the Department meetings of the Department to which they are assigned. Practitioners with twenty-five (25) or more years of service at the Hospital are exempt from the attendance requirement for Department meetings. Meeting attendance shall be considered at the time of reappointment.

13.7. Special Attendance Requirements.

13.7.1 Mandatory Attendance of Concerned Practitioner. The chair of a Medical Staff committee or Chair of a Practitioner's Department may request the attendance of a particular Practitioner at a committee or Department meeting to address particular concerns related to the professional behavior or activities of the Practitioner. The committee chair or the Chair of the Department requesting the attendance shall confirm that the Practitioner is given advance written notice of the date, time, and place of the meeting at which his attendance is expected. The notice shall provide the Practitioner with the reasons for the requested attendance and a statement that his attendance at the meeting is mandatory.

13.7.2 Postponement. If the Practitioner shall make a timely request for postponement, supported by an adequate showing that his absence will be unavoidable, his mandatory attendance may be postponed until not later than the next regular meeting of the committee or Department.

13.7.3 Consequences of Failure to Attend. Failure by a Practitioner to attend the committee or Department meeting for which he was given notice that his attendance was mandatory to address specific committee or Department concerns, unless excused by the Executive Committee upon a showing of good cause, may result in an administrative suspension of all or such portion of the Practitioner's clinical privileges as the Executive Committee may direct. Such suspension shall remain in effect until the matter is resolved through any mechanism that may be appropriate, including corrective action, if necessary.

ARTICLE XIV
IMMUNITY FROM LIABILITY

The following shall be express conditions to any Practitioner's application for, or exercise of clinical privileges at the Hospital.

First, that any act, communication, report, recommendation, or disclosure, with respect to any such Practitioner, performed or made in good faith and without malice and at the request of an authorized representative of the Hospital or any other health care facility, for the purpose of achieving and maintaining quality patient care in the Hospital or any other health care facility, shall be privileged.

Second, that such privilege shall extend to members of the Hospital's Medical Staff and its Board, its other Practitioners, members of the Hospital Staff, and all agents or employees of the Hospital, its Chief Executive Officer and his representatives, and to third parties who supply information to any of the foregoing authorized to receive, release, or act upon the information. For the purpose of this Article, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Board or of the Medical Staff.

Third, that there shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

Fourth, that such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to: (1) applications for appointment to the Medical Staff or clinical privileges; (2) periodic reappraisals for reappointment or clinical privileges; (3) corrective action, including summary suspensions; (4) hearings and appellate reviews; (5) medical care evaluations; (6) utilization reviews; and (7) other Hospital, Department, or committee activities related to quality patient care, professional conduct, professional practice, and professional qualifications.

Fifth, that the acts, communications, reports, recommendations, and disclosures referred to in this Article may relate to a Practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

Sixth, that in furtherance of the foregoing, each Practitioner shall, upon request of the Hospital, execute releases in accordance with this Article in favor of the individuals and organizations specified above, subject to such requirements, including those of good faith, absence of malice, and the

exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State.

Seventh, that any consents, authorizations, releases, rights, privileges, and immunities provided any other section of these Bylaws for the protection of Practitioners at the Hospital, other appropriate Hospital officials and personnel and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article.

ARTICLE XV
CONFLICTS OF INTEREST

The responsibility for acting on a question of conflict of interest remains with each member of the Medical Staff. When a member of the Medical Staff finds himself in a situation in which his other interests could be interpreted as being in conflict with the interests of the Medical Staff, that member must disclose the potential conflict. Once the conflict is disclosed, the Medical Staff member may also be required by the Chair to remove himself from participation in any aspect of the decision-making process with regard to that situation. A majority vote of the members present may ultimately determine the affected member's level of participation in further deliberations. All members of the Medical Staff are encouraged to inquire about potential conflicts of interest in any decision-making process.

ARTICLE XVI
RULES AND REGULATIONS

The Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws subject to the approval of the Board. These rules and regulations shall relate to the proper conduct of Medical Staff organizational activities and endeavor to embody the level of practice that is to be required of each Practitioner in the Hospital. Such rules and regulations shall be made a part of these Bylaws, which will be amended in accordance with the amendment procedures in the Bylaws. Such changes shall become effective when approved by the Board.

ARTICLE XVII
AMENDMENTS

17.1. Amendment Process.

17.1.1 Proposal of Amendments. Proposed amendments to the Medical Staff Bylaws, Rules & Regulations, Fair Hearing Plan, and Allied Health Professional Manual shall be developed by or referred to the Bylaws and Rules Committee, which shall prepare proposed amendments and submit them to the Executive Committee for consideration and approval. If the Bylaws and Rules Committee determines that any proposed amendments should not be included in the applicable Medical Staff document, a report, which includes the reasons for not developing such amendments, shall be provided to the Executive Committee. Following receipt and consideration of the proposed amendments and/or report, the Executive Committee, at its discretion, may approve the proposed amendments, may refer the proposed amendments back to the Bylaws and Rules Committee for further development or revision, or may make such revisions to the proposed amendments, including amendments that were the subject of the report, which the Executive Committee deems appropriate, following a majority vote at which a quorum is present. All proposed amendments must be reported to the Medical Staff at a quarterly meeting of the Medical Staff within two quarters (six months) of the time that they are submitted, in writing, to the Bylaws and Rules Committee. The proposed amendments shall be published and presented at the quarterly meeting of the Medical Staff. They will be published in their original form. The outcome of the proposed changes, whether they are accepted, any changes that have been made, or whether they are rejected, shall also be published.

17.1.2 Submission to the Medical Staff. After approval or authorized revision by the Executive Committee, the Executive Committee shall provide a report on the proposed Bylaw amendments by mailing the proposed amendments and a report summarizing them to the members of the Active Staff. The amendment(s) will be acted upon at the next regular or special meeting of the Medical Staff. Before the applicable document(s) may be amended, all proposed amendments must be submitted in writing by mail or other delivery to each member of the Active Staff at least twenty-one (21) days prior to any regular or special meeting of the Medical Staff at which a vote on the amendments shall be taken. Any requested revisions to the proposed amendments must be submitted in writing to the Medical Staff Services Department at least

fourteen (14) days prior to the date of the meeting at which a vote on the amendment(s) will be taken.

17.1.3 Voting. Members of the Active Staff must be present at the regular or special meeting of the Medical Staff in order to vote on proposed amendments. Any requested revisions to the proposed amendments, which have been submitted on a timely basis to the Medical Staff Services Department, shall be forwarded to the Active Staff by electronic or other means prior to the meeting at which the vote will be taken. Copies of the proposed amendments and any requested revisions will be available at the regular or special meeting of the Medical Staff. A simple majority vote of the Active Staff shall determine whether the originally proposed amendment(s) or the requested revision(s) shall be submitted for the vote on the relevant proposed amendment(s). Motions to amend the proposed amendment(s) or requested revision(s) shall not be taken from the floor.

17.1.4 Adoption. To be adopted, an amendment shall require a two-thirds vote of the members of the Active Staff who are present and voting at a meeting at which a quorum is present.

17.1.5 Approval by the Board. Adopted amendments shall be effective when approved by the Board. These Bylaws, Rules & Regulations, Fair Hearing Plan, and Allied Health Professional Manual may not be unilaterally amended by the Board or the Medical Staff without the consent of the other.

17.2. Editorial Amendments. Notwithstanding Section 17.1 hereof, the Medical Staff Services Department shall have the authority to make non-substantive editorial changes to the applicable documents and to correct any typographical, formatting, and inadvertent errors.

ARTICLE XVIII
ADOPTION

The bylaws, rules and regulations, fair hearing plan and allied health professional manual shall be adopted by any regular or special meeting of the active medical staff, and shall replace any previously adopted document and shall become effective when approved by the board of the hospital.

ARTICLE XIX
PARLIAMENTARY PROCEDURE

The rules contained in the current edition of Roberts Rules of Order Newly Revised shall govern the Medical Staff in all cases to which they are applicable and in which they are not inconsistent with these bylaws or any special rules of order the Medical Staff may adopt.

ADOPTED by the Active Medical Staff on the 28th day of April, 2010.

Karen L. Woods, M.D. Secretary, Medical Staff	Wade R. Rosenberg, M.D. President, Medical Staff

APPROVED by the Board on the 28th day of April, 2010.

D. Gibson Walton Secretary, Board of Directors	Hon. Ewing Werlein, Jr. Chairman, Board of Directors