Northwest Texas
Healthcare System

MEDICAL STAFF BYLAWS

CERTIFICATION OF ADOPTION AND APPROVAL:

MEDICAL STAFF

Approved by the Medical Staff of Northwest Texas Healthcare System on November 5, 2012.

By:______________________ Date: 11/13/12

President of Staff

BOARD OF DIRECTORS

Approved and adopted by the Board of Directors of Northwest Texas Healthcare System on November 20, 2012.

By:______________________ Date: November 20, 2012

Chair of the Board

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DEFINITIONS

ADVERSE DECISION: means a professional review action (as defined by the federal Health Care Quality Improvement Act) in which the Board or Medical Executive Committee denies, terminates, limits, suspends or modifies a grant of Privileges or Medical Staff membership for reasons relating to professional conduct or competency.

ALLIED HEALTH PROFESSIONAL Independent (AHP): An individual who provides direct patient care services in the Hospital, generally under a defined degree of supervision unless permitted by State law and the Hospital's policy to practice independently, exercising judgment within the areas of documented professional competence and consistent with applicable law. AHPs are designated by the Board to be credentialed through the Medical Staff system and are granted Clinical Privileges as an independent healthcare professional as defined in these Bylaws. AHPs are not eligible for Medical Staff membership. The Board has determined the categories of individuals eligible for Clinical Privileges as an AHP are: physician assistants (PA), certified registered nurse anesthetists (CRNA), Sexual Assault Nurse Examiners (SANE), certified nurse midwives (CNM), clinical psychologists (Ph.D.) and advanced registered nurse practitioners (ARNP).

ANCILLARY MANUALS: means the Credentials Manual and Corrective Action and Fair Hearing Manual.

APPLICANTS: means all physicians, podiatrists, dentists, or AHPs applying for appointment or reappointment to membership on the Medical Staff or for Privileges.

BOARD, HOSPITAL BOARD or GOVERNING BOARD: means the local governing body of the Hospital which has been delegated specific authority and responsibility, and appointed by the Board of Directors of the Hospital. The Board is the "governing body" as described in the standards of the Joint Commission and the Medicare Conditions of Participation and serves as the legal and policy-making board of the Hospital.

BOARD CERTIFICATION: The designation conferred by one of the affiliated specialties of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the American Board of Oral and Maxillofacial Surgery, or American Board of Podiatric Surgery (ABPS) as applicable, upon a physician, dentist, or podiatrist who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the applicant's area of clinical practice.

BYLAWS: means these Medical Staff Bylaws that provide the framework for the organized Medical Staff, its responsibilities, and mechanisms for self-governance of the Medical Staff; and the working relationship with and accountability to the Board.

CHAIR: The individual responsible for directing the functions and meetings of a clinical department or a committee.

CHIEF EXECUTIVE OFFICER (CEO): The individual appointed by the Board to act on

its behalf in the overall administrative management of the Hospital.

PRESIDENT OF STAFF: A member of the active Medical Staff who is elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of the Hospital.

CONTRACT PHYSICIAN: is a practitioner whose privileges are contingent upon a contractual relationship.

CORRECTIVE ACTION: An action taken by the Medical Staff or Board which restricts, modifies, limits, denies, or terminates the privileges or Medical Staff membership of a Practitioner for reasons concerning professional conduct or concerns about competency, which entitles the Practitioner to procedural rights as outlined in these Bylaws. Required evaluations, warning, reprimands, and performance monitoring are not considered Corrective Actions.

CREDENTIALS COMMITTEE: means the credentialing and privileging committee of the Hospital which reviews applications for initial membership and reappointment to the Medical Staff, makes recommendations to the Medical Executive Committee of the Hospital regarding assignment of Privileges, recommends policies and procedures related to the credentialing of Practitioners, conducts investigations when applicable and may serve as a peer review committee or professional review body.

CVO: Credentials Verification Organization of the Hospital.

DATE OF RECEIPT: The date any Notice, Special Notice, or other communication is delivered personally, by facsimile, or by electronic mail (email); or if such Notice, special Notice, or communication was sent by mail, it shall mean seventy-two (72) hours after the Notice, Special Notice, or communication was deposited, postage prepaid, in the United States mail.

DAYS: Calendar days, unless otherwise noted.

DELEGATION OF FUNCTIONS: means when a function is to be carried out by a person or committee, the person, or the committee through its Chairperson, may delegate performance of the function to one or more qualified designees.

DENTIST: A dentist or oral surgeon holding a D.D.S. or equivalent degree and a valid license to practice dentistry in the State.

DEPARTMENT: means a major division of the Medical Staff of practice related specialties which will have a Chief duly elected in accordance with these Bylaws to serve as head of a department

DEPENDENT ALLIED HEALTHCARE PROFESSIONAL: means a professional not employed by the Hospital who provides patient care services in support of, or under the direction of, a Medical Staff member. Dependent Allied Healthcare Professionals shall include, without limitation, operating room nurses and technicians, perfusionist, surgical

first assistants, clinical assistants, autotransfusionists, orthotists/prosthetists, registered and practical nurses, dental technicians, and medical assistants. The foregoing categories of Dependent Allied Healthcare Professionals are separate and distinct from the independent AHPs. Hospital policies and procedures shall govern the actions and patient care services provided by Dependent Allied Healthcare Professionals and shall have their qualifications and ongoing competence verified and maintained through a process administered by the Hospital. Dependent Allied Healthcare Professionals shall work under the same job description as hospital personnel.

EX-OFFICIO: means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means ***with*** voting rights.

GOVERNORING BODY: means the Board of Governors of Northwest Texas Healthcare Systems.

HOSPITAL: means Northwest Texas Healthcare System and includes all of its facilities and all of its personnel and organizational entities, including the Medical Staff.

HOUSE STAFF: refers to those practitioners (interns, residents and fellows) who are currently in a post graduate training program and who are present as part of an approved educational program.

MAJORITY: means more than one-half of those present, voting or ballots received; whichever is appropriate.

MEDICAL EXECUTIVE COMMITTEE (MEC): means the executive committee of the Medical Staff.

MEDICAL STAFF LEADERS: provide the framework for planning, directing, coordinating, providing, and improving health care services and are defined as, but not limited to, the following: Staff Officers, Chiefs of Departments/Services, Medical Directors of Departments/Services, and Committee Chairman.

MEDICAL STAFF OFFICERS: means the President, President elect, or Past President of the Medical Staff

MEDICAL STAFF or STAFF: means the formal organization of Members privileged through the organized medical staff process in these Bylaws accountable to the Board. The Medical Staff is a self-governing entity accountable to the Board and operates under these Bylaws, Rules and Regulations and Policies adopted by the voting Members and approved by the Board.

MEDICAL STAFF YEAR: means the period from January 1 to December 31 of each calendar year.

MEMBER: means a Practitioner who has been appointed by the Board to be a Member of the Medical Staff.

NON-PATIENT CARE PROVIDER: refers to any individual who do not provide direct patient care. These individuals work for an agency or physician. Their main function is to collect data

NOTICE: A written or electronically transmitted communication delivered personally to the addressee or sent by United States mail, first-class postage prepaid, addressed to the addressee at the last address as it appears in the official records of the Medical Staff or Hospital.

ORGANIZED HEALTH CARE ARRANGEMENT: A clinically integrated care setting in which individuals typically receive health care from more than one provider and which is defined in 45 C.F.R. § 160.103 commonly known as the HIPAA Privacy Regulations.

PEER REVIEW: The review of an individual's performance of clinical professional activities as part of the Medical Staff's quality oversight and performance improvement responsibilities.

PERFORMANCE IMPROVEMENT COMMITTEE: (also referred to as a PROFESSIONAL REVIEW BODY): Any committee of Medical Staff and Hospital personnel that operates under written bylaws approved by the Board and is organized to evaluate the quality of medical and health care services, including the evaluation of performance and professional conduct or the competence of Practitioners.

PHYSICIAN: An individual with an M.D, DMD, DPM. or D.O., degree who is licensed to practice in the State.

POLICIES: All Medical Staff and Hospital policies approved by the MEC and ratified by the Board referred to in these Medical Staff Bylaws including the Ancillary Manuals all of which can be obtained through the Medical Staff office of the Hospital or the Hospital CEO.

PRACTITIONER: Any person licensed or otherwise authorized by State law to provide health care services and who has been granted Privileges by the Board.

PRIVILEGE: The permission granted by the Board to a Practitioner to render or exercise specific diagnostic, therapeutic, medical, surgical or dental services and/or procedures in the Hospital or any of its facilities.

PROFESSIONAL REVIEW ACTION: An action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual Practitioner (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the Privileges of a Practitioner.

PRONOUNS: The use of the male pronoun (he/his/him) throughout these Bylaws is applicable to either male or female individuals.

RULES & REGULATIONS: Are Medical Staff policies approved by the MEC and ratified

by the Board.

SECTION: means the group of practitioners who have similar privileges in one of the clinical departments who are approved as a Section under these bylaws.

SUPERVISION: means the process of monitoring and directing patient care activities and shall include close supervision (physically present), direct supervision and indirect supervision

SPECIAL NOTICE: Written notification sent by hand delivery, certified or registered mail return receipt requested.

STATE: The State in which the Hospital operates and is licensed to provide patient care services, which is Texas.

TIME LIMITS: Unless otherwise required by law, all time limits referred to in these Bylaws, the Ancillary Manuals, or in any other Medical Staff Rules, Regulations, or Policies are advisory only, and are not mandatory unless a specific provision states that a particular right is waived by failing to take action within a specified time period

ARTICLE I

PURPOSE

The Medical Staff of Northwest Texas Healthcare System is established by the Board to assist the Hospital in meeting its mission and to carry out duties assigned to it by the Board in order to enhance the quality and safety of care, treatment, and services provided to patients. The Medical Staff is considered part of the Hospital's Organized Health Care Arrangement.

ARTICLE II

MEDICAL STAFF MEMBERSHIP & CATEGORIES

2.1 Eligibility and Qualification for Membership

Membership on the Medical Staff is a privilege granted only to professionally competent applicants who continuously meet the qualifications, standards and requirements set forth in these Bylaws and in Medical Staff Hospital Policies.

To be eligible to apply for initial Membership appointment or reappointment to the Medical Staff of Hospital, applicants must hold a license to practice in the State as a Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, or Dentist with a Doctor of Dental Medicine or Dental Surgery degree. Membership applicants to the Medical Staff have the burden of documenting to the satisfaction of the Board that they will contribute to meeting the mission of the Hospital and have the ability to do so competently, safely, and collaboratively by providing requested information on their:

a. background
b. clinical experience
c. education and training
d. clinical judgment
e. demonstrated professional competence
f. individual character and ability to work with others collaboratively
g. physical and mental capabilities and ability to safely and competently exercise any privileges requested
h. intended practice plans, and
i. adherence to the ethics of their profession.

Specifically, physicians, podiatrists, and dentists must:
a. Have a current, unrestricted license to practice in Texas;
b. Where applicable to his practice, have a current unrestricted Federal Drug Enforcement agency registration and State Controlled Substances certification;
c. Possess current, valid professional liability insurance that covers all privileges requested with an insurance carrier authorized by the State of Texas Department of Insurance as a licensed provider of professional malpractice insurance. Insurance must be carried in a form and amount as determined from time to time by the Board.

d. Must reside and practice in Potter/Randall county. This requirement may be waived for Affiliated Staff members.
e. Not be seeking only Privileges that are subject to an exclusive contract with the Hospital;
f. Be eligible to participate in Medicare, Medicaid, and other federally sponsored healthcare reimbursement programs;
g. Be able to demonstrate the ability to work cooperatively with others and to treat others within the Hospital with respect at all times. Evidence of ability to display appropriate conduct and behavior shall include, but shall not be limited to, responses to related questions provided in information from training programs, peers, and other facility affiliations.
h. Understand that if there is any material misstatement in, or material omission from, an application for appointment or reappointment, the Hospital may stop processing the application because the application will be deemed incomplete. There shall be no entitlement to a hearing or appeal if the application is deemed incomplete;

Additional membership and privileging requirements considered associated details can be found in the Medical Staff Credentials Manual or in the Medical Staff's delineation of privileges forms.

An applicant who does not meet the basic qualifications is ineligible to apply for Medical Staff Membership and his application shall not be processed. The qualifications for Membership must be documented with sufficient adequacy to satisfy the Medical Staff and Board that each has enough information to make a fully informed decision regarding appointment and assignment of privileges.

No applicant may be entitled to Membership on the Medical Staff or to the exercise of particular Privileges in the Hospital merely by virtue of licensure to practice in Texas or any other state, membership in any professional organization, certification by any American Board of Medical Specialty (ABMS), privileges at another hospital, or the demonstration of clinical competence.

No applicant shall be appointed to the Medical Staff if the Hospital, in its sole discretion, does not provide the service to which the applicant is applying or the Hospital is unable to provide adequate facilities and support services for the applicant or his patients. Refusal to accept or review requests for Staff Membership or Privileges based upon Hospital's ability to accommodate, as described in this section, shall not constitute a denial of Staff Membership or Privileges and shall not entitle the individual to any procedural rights of hearing or appeal. Any portion of the application which is accepted (e.g., requests for Privileges that are not subject to a limitation) shall be processed in accord with these Bylaws. The Board may make exceptions or additions to any of the above qualifications and requirements after consultation with the Medical Staff through a Joint Conference.

2.2 Non-Discrimination

The Hospital will not discriminate in granting Medical Staff Membership and/or Privileges on the basis of gender, race, religion, national origin, disability unrelated to the provision of patient care or required Medical Staff responsibilities, or any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified.

2.3 Responsibilities of Membership

Each Member of the Medical Staff must continuously comply with the provisions of these Bylaws, the Ancillary Manuals and Medical Staff Rules, Regulations and Policies. Members also must:

a. Provide continuous and timely care to all patients for whom the individual has responsibility;
b. Provide, with or without request, new and updated information to the Hospital as it occurs, pertinent to any question found on the initial application or reappointment forms;
c. Appear for personal interviews (in person or by teleconference) in regard to an application for initial appointment or reappointment, as requested by the Hospital;
d. Refrain from illegal fee splitting or other illegal inducements or remuneration relating to patient referrals;
e. Refrain from deceiving patients as to the identify of any individual providing treatment or services;
f. Seek an appropriate consultation whenever necessary to assure adequate quality of care;
g. Complete in a timely manner all medical and other required records, inputting all information required by the Hospital;
h. Satisfy continuing medical education requirements for licensure and as may be required under policies adopted from time to time by the Medical Staff;
i. Supervise the work of any allied health professional under his direction;
j. Assist other Practitioners in the care of their patients when asked in order to meet an urgent patient need or assure the well-being of a patient;
k. Treat employees, patients, visitors, and other physicians in a dignified and courteous manner at all times.
l. Maintain back-up coverage to be provided by a Member of the Hospital's Medical Staff.

Furthermore, each Member of the Medial Staff by accepting Medical Staff appointment agrees:

m. To abide by these Bylaws, all supplemental Medical Staff manuals and Medical Staff Rules, Regulations, and Policies;
n. To participate in and collaborate with the peer review and performance improvement activities of the Medical Staff and Hospital. These include monitoring and evaluation tasks performed by the Medical Staff, and compliance with Hospital efforts to meet standards such as those established by the Joint Commission, insurers, Centers for Medicare and Medicaid Services (CMS) and other governmental agencies (e.g. core measures);

o. To assist the Hospital in fulfilling its responsibilities for providing emergency and charitable care in accordance with Policies passed by the MEC and Board;

p. To undergo any type of health evaluation by a consultant selected by the Hospital, including random drug testing, as requested by the officers of the Medical Staff, Chief Executive Officer (CEO), and/or MEC when it appears necessary to protect the well-being of patients and/or staff, or when requested by the MEC or Credentials Committee as part of an evaluation of the Member's ability to exercise Privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any Medical Staff and Hospital Policies addressing physician health or impairment.

q. To participate in any type of competency evaluation when determined necessary by the MEC and/or Board in order to properly delineate that Member's Privileges.

r. To provide patient care and management only within the parameters of his professional competence, as reflected in the scope of Privileges granted to the Member by the Board.

s. To hold harmless and agree to refrain from legal action against any individual, the Medical Staff, or Hospital that appropriately shares peer review and performance information with a legitimate health care entity or state licensing board assessing the credentials of the Member.

t. To abide by the current Principles of Medical Ethics of the American Medical Association, the American Osteopathic Association, the Code of Ethics of the American Dental Association, or the ethical standards governing the Member's practice. The Member shall also agree to abide by any applicable codes of conduct adopted by the Medical Staff and/or Hospital.

u. To abide by all local, state and federal laws and regulations, Joint Commission standards, and state licensure and professional review regulations and standards, as applicable to the Member's professional practice.

v. Participate in emergency call roster. Such call will be compliant with federal and state laws, including but not limited to, 42 U.S.C., Par. 1395dd ("patient dumping statute"), as such statute may be amended from time to time, and as required by the medical staff bylaws and departmental rules and regulations pertaining to emergency treatment adopted by the Medical Executive Committee and Board of Governors. Plans for emergency call (to be included in departmental rules/regulations) will be submitted by each department to the Executive Committee and Board of Governors. Physicians may choose to be exempt from participation in the emergency call roster at age 65.

   Those members of the Affiliate Staff who have been granted privileges to admit and who primarily reside and practice in Potter/Randall Counties may be required to participate in the emergency call roster.

w. Participate in the community wide disaster plan in the event of a disaster.

2.4 Categories of Medical Staff Membership

The Medical Staff shall be divided into the following categories: Provisional, Active, Associate, Affiliate, and Honorary. Category status for each Physician will be recommended by the MEC at appointment or reappointment and ratified by the Board.

2.4.1 Provisional Staff

Provisional appointment to the Medical Staff will begin to be counted with appointment by the Board of Governors. If the provisional staff member has completed the terms of the provisional period as noted below, and has satisfactorily demonstrated competence in the clinical privileges initially granted during the Provisional Period, the member shall be advancement to the Active or Associate staff upon approval by the Board of Governors. Failure of an appointee to satisfy requirements for advancement from the Provisional Staff will automatically be appointed to the Affiliate Staff.

Terms:

A member shall remain on the provisional staff for a minimum of one (1) year, but may be continued for a period of time, not to exceed two years, or as determined by the Executive Committee.

All provisional staff members will have a focused professional practice evaluation. Provisional Staff members must regularly admit, or otherwise be regularly involved in the care of, three (3) or more patients during the one-year provisional period in order to be eligible to advance to the Active or Associate Staff.

Qualifications:

a. Must reside and practice within Potter or Randall County.
b. Meet the basic responsibilities of Medical Staff membership, as defined in Article 2.3, and contribute to the organizational and administrative affairs of the Medical Staff.

Prerogatives:

a. To admit patients without limitation unless otherwise provided in the bylaws or in the medical staff rules and regulations.
b. To exercise such clinical privileges as are granted to him
c. Following completion of any required proctorship and required tenure, may advance to Active, Associate or Affiliate Staff.
d. May not serve on the primary committees as listed in Article VIII, unless it is determined that their particular area of expertise is required. If appointed/elected to serve, the right to vote must be specified at the time of committee appointment/election. Shall not be eligible to hold office or serve as Chairman of a Committee.

Responsibilities: Appointees to this category must:

- a. Actively participate in recognized functions of staff appointment, including performance improvement, peer review, risk and utilization management, the monitoring of initial appointees, credentialing activities, medical records completion, and the discharge of other Medical Staff functions and departmental obligations as may be required from time to time.
- b. Comply with these Bylaws, the Ancillary Manuals and all applicable Hospital and/or Medical Staff Rules, Regulations, and Policies.
- c. Participate in providing Emergency call and in other coverage arrangements as defined in Policies.
- d. Perform such further duties as may be required under these Bylaws or Policies, including any future changes to these documents.

2.4.2 Active Staff

Qualifications: Appointees to this category must:

Be involved in a minimum of thirty-six (36) patient contacts at the Hospital, over a twenty-four (24) month period or at time of reappointment, whichever is sooner. A patient contact is defined as any admission, inpatient evaluation, consultation, or procedure, performed in the Hospital. The patient contact must be documented in the medical record. After initial appointment, category status will be assigned at reappointment time based on contact activity during the previous twenty-four (24) month period or at anytime by request of the Medical Staff Member. Members may be promoted to this category at any such time, at their request, when they meet the minimum required patient contacts at the Hospital. Where a Physician brings particular skills, contributions, or benefits to the Hospital and Medical Staff, the Board may appoint the Physician to the Active Staff even if the Physician does not meet the minimum activity requirements.

Prerogatives: Appointees to this category may:

- a. Exercise those Privileges granted by the Board.
- b. Vote on all matters presented at general and special meetings of the Medical Staff, and at meetings of department(s) and committees to which he is appointed.
- c. Hold office and sit on or act as chair of any committee, unless otherwise specified elsewhere in these Bylaws.

Responsibilities: Appointees to this category must:

- a. Meet the basic responsibilities of Medical Staff membership, as defined in Article 2.3, and contribute to the organizational and administrative affairs of the Medical Staff.
- b. Actively participate in recognized functions of staff appointment, including performance improvement, peer review, risk and utilization

management, the monitoring of initial appointees, credentialing activities, medical records completion, and the discharge of other Medical Staff functions and departmental obligations as may be required from time to time.

c. Comply with these Bylaws, the Ancillary Manuals and all applicable Hospital and/or Medical Staff Rules, Regulations, and Policies.

d. Participate in providing Emergency call and in other coverage arrangements as defined in Policies.

e. Perform such further duties as may be required under these Bylaws or Policies, including any future changes to these documents.

2.4.3 Associate Staff

Qualifications: Appointees to this category must:

a. Be interested in the clinical affairs of the Hospital and hold Privileges to actively manage patient care or to refer and follow hospitalized patients.
b. Admit or otherwise be involved in the care or treatment of less than thirty-six (36) patient contacts (as defined in Section 2.4.1 under the Active Category) in an appointment period.
c. Engage in the active practice of medicine at some location so that the Medical Staff and Board can assess the Member's compliance with membership and privileging requirements as stated under these Bylaws and Policies.

At each reappointment time, the Associate Staff Member may be asked to provide evidence of clinical performance at other hospitals where the Member holds privileges. In addition, especially for an Associate Staff Member who does not maintain appointment at another hospital, the Member shall provide other information as may be requested by the Medical Staff or Board in order to perform an appropriate evaluation of qualifications. Such information may include, but will not be limited to, data from the Member's office practice, information from managed care organizations in which the Member participates, and/or receipt of confidential evaluations forms completed by referring/referred to physicians.

Prerogatives: Appointees to this category may

a. Exercise those Privileges granted by the Board.
b. Attend meetings of the Staff and Department to which he is appointed in a non-voting capacity, except in committees to which the Member is appointed. Associate Staff may attend all educational programs presented by the Medical Staff and/or Hospital.
c. Not vote or hold office within the Medical Staff organization. An Associate Staff Member may serve on committees of the Medical Staff or Hospital as a voting Member and may also attend Medical Staff and Department meetings, but as a non-voting Member.

Responsibilities: Appointees to this category must:

a. Meet the basic responsibilities of Medical Staff membership, as defined in Article 2.3, and contribute to the organizational and administrative affairs of the Medical Staff.
b. Actively participate, when asked, in recognized functions of Staff appointment, including performance improvement, peer review, risk and utilization management, the monitoring of initial appointees, credentialing activities, medical records completion, and the discharge of other Medical Staff functions and departmental obligations as may be required from time to time.
c. Comply with these Bylaws, the Ancillary Manuals and all applicable Policies and Rules and Regulations.
d. Participate in providing Emergency call and other coverage arrangements as defined in policies adopted by the MEC and Hospital Board.

e. Perform such further duties as may be required under these Bylaws or Medical Staff Rules, Regulations, or Policies, including any future changes to these documents.

2.4.4 Affiliate Staff

Qualifications:

The Affiliate Staff category shall consist of Physicians who are not actively involved in Medical Staff affairs and are not major contributors to fulfillment of Medical Staff functions, due to practicing primarily at another hospital or in an office-based specialty, or other reasons, but who wish to remain affiliated with the Hospital for referral of patients or other patient care purposes.

Appointees to this category may;

a. Refer patients for outpatient diagnostic testing and specialty services provided by the Hospital;

b. Refer patients to other appointees of the Medical Staff for admission, evaluation, and/or care and treatment;

c. Visit their hospitalized patients, review their hospital medical records and provide advice and guidance to the attending physician, but shall not be permitted to admit patients, to attend patients, to exercise any Privileges, to write orders or progress notes, to make any notations in the medical record or to actively participate in the provision of care or management of patients in the hospital. They are encouraged to attend educational programs sponsored by the hospital or Medical Staff and attend meetings of the full Medical Staff and the Department to which they are assigned.

Appointees of this category shall not vote on Medical Staff matters, or hold office, but may serve and vote on Medical Staff Committees, if assigned. Appointees of this category further acknowledge that appointment and reappointment to the Affiliate

Staff is a courtesy which may be terminated by the Board upon recommendation of the MEC with sixty (60) days written notice, without the right to due process, , as set forth in these Bylaws.

2.4.5 Honorary Medical Staff

The Honorary Staff Category is restricted to Members the Medical Staff wishes to honor. Criteria for this status include, but are not limited to, Physicians who have actively participated in Hospital affairs, committee activity and have had a Medical Staff leadership role. The Department or the MEC may forward the names of Members being considered for this category and will submit a recommendation to the MEC for consideration and decision. Such Staff appointees are not eligible to admit patients to the Hospital or to exercise Privileges in the Hospital, nor vote at any meetings attended. Honorary Staff may, however, attend Medical Staff and Department meetings and educational programs. They may also be appointed as voting or non-voting members of committees when interested so that the Medical Staff may take advantage of their unique experience or talents. Honorary Staff shall not vote or hold office within the Medical Staff organization. An Honorary Staff Member may serve on committees of the Medical Staff or Hospital as a voting Member and may also attend Medical Staff and department meetings, but as a non-voting Member

Prerogatives: Individuals in the Honorary Medical Staff category shall be invited and welcome to attend education and social functions of the Hospital and Medical Staff as appropriate.

Responsibilities: Individuals in the Honorary Medical Staff category will conduct themselves at all times in a manner that will not diminish or tarnish the reputation of the Medical Staff or the Hospital.

2.4.6 The House Staff

Qualifications:

The House Staff shall consist of medical postgraduate students associated with the hospital through an affiliation agreement with Texas Tech University Health Sciences Center as a formal medical education program. Participation as a House Staff member will be extended only to those individuals whose name and other pertinent data have been provided to the hospital.

a) The House Staff must have completed the minimal educational requirements to participate in a residency accredited or approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association.
b) House Staff members are not members of the Medical Staff. House Staff members will be excluded from the usual Medical Staff process of appointment, reappointment and privileges. Appointments, evaluations,

advancements and terminations will be handled through the TTUHSC Graduate Medical Education Committee.

Prerogatives:

a) House Staff members will participate in the management of the health care of patients but only under the supervision of an attending/supervising physician.

House Staff members will participate only in those clinical activities which are within the scope of the clinical privileges of his attending/supervising physician at the hospital. House Staff members shall not perform actions beyond his skills or competence without proper supervision. House Staff members shall not have admitting privileges.

b) House Staff members shall attend meetings of committees to which they are appointed and any staff or hospital education program.

c) The prerogative of House Staff members to write orders on patients does not preclude the writing of orders by the physician of record.
(See also General Rules/Regulations, Section 3.C.3.)

Eligibility for Voting or Holding Office:

House Staff members shall not be eligible to vote except in committees to which they are appointed. Additionally, House Staff members shall not be eligible to hold a Medical Staff office.

Responsibilities of House Staff members:

a) House Staff members shall be required to discharge the basic responsibilities specified for Medical Staff membership in Article II and duties assigned by his Program.

b) When it is felt that discipline of a House Staff member may be indicated, the Chief Medical Officer of NWTHS should be contacted so that such information may be communicated to the TTUHSC Regional Dean and/or the TTUHSC Regional Chair of the appropriate department. TTUHSC will be requested to respond to the Chief Medical Officer regarding action taken.

House Staff members shall have no right to hearing and appellate review as set out in Policy and Procedure.

Responsibilities of the Medical School:

a) A supervising/attending physician shall be directly responsible for the activities and actions of House Staff members under his supervision at the hospital.

b) Following completion of the residency Match in March of each year, the TTUHSC Education Department will submit a list of House Staff participating in the education program to the Northwest Texas Healthcare System Medical Staff Office. The list will include the residents name, and PGY status.

The TTUHSC Graduate Medical Education Department will submit a list of residents who are expected to complete or leave the program and the dates of anticipated departure.

c) The TTUHSC Graduate Medical Education Department will notify the Northwest Texas Hospital Medical Staff Office of any change in the residents status (advancement, termination, leave of absence, etc).

2.4.7 Change in Staff Category

Pursuant to a request by the Medical Staff Member, upon a recommendation by the Credentials Committee, or pursuant to its own action, the MEC may recommend a change in Medical Staff category of a Member consistent with the requirements of these Bylaws. The Board shall approve any change in category. Determinations regarding assignment of Staff category are not subject to review under the due process provisions of these Bylaws.

2.4.8 Limitation of Prerogatives

The prerogatives of Medical Staff membership set forth in these Bylaws are general in nature and may be subject to limitation or restriction by special conditions attached to an individual's appointment, reappointment, or Privileges, by state or federal law or regulations, by other provisions of these Bylaws or by other Policies, or by commitments, contracts, or agreements of the Hospital.

2.5 Member Rights

Members appointed to the Medical Staff shall have the following rights, in addition to the procedural due process rights enumerated in these Bylaws:

2.5.1 Each Member of the Medical Staff has the right to an audience with the MEC on matters relevant to the responsibilities of the MEC. In the event that such Member is unable to resolve a matter of concern after discussion with the appropriate Department or committee chair or other appropriate Medical Staff leader(s), that Member may, upon written notice to the President of Staff at least two weeks in advance of a regular meeting of the MEC, meet with the MEC or MEC subcommittee to discuss the issue. The President of Staff will have discretion regarding the timing and placement of the issue on the MEC agenda or direction of the issue to a subcommittee.

2.5.2 Each Member of the Active Medical Staff has the right to initiate a recall vote of Medical Staff officers or Department chairs in accordance with the recall provisions provided in these Bylaws.

2.5.3 Each Member of the Active Staff has a right to petition to call a special meeting of the general Medical Staff to discuss a matter relevant to the Medical Staff. Upon presentation by the Member of a petition signed by ten percent (10%) of Members of the Active Staff category, the MEC shall schedule a special meeting of the Medical Staff for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted at this meeting.

2.5.4 Each Member of the Active Staff may petition to raise a challenge to any Policy rule or Regulation established by the MEC. If presented by such Member with a petition signed by ten percent (10%) of the Active Staff Members of the Medical Staff, the MEC will do one of the following:

a. Provide the petitioners with information clarifying the intent of such Policy and the justifications for its adoption; and/or

b. Schedule a meeting with the petitioners to discuss the issues raised with regard to the Policy. The conflict management process set forth in Article XI, Section 11.6 of these Bylaws shall apply.

2.5.5 Any Member of the Active Staff or Associate Staff may call for a department meeting by presenting a petition signed by twenty-five percent (25%) of the Members of the Department. Upon presentation of such a petition, the Department Chair will schedule a Department meeting to discuss the concerns raised by the petitioners.

2.5.6 The above sections on Member Rights (2.5.1 through 2.5.5) do not pertain to issues involving individual peer review or performance evaluation (including focused and ongoing professional practice evaluation), formal investigations of professional performance or conduct, denial of requests for appointment or privileges, restriction or conditions placed on appointment or Privileges, or any other matter relating to individual Membership or Privileges. Recourse with regard to these matters is described in Article X.

2.6 Allied Health Professionals

2.6.1 Category: AHPs are person(s) other than Physicians who are granted Privileges to practice in the Hospital and are directly involved in patient care but are not Members of the Medical Staff but are instead appointed to the AHP Staff. AHP Staff may be employed by Physicians on the Medical Staff, but whether or not so employed, must be under the direct supervision and direction of a Physician, unless permitted by State law and the Hospital's policy to practice independently, and not exceed the limitations of practice set forth by their respective State licensing board.

2.6.2 Qualifications: Only AHPs holding a license, certificate or other official credential as provided under State law, shall be eligible to provide specified services in the Hospital as delineated by the MEC and approved by the Board.
AHP's must:

a. Document their professional experience, background, education, training, demonstrated ability, current competence and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide needed services within the Hospital;

b. Establish, on the basis of documented references, that they adhere strictly to the ethics of their respective professions, work cooperatively with others and are willing to participate in the discharge of AHP Staff responsibilities;

c. Have professional liability insurance in the amount required by these Bylaws;

d. Provide a needed service within the Hospital; and

e. Unless permitted otherwise by law and by the Hospital to practice independently, provide written documentation that a Physician has assumed responsibility for directing and supervising the AHP.

2.6.3 Prerogatives: Upon establishing professional experience, background, education, training, demonstrated ability, current competence, and physical and mental health status, AHPs, as identified in this Section 2.6, shall have the following prerogatives:

a. To exercise professional judgment within the AHP's area of competence, providing that a Physician has the ultimate responsibility for patient care except as otherwise specifically permitted by law and Hospital policy;

b. To participate directly, including writing orders to the extent permitted by State law, in the management of patients under the supervision or direction of a Physician; and

c. To participate as appropriate in patient care evaluation and other quality assessment and monitoring activities required of the Medical Staff, and to discharge such other Staff functions as may be required from time-to-time.

2.6.4 Conditions of Appointment:

a. AHPs shall be credentialed in the same manner as outlined in Article III of the Medical Staff Bylaws for credentialing of Medical Staff Members and other Practitioners. Each AHP shall be assigned to the appropriate Department and shall be granted Privileges relevant to the care provided in that Department. The Board in consultation with the MEC shall determine the scope of the activities which each AHP may undertake. Such determinations shall be furnished in writing to the AHP, shall be final, and shall not entitle the AHP to due process, except as specifically and expressly provided in these Bylaws or unless otherwise required by State law.

b. Appointment of AHPs must be approved by the Board.

2.6.5 Adverse Actions or Recommendations:

a. Adverse actions or recommendations made by the Credentials Committee, Performance Improvement Committee, or a Peer Review Committee specifically established for AHPs as required by State law (collectively "Committee" for this subsection 2.6.5), affecting an AHP's Privileges shall not entitle the AHP to the same due process as set forth in Article X of these Bylaws. Unless additional procedures are required by State law, the affected AHP shall have the following procedural rights instead:

   i. Notice that his practice is being reviewed;
   ii. A brief description of the incident(s) leading to the review;
   iii. The contact information for the Committee Representative;
   iv. Notice of the date of the Committee meeting;
   v. Copies of the Committee's Peer Review policies and procedures ;
   vi. An opportunity to review, in person or by attorney or authorized representative, documents concerning the incident(s) leading to the review at least fifteen (15) days prior to the Committee meeting;
   vii. An opportunity to submit a preliminary written statement regarding the incident(s) under review;
   viii. A duty to provide the Committee written notice of the witnesses the AHP intends to call with their contact information and to inform the Committee of legal representation, no later than 72 hours prior to the Committee meeting; and
   ix. An opportunity to call witnesses, question witnesses, is present when testimony or evidence is presented to the Committee, and to make an opening and closing statement to the Committee.

b. A record of the Committee meeting shall be made.

c. Within ten (10) days after the Committee's review has been completed, the AHP shall be provided, in person or by certified mail, return receipt requested, a written notice of the Committee's determination.

d. The AHP shall have the right to submit a written rebuttal to the Committee's recommendation. The written rebuttal shall be made a permanent part of the Committee's record, and included whenever the findings of the Committee are disclosed.

e. Unless otherwise limited by State law, the AHP shall have a right to appeal to the Board any decision rendered by the Committee. Any request for appeal shall be required to be made within fifteen (15) days after the date of the receipt of the Committee's decision. The written request shall be delivered to the President of Staff and shall include a brief statement of the reasons for the appeal. If appellate review is not requested within such period, the AHP shall be deemed to have accepted the Committee's determination which shall thereupon become final and effective immediately upon affirmation by the MEC and the Board. If appellate review is requested the Board shall, within fifteen (15) days after the receipt of

such an appeal notice, schedule and arrange for appellate review. The Board shall give the AHP notice of the time, place and date of the appellate review which shall not be less than fifteen (15) days nor more than ninety (90) days from the date of the request for the appellate review. The appeal shall be in writing only, and the AHP's written statement must be submitted at least five (5) days before the review. New evidence and oral testimony will not be permitted. The Board shall thereafter decide the matter by a majority vote of those Board members present during the appellate proceedings. A record of the appellate proceedings shall be maintained.

2.6.6 Termination of Privileges:

a. An AHP's Privileges and AHP Staff appointment may be terminated by the Board or the CEO.

b. An AHP's Privileges and AHP Staff appointment shall automatically terminate upon revocation of the Privileges of the AHP's supervising Physician, unless another qualified physician indicates his willingness to supervise the AHP and complies with all requirements hereunder for undertaking such supervision. In the event that an AHP's supervising Physician's Privileges are significantly reduced or restricted, the AHP's Privileges shall be reviewed and modified by the Board upon recommendation of the MEC. Such actions shall not be covered by the due process provisions of Article X of these Bylaws. In the case of CRNAs who are supervised by an operating surgeon, the CRNA's privileges shall be unaffected by the termination of a given surgeon's privileges so long as other surgeons remain willing to supervise the CRNA for purposes of their cases.

2.6.7 Responsibilities:

An AHP granted Privileges shall:

a. Provide his patients with continuous care at the generally recognized professional level of quality;
b. Abide by these Medical Staff Bylaws and other lawful standards, Policies and Procedures, and Rules & Regulations of the Medical Staff, if applicable;
c. Discharge any committee functions for which he is responsible;
d. Cooperate with Members of the Medical Staff, administration, the Board and employees of the Hospital;
e. Adequately prepare and complete in a timely fashion the medical and other required records for which he is responsible;
f. Abide by the ethical principles of his profession and specialty; and
g. Notify the CEO and the President of Staff immediately (but in no case later than five (5) days) if:

    (1) His professional license in any state is suspended or revoked;

    (2) His professional liability insurance is modified or terminated;

(3) He is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he committed professional negligence or fraud; or

(4) He ceases to meet any of the standards or requirements set forth herein for continued enjoyment of AHP Staff appointment and/or Privileges;

(5) He becomes ineligible to participate in Medicare, Medicaid, and other federally sponsored healthcare reimbursement programs.

h. Comply with all State and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act of 1996, as amended, and its associated regulations, the Health Information Technology for Economic and Clinical Health ("HITECH") Act, and execute a health information confidentiality agreement with the Hospital.

2.7 Dependent Healthcare Practitioners Not Employed by Hospital

Other categories of dependent healthcare professionals who are not Hospital employees but who provide patient care services in support of, or under the direction of, a Medical Staff Member shall have their qualifications and ongoing competence verified and maintained through a process administered by the Hospital. Categories of Dependent Healthcare Professionals subject to such Hospital processes, policies and procedures shall include, without limitation, medical device or pharmaceutical representatives, operating room nurses and technicians, perfusionist, surgical first assistants, clinical assistants, autotransfusionists, orthotists/prosthetists, registered and practical nurses, dental technicians, lactation consultants, doulas, and medical assistants. Hospital policies and procedures shall govern the actions and patient care services provided by Dependent Healthcare Professionals. These categories of Dependent Healthcare Professionals are considered AHPs. A Medical Staff Member may provide employment, sponsorship and supervision of a non-Hospital-employed Dependent Healthcare Professional through the terms of a sponsorship agreement, which shall impose binding responsibilities upon the Medical Staff member, these Bylaws shall not apply to such Dependent Healthcare Professionals.

ARTICLE III
CREDENTIALING AND THE DETERMINATION OF PRIVILEGES

3.1 Appointment and Reappointment of Medical Staff Membership

The following steps describe the process for credentialing (appointment and reappointment) of Medical Staff Members and other Practitioners. Associated details may be found in the Medical Staff Credentials Manual.

a. Individuals interested in appointment to the Medical Staff or Privileges may request from the Hospital or the CVO an application and a list of the eligibility requirements for Membership and/or Privileges. Eligible Members of the Medical Staff will automatically be sent an application for reappointment in a timely fashion.

b. Upon completion and submission of the application to the CVO, a designated individual will verify the contents and confirm that the applicant is eligible to have the application processed further. If the application shows the applicant is not eligible for Membership or Privileges, he will be notified that no further evaluation or action will occur regarding the application.

c. A completed and verified application will be forwarded by the Medical Staff Assistant or CVO to the Hospital Medical Staff Office. The Medical Staff Office will prepare the file for review and evaluation by the appropriate Department Chair (or designee). This review will include consideration of the applicant's individual character, individual clinical competence, individual training, individual experience, and individual professional judgment and conduct, and Medicare and Medicaid participating provider status. The Department Chair will forward a recommendation concerning appointment of the applicant to the Credentials Committee.

d. The Credentials Committee will review the application and forward its recommendation to the MEC.

e. The MEC will review the application and forward its recommendation to the Hospital Board regarding Membership, Privileges, and if appropriate, Staff category, and Department assignment. The MEC may refer an application back to the Credentials Committee if it feels more information or evaluation of the applicant is necessary.

f. The Board will review the application and determine whether to offer the applicant Membership and/or Privileges and whether any restrictions or conditions should be attached to an offer of Membership and/or Privileges. Membership will be offered upon action by the Board and Membership will become effective upon acceptance of the offer by the applicant.

g. applicants may appeal adverse recommendations by the MEC and adverse decisions made by the Board in accordance with provisions in these Bylaws or Ancillary Manuals, as applicable, except in cases where the application is deemed incomplete, contains material misstatements or omissions, minimum criteria for processing is not met, or appeal is not afforded in these Bylaws.

3.2 Granting of Clinical Privileges

The following steps describe the process for granting Privileges to qualified applicants. Associated details may be found in the Medical Staff Credentials Manual and on Medical Staff Delineation of Privileges documents. Practitioners shall be entitled to exercise only those Privileges specifically granted to them by the Board. The Medical Staff may recommend Privileges for Practitioners who are not Members of the Medical Staff but who hold a license to practice dependently or independently.

a. Applicants initially applying for Medical Staff Membership or for reappointment must complete the appropriate forms to request specific Privileges. Applicants ineligible for Medical Staff membership but eligible for Privileges will complete the appropriate request forms. These forms are available from the Hospital or CVO.

b. Upon completion and submission of the appropriate forms to the Medical Staff Assistant or CVO, a designated individual will confirm that the applicant is eligible to have the requests processed further. Privilege requests that do not demonstrate compliance with eligibility requirements will not be processed further.

c. Completed Privilege request forms will be forwarded by the Medical Staff Assistant or CVO to the appropriate Department Chair (or designee) for review and evaluation. This review will include consideration of the applicant's individual character, individual clinical competence, individual training, individual experience, individual professional judgment and conduct, and current Medicare and Medicaid participating provider status.

d. The Department Chair will forward a recommendation to the Credentials Committee.

e. The Credentials Committee will review the applicant's requests and the input of the Department Chair and recommend a specific action to the Hospital MEC.

f. The MEC will review the privileging requests and recommend specific actions on them to the Hospital Board.

g. The Hospital Board will review the privileging requests and either reject the requests, modify them, or grant the Privileges being sought.

h. Applicants may appeal adverse recommendations by the MEC and adverse decisions made by the Board in accordance with provisions in these Bylaws and the associated details in the Medical Staff Corrective Action and Fair Hearing Manual.

i. Applications for Membership and/or Privileges will be processed in accordance with the time lines required by State law.

3.3 Medical Staff Credentials Manual

The Medical Staff delegates to the MEC the authority to adopt associated details elaborating on the credentialing and privileging process. Such associated details are

found in the Medical Staff Credentials Manual which will be modified from time to time.

ARTICLE IV

OFFICERS

4.1 Officers of the Medical Staff

The officers of the Medical Staff shall be:

President of Staff
President Elect of Staff
Immediate Past President of Staff

4.2 Qualifications

Officers of the Medical Staff must satisfy the following criteria at the time of nomination and continually throughout the term of their office:

a. is an appointee to the Active Staff;

b. has no pending adverse recommendation before the Board concerning Medical Staff appointment or Privileges;

c. has constructively participated in Medical Staff activities, including, but not limited to activities such as performance improvement and professional peer review;

d. is willing to discharge faithfully the duties and responsibilities of the position;

e. has experience in a medical staff leadership position, or other involvement in performance improvement functions for at least two years;

f. is willing to attend continuing education programs relating to Medical Staff leadership and/or credentialing functions prior to or during the term of office;

g. be in compliance with any and all Policies including Conflicts of Interest; and,

h. must have demonstrated an ability to work well with others.

4.3 Selection

The Nominating Committee as outlined in Article VI of these Bylaws shall select nominees for placement on the election ballot for officers. The Immediate Past President of Staff will automatically assume this position whenever he leaves the office of President of Staff, unless removed for cause. In event there is not an Immediate Past President of Staff, the President of Staff will appoint an Active Member of the Medical Staff to serve in this capacity.

4.4 Election

a. Officers of the Medical Staff shall be elected using a secret ballot which may be distributed to eligible voting members of the Medical Staff at a general Medical Staff meeting, by mail, or electronically. The mechanics of distributing ballots and counting votes will be determined by the MEC. Only Members of the Active Staff shall be eligible to vote. The winner of an election shall be the individual who receives the greatest number of votes from Active Staff Members who received ballots and voted. Voting by proxy is not permitted.

b. Officers shall be eligible to assume office once the Board has ratified their election. Such ratification cannot be unreasonably withheld.

c. Elections for officers will take place in the October, November or December of odd numbered years as scheduled by the Hospital under procedures approved by the MEC.

4.5 Term

Chiefs and Vice Chiefs of Departments will serve for two years commencing on the first day of the medical staff year following their election. In the absence of the Chief, the Vice Chief will assume all duties and authority of the Chief, to include attendance at Medical Staff meetings on his behalf. At the end of the Chief's term, the Vice Chief shall automatically assume the office of the Department Chief.

Election

In even years the following departments will elect Vice Chiefs:
Department of Surgery
Department of Obstetrics/Gynecology
Department of Psychiatry

In odd years the following departments will elect Vice Chiefs:
Department of Emergency Medicine
Department of Medicine/Family Practice
Department of Pediatrics

4.6 Duties of Elected Officers

a. President of Staff:

The Present of Staff shall serve as the Chief Administrative Officer and principal elected official on the Medical Staff. As such, he shall be responsible for implementing the general responsibilities of the Medical Staff, including, without limitation:

1. Aiding and coordinating Medical Staff activities with the activities and concerns of the Board, Administration of the Hospital, Nursing, and other patient care services.

2. Accounting to the Board and Medical Staff in conjunction with the MEC and the respective Departments for the quality, efficiency and performance of patient care services within the Hospital.

3. Developing and implementing, in coordination with the chiefs of the respective Departments, continuing education programs, utilization review, performance improvement programs, and methods for credentials review, delineation of privileges, and monitoring of patient care within Departments.

4. Communicating and representing the concerns and recommendations of the Medical Staff to the Board, the CEO, and other leaders of the Medical Staff.

5. Assuming responsibility for the enforcement of these Bylaws and any Policies, Rules and Regulations, for implementation of appropriate sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where appropriate, as provided under these Bylaws.

6. Calling and presiding at all general and special meetings of the Medical Staff and of the MEC.

7. Serving as chair of the MEC, and as an ex-officio Member of all Medical Staff committees.

8. Appointing the members of all Standing, Special and multi-disciplinary Medical Staff committees, except the MEC, in consultation with the Chair of each such committee.

9. Serving as an ex-officio Member of the Board.

10. Performing all other functions as may be assigned to the President of Staff by these Bylaws, the Medical Staff, the MEC, or the Board.

b. President-Elect of Staff:

The President-Elect of Staff shall be a member of the MEC and shall be required to assist the President of Staff and to perform such duties as may be assigned to him by the President of Staff. In the absence of the President of Staff or upon the occurrence of a vacancy in the office of President of Staff, the President Elect of Staff shall assume the responsibilities, exercise the authority, and perform the duties assigned to the President of Staff until the President of Staff returns or that office is filled.

c. Immediate Past President of Staff:

The Immediate Past President of Staff shall be a member of the MEC and shall serve as an advisor to the President of Staff and perform those functions delegated to him by the President of Staff.

4.7 Removal

a. Officers of the Medical Staff may be removed by an affirmative vote of two-thirds (2/3) of the Active Staff present and voting at any general or special meeting, subject to the approval of the Board, in circumstances where such removal is necessary to protect the interests of the Hospital. Each of the following conditions constitutes cause for removal of an officer from office:

1. Failure to comply with or support enforcement of these Medical Staff Bylaws, Policies and Rules and Regulations;
2. Failure to perform the required duties of the office;
3. Failure to adhere to professional ethics;
4. Abuse of office;
5. Conduct unbecoming a Medical Staff member and officer; and
6. Failure to continuously satisfy the criteria set forth in Article IV.4.2 of these Bylaws.

b. At least ten (10) days prior to the initiation of any removal action, the officer shall be given special notice of the date of the meeting at which action is to be considered. The officer shall be afforded an opportunity to speak to the Medical Staff prior to a vote on removal.

c. Automatic removal will occur (without need for a vote) in the event any of the following affects the officer in question:

1. Loss or suspension of the officer's medical license in the State;
2. Ineligibility of membership to the Active Staff;
3. Recommendation by the MEC to the Board for the imposition of corrective action or the acceptance of such recommendation by the Board, limited to summary suspension or recommendation for suspension or revocation.

d. Where the President of Staff is removed from that position, he shall be ineligible to hold the office of Immediate Past President of Staff.

4.8 Vacancies

If the President of Staff is temporarily unable to fulfill the responsibilities of the office, the Immediate Past President, or President Elect of Staff shall assume these responsibilities until the President of Staff can resume those duties. When a vacancy occurs in the President of Staff office, the Immediate Past President, or President Elect of Staff will assume this position for the remainder of the existing term. The MEC shall appoint the Immediate Past President, or President Elect of Staff to complete the term whenever this position is vacated. If the Immediate Past President of Staff resigns or is not eligible to hold this position, the President of Staff shall appoint another former President of Staff to fulfill the remainder of the term or it shall remain vacant until the current President of Staff becomes available to carry out the role.

ARTICLE V
CLINICAL DEPARTMENTS AND SERVICES

5.1 Designation of Clinical Departments

The Medical Staff shall be divided into the following Departments:

1. Department of Emergency Medicine
2. Department of Obstetrics and Gynecology
3. Department of Pediatrics
4. Department of Psychiatry
5. Department of Surgery and
6. Department of Medicine/Family Practice

The Board, with input from the MEC, may create additional Medical Staff clinical departments where this would improve the effectiveness of the Medical Staff in carrying out its responsibilities.

5.2 Organization of Clinical Departments

Each Department shall be organized as an organizational division of the Medical Staff and shall have a qualified Chair that has the authority, duties, and responsibilities set forth in these Bylaws. Each Department is accountable to the oversight and authority of the MEC and the Board.

5.3 Functions of Departments

a. Review and Evaluation Activities

Each Department's primary responsibility shall be to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided by members of the Department. These may include discussion of information relevant to the care and treatment of patients served by members of the Department along with the detailed consideration of relevant cases, including, without limitation, operative and other procedure review, medical record review, infection control review, pharmacy and therapeutic review, blood utilization review, efficiency of clinical practice patterns, significant departures from established patterns of clinical practice, quality review reports, patient safety initiatives, and medical assessment and treatment of patients within the Department and the Hospital.

b. Additional Activities

At the discretion of Department members and its Chief, the Department may be utilized to organize and promote any of the following collegial and professional activities: continuing medical education; communication and dialogue regarding

issues relevant to members of the Department; social networking; and interdisciplinary projects and coordination.

c. Member Accountability

Members and other Practitioners assigned to the Department are accountable to the Department Chief and must be responsive to requests for information, participation in departmental activities, participation in a mandatory special meetings, and compliance with Hospital, Medical Staff, or Department Rules and Regulations, policies, procedures, or requirements.

5.4 Department Chiefs/Vice-Chief

Each department will elect a Vice-Chief in accordance with the Medical Staff Bylaws and Department Rules and Regulations.

a. Qualifications

Each Department Chief shall be:

1) A Member of the Active Staff;
2) Board certified by a specialty board recognized by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) or found to have comparable competency by actions of the Credentials Committee and MEC;

3) Qualified by experience within the Department and by administrative ability to supervise the functions of the department, and

4) Willing and able to discharge the functions of the Department Chief.

b. Selection

1. Each Department Chief/Vice-Chief shall be elected by a plurality of the votes cast by Members of the Department on the Active Staff. Department Chiefs shall be select using a secret ballot which may be distributed to eligible voting Members of the Medical Staff by mail, or electronically. The mechanics of distributing ballots and counting votes will be determined by the MEC. Only Members of the Active Staff shall be eligible to vote. The winner of an election shall be the Member who receives the greatest number of votes from Active Staff Members who received ballots and voted. Voting by proxy is not permitted.

2. Department Chiefs/Vice-Chief shall be eligible to assume office once the Board has ratified their election. Such ratification cannot be unreasonably withheld.
3. Elections for Chiefs/Vice-Chief will take place in the October, November or December of even numbered years as scheduled by the Hospital under procedures approved by the MEC.

4. If there is a vacancy prior to completion of a term of office, the Vice-Chief of the Department will complete the unfilled term.

5. Any member of the Department may be placed by request on the ballot unless he does not meet the qualifications in Article V.5.4.a above. A member must give assent to be placed on the ballot.

6. The Chief's and Vice-Chiefs of Departments will perform a substantial part of their hospital practice at Northwest Texas Healthcare System. They will not hold concurrently a position as President of Staff, or Chief of a Department on any other hospital staff.

c. Term

1. Each Department Chief/Vice-Chief shall take office on the 1st day of the calendar year and shall serve a term of two (2) years.

2. A Department Chief/Vice-Chief may be elected for successive terms, not to exceed 2 terms unless otherwise provided by the MEC or Board.

5.5 Removal of Department Chief

Upon petition by twenty-five percent (25%) of Department Members or upon recommendation of the MEC, the Medical Staff office shall arrange for a recall vote at the next scheduled meeting of the Department. Removal may be accomplished by a two-thirds (2/3) vote of those eligible members of the department voting and following ratification of the action by the Hospital Board.

5.6 Functions of the Department Chief

Responsibilities:

Each Department Chief shall have responsibility for the organization and administration of the Department, including, without limitation:

1. All clinically related activities of the Department;

2. All administratively related activities of the Department (including presiding at all meetings of the Department), unless otherwise provided for by the Hospital;

3. Continuing surveillance of the professional performance of all individuals in the Department who have delineated Privileges;

4. Recommending to the Medical Staff the criteria for Privileges that are relevant to the care provided in the Department;
5. Recommending Privileges for each Member or Practitioner of the Department;

6. Assessing and recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the Department or the Hospital;

7. The integration of the Department or service into the primary functions of the Hospital;

8. The coordination and integration of interdepartmental and intradepartmental services;

9. The development and implementation of policies and procedures that guide and support the provision of services;

10. The recommendations for a sufficient number of qualified and competent persons to provide care or service;

11. Advising on the qualifications and competence of Department or service personnel who are not licensed independent practitioners and who provide patient care services;

12. The continuous assessment and improvement of the quality of care and services provided;

13. The maintenance of quality control programs, as appropriate;

14. The orientation and continuing education of all persons in the Department or service; and

15. Recommending space and other resources needed by the Department or service.

5.7 Department Meetings

1. Department meetings will meet as necessary to conduct business, but no less than annually.

Department meetings may be called by any of the following:

- The President of Staff
- The Executive Committee
- The Department Chief
- 25% of the Active Staff membership of the department and/or
- Any section/subspecialty group when a majority of the members/specialists believe that the department and/or Joint Practice Committee have not acted appropriately.

2. Minutes of Meetings:

Minutes of each Department meeting will be kept with the permanent records of the Medical staff.

3. Meeting Attendance:

Any committee member who is absent from three (3) consecutive meetings or who does not attend at least two thirds (2/3) of such meetings in any one calendar

year without adequate reason or advanced notice, shall be considered to have resigned from the committee.

4. Voting Privileges in Department Meetings:

Only Active members of the Medical Staff assigned to a Department may vote at Department meetings. Simple majority vote prevails.

5. Rules and Regulations of the Department

Departments shall establish departmental rules and policies for areas of the Hospital within their jurisdiction and for the professional activities performed by members of the Department. Such rules must be approved by the appropriate department, the Executive Committee, and the Board of Governors for inclusion in the Rules and Regulations of the Medical Staff of Northwest Texas Healthcare System.

5.8 Formation of Sections

Any group of five or more individuals may form a Section related to a recognized specialty, subject to the approval of the Executive Committee, for the purpose of identifying problems related to their specialty area and ongoing medical education.

Sections may be identified as belonging to one of two categories:

a. Hospital-Specific Sections

Hospital-Specific Sections are those Sections which meet to discuss business specific to NWTHS.

Rules governing Hospital-Specific Sections are as follows:

1. Chiefs of Hospital-Specific Sections must be members of the Active Staff in good standing. The mechanism of election/appointment of Chiefs of Hospital-Specific Sections and duration of their terms shall be developed by members of the Section and approved by the Department under which the section exists.
2. The Chief of a Section will be directly responsible for the performance of his duties to the Chief of his Department
3. Chiefs of Sections may be invited to attend meetings of the Executive Committee at the discretion of the Committee
4. Sections are required to establish rules and policies for areas of the Hospital within their jurisdiction, and for the professional activities performed by members of the Section. Such rules and policies shall include rules governing participation in the emergency call roster. Rules and Regulations of these Sections shall be submitted to the appropriate Department for incorporation into the Departmental Rules and Regulations. As per Rules

and Regulations approved by the Department must be submitted to the Executive Committee and the Board of Governors for final approval.

b. City-Wide Sections

City-Wide Sections are those Sections which meet to discuss business which is not necessarily exclusive to NWTHS, but may include business related to the other hospital(s) as well.

5.9 Clinical Services

a. The MEC may recognize any group of Members and/or Practitioners interested in forming an optional clinical service. Such a clinical service shall be completely optional and shall exist to perform any of the following:

1. Provide a forum for discussion for clinicians in a particular specialty or interdisciplinary group of specialties.

2. Offer continuing medical education and discussion of patient care issues.

3. Sponsor "grand rounds", morbidity & mortality (M&M) conferences, or clinico-pathologic conferences (CPCs).

4. Provide a vehicle for discussion of Policies & Procedures or equipment needs in a specialty or service line area.

5. Create an opportunity for networking and collegial interaction among Practitioners with common interests.

6. Develop recommendations for submission to the MEC.

7. Participate in the development of criteria for Privileges when requested for input by the Credentials Committee or MEC.

8. Participate in the development of clinical protocols when asked to by the MEC or an appropriate Medical Staff Committee.

9. Discuss a specific issue at the request of a Medical Staff Committee.

b. Clinical Services are not required to hold regular meetings, keep minutes or track attendance, and have no regularly assigned responsibilities. A written report is required only when a clinical service wishes to make a formal recommendation to the MEC, another Medical Staff Committee, or to the Hospital's administrative team.

ARTICLE VI
MEDICAL STAFF +COMMITTEES AND LIAISONS

6.1 Types of Committees

1. The Medical Executive Committee
2. The Credentials Committee
3. The Bylaws Committee
4. The Medical Staff Quality Improvement Peer Review Committee
5. The Pharmacy and Therapeutics
6. The Infection Prevention Committee
6. The Critical Care Committee
7. The Trauma Committee
8. The Physician Health and Wellness Committee
9. The Cancer Committee
10. The Outpatient Pharmacy Committee

Except as specifically stated in these Bylaws, membership on Medical Staff Standing Committees is restricted to members of the Medical Staff. Other non-Medical Staff members may be designated as members of the committee, with or without the right to vote by vote of the committee membership at the first meeting of each Medical Staff year.

No person shall be denied committee membership/chairmanship based on sex, race, creed, age, or national origin

6.2 Committee Chair

a. Selection: With the exception of the MEC and departmental committees, the Chair of each standing or special committee shall be appointed by the President of Staff, subject to the approval of the MEC. The President of Staff shall serve as Chair of the MEC.

b. Term: Unless specified otherwise in these Bylaws, each committee Chair shall be appointed to a term of two (2) years.

6.3 Membership and Appointment

a. Eligibility

1. Members of the Active Staff shall be eligible for appointment to any standing or special committee of the Medical Staff established to perform one or more of the functions required by these Bylaws.

2. Members of the Associate Staff shall be eligible for appointment to any standing or special committee of the Medical Staff established to perform one or more of the functions required by these Bylaws, with the exception of the Nominating Committee and MEC.

3. Where specified in these Bylaws, or where the MEC deems it appropriate to the functions of a committee of the Medical Staff, Members of the Affiliate Staff or Honorary Staff category and representatives from various services of the Hospital, including, without limitation, Administration, Laboratory, Nursing, Information Management and Pharmacy Services, shall be eligible for appointment to specific committees of the Medical Staff.

b. Selection

Unless otherwise provided in these Bylaws, Medical Staff members of any Medical Staff committees, other than the MEC, shall be appointed by the President of Staff in consultation with the Chair of that committee. Members of the Medical Staff committees representing non-Medical Staff Hospital services shall be appointed by the Chief Executive Officer or designee.

c. Chief Executive Officer

Unless otherwise provided in these Bylaws, the CEO or his designee shall serve as an ex-officio member, without a vote, of all Medical Staff committees.

d. Voting

Only Medical Staff committee members and other members designated in these Bylaws as having the right to vote shall have the right to vote on matters at that meeting. The decision of the committee in this matter shall remain in effect only for that Medical Staff year.

e. Term

Unless specified otherwise in these Bylaws, each Medical Staff committee member shall be appointed to a term of two (2) years, and may be reappointed as often as the individual or party responsible for such reappointment may deem advisable.

6.4 Medical Executive Committee

Membership

All Members of the organized Medical Staff, of any discipline or specialty, are eligible for membership on the MEC providing that they have attained Active Medical Staff membership. MEC members shall not serve on more than one hospital's MEC at the same time.

Composition

- President of Staff
- Immediate Past President, President Elect of Staff
- Regional Dean of Texas Tech University School of Medicine Health Science Center in Amarillo
- Committee Chairmen of:
  - The Credentials Committee

  - Critical Care Committee
  - Pharmacy and Therapeutics Committee
  - Infection Prevention Committee
  - Trauma Committee and
  - Bylaws Committee
- Department Chiefs of:
  - Emergency Medicine
  - Medicine/Family Practice
  - Obstetrics/Gynecology
  - Pediatrics
  - Psychiatry
  - Surgery and

One member representative from the Hospital Based Services, and Medical Director(s) as determined by the MEC will be appointed by the President of Staff to serve a one year term

The following individuals will be non-voting members of the MEC:

- Representative(s) of the Board of Governors
- Chief Executive Officer/Managing Director and other Administrative Representatives as necessary to perform the functions of the committee

The MEC may invite additional guests as needed to assist in carrying out its work. Each Medical Staff member has the right to an audience with The Medical Executive Committee. In the event a practitioner is unable to resolve an issue with the respective Department Chief, that member may, upon presentation of a written notice to the President of Staff, meet with the committee to discuss the issue.

Committee members so designated above may not send a substitute to attend Executive Committee meetings in their absence, with the exception of Vice Chiefs of Departments. In the event the Department Chief is unable to fulfill his obligations as an Executive Committee member, the Department Vice Chief can be designated to assume all duties and authority as the respective Department representative on The Medical Executive Committee to include voting rights.

d. Removal from the MEC

Officers, Department Chief's and Committee Chairmen serving on the MEC will lose their membership if removed from their position as an officer, Department or committee chair as described elsewhere in these Bylaws. Any member of the MEC may be removed by an affirmative vote of two-thirds (2/3) of the MEC membership. Grounds for removal include:

- Failure to meet the attendance requirements for MEC members;
- Disruptive conduct at MEC meetings; and
- Failure to carry out assigned duties as an MEC member.

Members of the MEC will be considered to have voluntarily resigned from the committee if any of the following occur:

- Termination or suspension of the member's license to practice in the State;
- Loss of membership on the Active Staff;
- The MEC recommends to the Board that the member be subject to Corrective Action.

Quorum

A quorum for MEC shall consist of at least fifty percent (50%) of the Active Staff members of the MEC.

Responsibilities

1. The MEC shall represent the Medical Staff, assume responsibility for the effectiveness of all medical activities of the Medical Staff, act on matters of concern and importance to the Medical Staff and act at all times as the authorized delegate of the Medical Staff in regard to general and specific functions of the Medical Staff.

2. The MEC is empowered to act for the Medical Staff in intervals between general Medical Staff meetings.

3. The MEC receives and acts on reports and recommendations from Medical Staff committees, Departments, Clinical Services, Hospital committees, consultants, and other relevant individuals.

4. The MEC consults with Hospital administrators on quality-related aspects of contracts for patient care service with entities outside the Hospital.

5. The MEC shall refer investigations in accordance with these Bylaws and the associated detail in the Corrective Action and Fair Hearing Manual to the Performance Improvement Committee and review the results of such investigation before making recommendations to the Board to terminate, limit, or restrict a Member's membership or a Practitioner's Privileges.

6. The MEC is responsible for making Medical Staff recommendations directly to the Governing Body for its approval. Such recommendations pertain to at least the following:

(a) The Medical Staff's structure;
(b) The mechanism used to review credentials and to delineate individual Privileges;
(c) Recommendations of individuals for Medical Staff Membership;
(d) Recommendations for delineated Privileges for each eligible individual;
(e) The participation of the Medical Staff in organization performance improvement activities;
(f) The mechanism by which Medical Staff Membership may be terminated;

(g) The mechanism for fair-hearing procedures; and
(h) The MEC's review of and actions on reports of Medical Staff committees, Departments, and other assigned activity groups.

Meetings

The MEC shall meet monthly at least ten (10) times per year and shall maintain a permanent record of all proceedings and actions at its meetings. The President of Staff or designee will preside at all meetings of the MEC.

Call of Special Meeting

The President of Staff may call special meetings of the MEC at any time. Such meetings may be held in person, through telephonic or electronic conferencing.

Notice

Notice of a Special Meeting of the MEC shall be by means of facsimile, telephone, posting of notice or e-mail.

Any Medical Staff member may raise a challenge to any rule or policy established by the Medical Executive Committee.

6.5 Nominating Committee

Composition

The Nominating Committee shall consist of:

1. President of Staff, Chief Medical Officer and additional members of the Medical Staff appointed by the President of Staff.
2. The President of Staff will give consideration to appointing other past Medical Staff officers to the committee. Members of the Nominating Committee cannot request nomination to run in a current election.

Responsibilities

The Nominating Committee shall be responsible for identifying nominees for officers of the Medical Staff when elections are held for these positions.

Procedures

1. The Nominating Committee will meet at least sixty (60) days, but no more than ninety (90) days prior to the General Staff Meeting at which the results of the election will be announced. The Nominating Committee shall circulate its list of nominees to the Active Members of the Medical Staff at least sixty (60) days prior to scheduled voting.

2. In order for a nomination to be placed on the ballot the following criteria must be met:

a. Candidates must meet the qualifications listed in these Bylaws for the position to which they wish to be elected. The Nominations Committee will have discretion to determine if these criteria have been met.

b. Candidates must be approved by the Nominations Committee for placement on the ballot.

c. Members of the Active staff who are not initially chosen by the Nominations Committee and wishing to have their names included on the election ballot must submit the signatures of ten percent (10%) of the Active Staff in support of their nomination or twenty (20) signatures of the Active Staff, whichever is less. Eligible members of the Medical Staff who wish to be included on the ballot, must file the required supporting signatures with the Medical Staff Office at least forty-five (45) days prior to the General Staff Meeting at which the results of the election will be announced.

3. The Nominating Committee shall notify each Active Staff member of its nominees for the positions set forth, not less than thirty (30) days before the biennial election of the Medical Staff officers, as set forth in these Bylaws.

4. Election results will be announced at the General Staff Meeting.

6.6 Credentials Committee

The Credentials Committee will report directly to the Medical Executive Committee of the Medical Staff and will meet as often as needed to conduct business, but no less than quarterly.

Composition

The Credentials Committee will consist of Vice-Chief from each Department. Ex-officio members will be the Chief Executive Officer or his designee, Chief Medical Officer, and other Administrative Representatives as necessary to perform the functions of the committee.

In the event the Vice-Chief is unable to serve, the Chief of the Department will appoint another qualified physician. The Chief of the Dental Section will also serve on the Committee. The tenure will be identical to those of the Departmental Chairperson. Vacancies will be filled by appointment by the respective Department Chief.

The President of the Medical Staff will designate the Chairperson each year. If no appointed member of the Committee agrees to serve as Chairperson, the President of the Medical Staff may appoint an additional member as Chairperson.

Functions

a. To investigate the credentials of all applicants for membership in the Medical Staff and all other individuals who apply for clinical privileges;

b. To review and report upon any matters that may be referred to it by Departments and Medical Staff Committees;

c. To review all information available regarding the competency of each Staff member;

d. To make recommendations regarding the reappointment, departmental assignment, and
professional privileges of members of the Medical Staff within the provisions of the Bylaws; and

e. To review credentials of independent allied health professionals.

6.7 Bylaws Committee

The Bylaws Committee will meet at least once a year and on call as necessary to presented to The Medical Executive Committee.

Composition

Membership will include three or more members of the Active Staff appointed by the President of the Medical Staff for a two-year term. All members will be members of the Active Staff. Ex-officio members will be at least one administrative representative and others as may be appointed at the discretion of the Chairperson.

Functions

a. To assist in the development and maintenance of operational guidelines for members of the Medical Staff

b. To review existing Bylaws to determine compliance with State or Federal Law, Regulatory Compliance Agencies, and/or current practice and

c. To receive and act upon recommendations for amendment to or repeal of the Bylaws or Rules and Regulations as requested by a member of the Medical Staff, the CEO/Managing Director, or any member of the Board of Governors.

6.8 Medical Staff Quality Improvement-Peer Review Committee

The Medical Staff Quality Improvement Peer Review committee will meet as necessary to conduct business, but no less than monthly. If immediate review is warranted, the peer review will be obtained and a special meeting will be called as soon as possible.

Composition

The Medical Staff Quality Improvement-Peer Review Committee shall consist of:

- The President of Staff
- Immediate Past-President, or President Elect,
- Credentials Committee Chairman
- Chiefs of the Medical Staff Departments
- Medical Director for Trauma

- The Immediate Past-President or President-Elect will serve as the Chairman for the committee.

Each Department Chief will make recommendations to the Medical Executive Committee for one or two additional members from their departments to serve on the committee. The Board of Governors will grant final approval of membership. Two reviewers will serve one, two or three year staggered terms.

The following shall serve as members without vote:
- Administrative and other Hospital Representatives
- Other members of the Medical Staff with special expertise may attend at the request of the Chairman of the committee.

Responsibilities
The Medical Staff Quality Improvement Peer Review Committee is responsible to the Medical Executive Committee, Administration, and the Board of Governors for the overall operations of the Performance Improvement Plan related to Peer Review.

Functions
1. Review referrals screened by Quality Management personnel
2. Assign quality of care scores
3. Review relevant information obtained from the FPPE and OPPE process that deviate from acceptable standards of care
4. Make recommendation to continue monitoring
5. Communicate an itemized list of issues with the physician being reviewed when appropriate, and
6. Refer to the Medical Executive Committee as needed findings that require action

Refer to the Peer Review Policy and Procedures for detailed function of the committee.

6.9 Pharmacy and Therapeutics

The Pharmacy and Therapeutics committee will meet at least quarterly and report to The Medical Executive Committee.

Membership
Physician members will be appointed by the President of Staff, and must be members of the Active Staff.

Composition
- Physician members shall include one representative from each Medical Staff Clinical Department for staggered two year terms identical to those of the respective Department Chief
- One representative from Community Health Services
- Pathologist
- Physician leaders of designated standing teams

- Physician representative from Public Health, if a member of the Medical Staff.

The Chairman will be appointed by the President of the Medical Staff with no specified number of terms, and may or may not be drawn from the members designated above.

Nonphysician membership
- Director of Pharmacy, or designee
- Other representatives will include, but are not limited to:
- The Dean, School of Pharmacy, or designee;
- Representative from nursing
- Nonphysician leaders of standing teams; Administrative Representative
- Microbiology Representative, and other members as may be appointed at the discretion of the chair.

Voting Rights

Decisions requiring a formal vote which impact directly on medical practice will be made only if the designated representative of the respective Medical Staff Department is present and/or appropriate Medical Staff input has been previously obtained. Furthermore, decisions which govern medical practice activities must be passed by the majority of Medical Staff representatives present.

General duties and responsibilities of the committee will include:

Function:
1. Assist in the development and recommendation of policies and procedures relating to:
   a. the selection, distribution, handling, use and administration of drugs and diagnostic testing materials
   b. maintenance of the system formulary and
   c. untoward drug reactions and medication errors

2. Review all significant untoward drug reactions
3. Assist in the process of routine collection and assessment of information to help identify opportunities to improve the use of medications and resolve problems in their use
4. Coordinate the documentation of drug therapy monitoring and performance improvement processes
5. Approve medication use evaluation protocols with input from appropriate departments and services and
6. Interface with the Institutional Review Board in matters of investigational medication use.

The authority and specific functions of the committee will be procedurally defined. Standing teams will support the work of the committee through the design and implementation of necessary performance monitoring systems and through presentation of findings and

recommendations to the committee. Standing teams will be designated by the committee. Ad hoc teams may be appointed at the discretion of the Chair.

6.10 Infection Prevention Committee

The Infection Prevention committee will meet not less than quarterly and as necessary.

Composition

- Two physicians
- Representatives from Administration, the Department of Nursing, Nursing Education, and Ancillary Departments

The Medical Director of the Infection Prevention Committee will preside over the Committee meeting.

Function

The Infection Prevention Committee has the authority to institute any surveillance, prevention or control measures, or study when there is reason to believe that any patient, personnel, or visitor may be at risk of contracting or transmitting infectious disease. This authority and responsibility includes but may not be limited to the following

a. Develop and implement a preventive and corrective program(s) designed to minimize infection hazards
b. Review and approve all policies and procedures related to infection surveillance, prevention, and control activities in all departments/services
c. Collaborate with the organization leadership to institute emergency measures to prevent infections such as closure of units, transfer of patients, halting construction, and other measures
d. Promote the application of organizational and departmental policies relating to infection
e. prevention and control involving, but not limited to, isolation procedures and techniques, sterilization procedures, prevention of cross-infection through equipment use, and the safe disposal of infectious or contaminated wastes
f. Support regulatory compliance

6.11 Critical Care

The Critical Care Committee will meet not less than quarterly and reports to The Medical Executive Committee, and to other Departments and Committees as needed.

Composition

Medical Directors of

- Medical/Surgical Intensive Care Unit

- Coronary Intensive Care Unit
- Neonatal Intensive Care Unit
- Pediatric Intensive Care Unit
- Emergency Department
- Surgery (Anesthesia) Department and
- Respiratory Care

Other members

- The Chairman of the Trauma Committee
- Representative from Texas Tech Health Sciences Center (preferably a pulmonologist or Intensivist)
- Appropriate Directors of the respective areas
- representatives from the ancillary departments
- Quality Management
- Administration or their designee..

Physician members must be members of the Active Staff. On a rotation basis the Medical Directors of the Critical Care units will serve as Chairman and Vice Chairman of the committee.

Function:

1) Provide guidance to the directors, assess and take opportunities to improve the quality and appropriateness of care provided to the critically ill patient;
2) Foster a climate of collaboration among the health care providers who care for the critically ill patient; and
3) Assist in the development and recommendation of policies and procedures relating to the critical care services of the hospital

6.12 Trauma Committee

The Trauma Committee will meet monthly and on call as needed, and will report directly to The Medical Executive Committee.

The Committee chairman will be the Medical Director of Trauma services or his designee.

Composition

Voting members:

- Chairman
- Medical Director of Trauma Services
- Associate Medical Director of Trauma Services
- Emergency Medicine physician(s)
- Pre-Hospital Medical Director(s)
- Orthopedic surgeon, neurosurgeon, plastic surgeon**,** pediatric surgeon, thoracic surgeon, anesthesiologist, oral surgeon**,** Chief Medical Officer, a radiologist, a

pathologist, all general surgeons on the Active Staff who participate in call for the Emergency Department

Non-voting members:

- Emergency Department Director
- Trauma Coordinator and
- Representatives from respiratory care, adult and pediatric intensive care, laboratory, diagnostic imaging, physical medicine, social services, quality management, pre-hospital services, medical/surgical services, surgical services and other hospital department or services as required. Non-voting members may choose to attend only those meetings at which issues related to their specific area are addressed.

Responsibilities

1) To provide support and organizational structure for the trauma care system
2) To provide hospital and community education in trauma injury prevention and control
3) To monitor adherence to the principles for pre-hospital trauma care and field triage
4) To recommend the qualifications for trauma care personnel
5) To utilize continuous quality improvement, peer review principles, and mortality/morbidity review in data collection, data analysis, and action plans to improve trauma care and care processes from point of injury through continuum of care
6) To conduct peer review activities related to trauma care, to include review of cases, and make recommendations as appropriate
7) Maintenance of a trauma registry according to the hospital reporting guidelines as established by the Texas Department of Health and
8) Develop and revise policies, procedures, and protocols that address the care and treatment of trauma patients.

6.13 Physician Health and Wellness

The committee will meet not less than annually and report to The Medical Executive Committee.

The Physician Health and Wellness Committee is an integral part of the NWTHS Impaired Physicians Program, and shares in its purpose to educate hospital leaders and the Medical Staff about practitioner health, address prevention of physical, psychiatric, or emotional illness, and to facilitate confidential diagnosis, treatment, and rehabilitation of licensed independent practitioners who suffer from a potentially impairing condition. The goal of the program is assistance and rehabilitation, and to aid licensed independent practitioners in retaining or regaining optimal professional functioning, consistent with protection of patients. Others may refer independent practitioners to the committee for assistance, or they may refer themselves. In any event, confidentiality will be maintained for all parties involved.

Composition

The Physician Health and Wellness Committee consist of at least three Medical Staff members appointed by the Medical Staff President. The Committee Chairman will be appointed by the President of the Medical Staff.

Non-voting members include the Chief Medical Officer and administrative staff.

Terms shall be for a two-year period, with two members to rotate off the committee on odd years, and one member to rotate off the committee on even years. Consecutive appointments are allowed.

Responsibilities

(1) Maintain a current list of all internal and external resource individuals and organizations that specialize in the diagnosis and treatment of impaired healthcare practitioners, and refer the practitioners for professional evaluation and or treatment

(2) Provide education regarding healthcare professional impairments, including education related to licensed independent practitioner health, prevention of physical, psychiatric and/or emotional illness, and the general components of the Impaired Professional program

(3) Investigate and evaluate all allegations, concerns, or complaints regarding possible impairment, whether such impairment is physical, mental, and/or emotional

(4) Serve as the monitoring body and receive reports concerning licensed independent practitioners under the mechanism determined by the committee members and the Program Advisor

(5) Forward to the Medical Staff Executive Committee for appropriate action pursuant to mandated state and federal reporting requirements any time it is determined that the affected licensed independent practitioner is unable to safely perform the privileges he/she has been granted

(6) Interview Medical Staff members or applicants for Medical Staff appointment and privileges and/or review for appropriateness letters from attending physicians relating to the health status, if requested to do so by the Credentials or Executive Committee, or the Board of Governors and

(7) Review and recommend policies and procedures concerning the physical, mental and emotional health and well-being of Medical Staff members and independent allied healthcare providers.

6.14 Cancer Committee

The Cancer Committee will meet at least quarterly.

Membership

The Chairman shall be appointed by the President of the Medical Staff for two-year terms.

Composition

Voting members shall include at least one board certified physician representative from each of the following disciplines: Surgery, Medical Oncology, Radiation Oncology, Diagnostic Radiology, Obstetrics/Gynecology, Pediatrics, Pain Management, and Pathology.

Non-voting members are representatives from Administration, Nursing, Social Services, Cancer Registry, and Quality Management. The President of the Medical Staff may appoint other physician and non-physician representatives as members of the committee, with or without vote, based on the cancer experience of NWTHS

The chairman shall be appointed from the members designated above by the President of the Medical Staff for a two-year term, and shall serve as an ex-officio member of The Medical Executive Committee. The committee shall elect a physician liaison, who shall also serve as a member of the committee and as a representative to the American College of Surgeons.

Responsibilities

1. Develops and evaluates the annual goals and objectives for the clinical, educational, and programmatic activities related to cancer
2. Promotes a coordinated, multidisciplinary approach to patient management, including pain management
3. Ensures that educational and consultative cancer conferences cover all major sites and related issues
4. Ensures that an active supportive care system is in place for patients, families, and staff
5. Monitors quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes
6. Promotes clinical research
7. Supervises the Cancer Registry and ensures accurate and timely abstracting, staging, and follow-up reporting
8. Performs quality control of registry data
9. Encourages data usage and regular reporting
10. Ensures content of the annual report meets requirements
11. Publishes the annual report by November 1 of the following year and
12. Upholds medical ethical standards.

6.15 Outpatient Pharmacy Committee

The Outpatient Pharmacy Committee shall meet on call and report to The Medical Executive Committee.

Responsibilities

The purpose of the Outpatient Pharmacy Committee is to have direct oversight of the Outpatient Formulary and Outpatient Drug Therapy Policies, including medication use evaluations (MUE).

Composition

Voting members of the Outpatient Pharmacy Committee shall be the J.O. Wyatt Clinic (Wyatt) Medical Director

- Two Wyatt Internal Medicine representatives
- Texas Tech Regional Chair of Internal Medicine or his designee
- Physician Specialist who holds clinics at Wyatt
- Medical Director of Emergency Services or his designee
- Wyatt Administrator or his designee
- Pharmacy Clinical Manager
- Wyatt Pharmacy Manager
- Ambulatory Care Pharmacist with the School of Pharmacy
- Wyatt Nurse Coordinator
- Emergency Department Nurse Coordinator.

The Wyatt Medical Director shall serve as Chair. The Chair shall appoint the Wyatt physician representatives, and may appoint other members, with or without vote, as necessary.

The Chair shall attend meetings of The Medical Executive Committee as needed to conduct business, but is not a member of The Medical Executive Committee.

6.16 Medical Staff Representation on Hospital Committees:

In order to further carry out the functions of the Medical Staff and to provide Medical Staff input where appropriate, the President of Staff may appoint Members to Hospital Committees. Operational Hospital Committees to which Medical Staff Members may be assigned include, but are not limited to: Quality, Cancer, Infection Prevention, Critical Care, Pharmacy & Therapeutics, Medical Records, Continuing Education, Bioethics, Patient Safety, Graduate Medical Education, Disaster, and Transfusion.

When Medical Staff Members sit on a Hospital Committee, the minutes of that Committee shall be available to the MEC. It shall be the responsibility of the Medical Staff Member(s) sitting on a Hospital Committee to bring to the attention of the MEC or a Medical Staff officer any matter brought before such Committee that requires the attention of the MEC or Medical Staff Officers.

6.17 Medical Staff Liaisons

When the Medical Staff is required by regulatory bodies or internal policies to collaborate with Hospital staff in carrying out a particular function, the President of Staff may appoint a member of the Medical Staff to serve as a formal liaison for that work. The liaison will report periodically to the MEC or other appropriate committee when matters require the attention of Medical Staff leaders.

6.18 Special or Ad Hoc Committees

The President of the Medical Staff or MEC may appoint ad hoc committees to address specific issues or concerns on behalf of the Medical Staff. In establishing such committees, there will be a notation made in the minutes of the MEC enumerating the committee's purpose and charge, and timeframes for its work, and the duration of its appointment. Such committees will report to and be accountable to the MEC.

ARTICLE VII
GENERAL MEDICAL STAFF MEETINGS

7.1 General Medical Staff Meetings

There shall be at least one (1) meeting of the Medical Staff held each year during the fourth quarter. Written notice of the meeting shall be sent in a manner determined by the Medical Staff office to all Medical Staff members. The MEC shall determine the time and place at which the meeting shall be held. The President of Staff or MEC may call additional general meetings for any reason they deem appropriate, including to promote communication with the Medical Staff, provide a forum for discussion on matters of Medical Staff interest, review quality and safety data and concerns, present educational programs, or address proposed changes to these Bylaws.

7.2 Special Meetings of the Medical Staff

a. Call of Special Meeting

A special meeting of the Medical Staff may be called at any time by the President of Staff, and shall also be called at the request of the Board, the MEC or in response to a petition presented to the of Staff and signed by ten percent (10%) of the Active Staff. No business shall be transacted at any special meeting, except that for which the meeting is called and stated in the notice of such meeting.

b. Notice

Notice stating the time, place and purpose(s) of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each Member of the Medical Staff in a manner determined by the Medical Staff office at least seven (7) days before the date of such meeting. The attendance of a Member of the Medical Staff at the meeting shall constitute a waiver of notice of such meeting.

7.3 Attendance at Meetings

Members of the Medical Staff are encouraged to attend Medical Staff meetings.

7.4 Quorum

Those Active Staff Members present and eligible to vote shall constitute a quorum at any meeting, unless otherwise specified in these Bylaws.

7.5 Minutes

Minutes of each regular and special meeting of the Medical Staff shall be prepared and shall include a record of the attendance of Members and any votes taken on matters

presented at the meeting. The minutes shall be signed by the presiding officer and maintained in a permanent file in the Medical Staff office. Minutes shall be made available to any Medical Staff Member upon request.

7.6 Conduct of Meetings

Meetings of the Medical Staff and meetings of committees and Departments (as described in Article VIII) will be run in a manner determined by the chair or designee who shall preside. Compliance with rules of parliamentary procedure is not required.

ARTICLE VIII
COMMITTEE AND DEPARTMENT MEETINGS

8.1 Regular Meetings

Departments and committees may, by resolution, establish the time for holding regular meetings without providing Members notice other than by announcement of such resolution in meeting minutes.

8.2 Special Meetings

A special meeting of any committee or Department may be called by or at the request of the Chair thereof, by the President of Staff, or by written request signed by ten percent (10%) of the current Members of the committee or Department, but not by fewer than two (2) such Members. Such meetings will be held within a reasonable period of time after their request.

8.3 Notice of Meetings

Written or oral notice stating the place, day and hour of any special meeting or any regular meeting, shall be provided to each Member of the committee or department that is to meet, not less than five (5) days before the time of such meeting. If mailed, the notice of the meeting shall be posted to the Member, at his address as it appears on the records of the Medical Staff, at least seven (7) days before the meeting. The attendance of a Member at a meeting shall constitute a waiver of notice of such meeting.

8.4 Quorum

A quorum for the MEC will be at least fifty percent (50%) of the Active Staff members of MEC. For all other committees and Departments, unless otherwise specified in these Bylaws, a quorum will be those Members present and eligible to vote, but not fewer than two (2) Members.

8.5 Manner of Action

The action of a majority of the Members present at a meeting at which a quorum is present shall be the action of a committee or Department. Action may be taken without

a meeting by unanimous consent in writing, setting forth the action so taken and signed by each Member who would be entitled to vote at that meeting.

8.6 Minutes

Minutes of required committees and any special meetings shall be prepared, including a record of the Members in attendance and the results of any votes taken at the meeting. The minutes shall be signed by the presiding officer and copies thereof shall be submitted to the attendees for approval. All minutes shall be made available to the MEC. Each committee and Department shall maintain a permanent file in the Medical Staff office of the minutes of each meeting.

8.7 Attendance Requirements

Any committee member who is absent from three (3) consecutive meetings or who does not attend at least two thirds (2/3) of such meetings in any one calendar year without adequate reason or advanced notice, shall be considered to have resigned from the committee.

8.8 Mandatory Special Appearance Requirement

Whenever suspected deviation from standard clinical or professional practice is identified, the Practitioner may be required to attend a meeting of a standing or ad hoc committee considering the matter. The Practitioner will be given special notice of the conference, including the date, time and place, a statement of the issue involved, and a statement that the Practitioner’s appearance is mandatory. Failure to attend a meeting when asked, unless excused by the President of Staff upon showing good cause, shall be considered an immediate and voluntary relinquishment of Privileges. The Practitioner is required to provide for patient coverage during any scheduled mandatory appearance.

ARTICLE IX
CONFIDENTIALITY, IMMUNITY, AUTHORIZATIONS AND RELEASES

9.1 Each applicant, Practitioner or Member shall, when requested by the Hospital, execute general and specific releases and provide documents when requested by the President of Staff, chair of the Credentials or Performance Improvement Committees or any Committee delegated Peer Review responsibilities, the Hospital CEO or their respective designees, to accomplish the provisions of this Article. Failure to execute such releases or provide requested documentation shall result in an application for appointment, reappointment, and/or Privileges being deemed voluntarily withdrawn, and it shall not be further processed. By submitting an application for Medical Staff appointment or reappointment, or by applying for or exercising privileges or providing specified patient care services within the Hospital, all applicants, Practitioners or Members, without limitation:

a. Authorize representatives of the Hospital and of the Medical Staff to solicit, procure, provide, and/or act upon information bearing on or reasonably believed to bear upon his professional abilities and qualifications;

b. Agree to be bound by the provisions of these Bylaws, Policies and Rules and Regulations regardless of whether Membership or Privileges are granted or subsequently restricted;

c. Acknowledge that the provisions of this Article are express conditions to an application for, or acceptance of, Staff Membership, and the continuation of such Membership and/or the exercise of Privileges or provision of specified patient care services at the Hospital;

d. Agree to release from legal liability and hold harmless the Hospital and Medical Staff, and any representative of the Hospital or Medical Staff who acts to carry out Medical Staff or Hospital policies or functions, including all persons engaged in Peer Review. In addition, all Practitioners agree that their sole remedy for any Corrective Action or Peer Review action taken or recommended by the MEC for failure to comply with these Bylaws, Policies or Rules and Regulations, will be the right to seek legal or equitable relief only after they have exhausted all the administrative remedies in these Bylaws.

e. Agree to release from legal liability and hold harmless any individual who or entity which provides information (including Peer Review information) regarding the Practitioner to the Hospital or its representatives;

9.2 Confidentiality

Information with respect to any applicant, Practitioner or Member that is submitted, collected or prepared by any representative of this or any other health care facility or organization or Medical Staff, for the purpose of evaluating and improving quality patient care, reducing morbidity or mortality, promoting efficiency, or contributing to medical education or clinical research, shall, to the fullest extent permitted by law, be confidential. Confidential information shall not be disseminated to anyone other than a representative(s) of the Hospital or of the Medical Staff with a legitimate need for access in order to carry out required functions or third party health care entities performing legitimate credentialing and peer review activities. Such confidentiality shall also extend to information of like kind that may be provided by third parties.

9.3 Immunity from Liability

a. For Actions Taken

Representatives of the Hospital and the Medical Staff shall have absolute release from any and all liability in any judicial proceeding for damages or other relief for any action taken or statement or recommendation made within the scope of their duties as such representatives, after a reasonable effort under the circumstances to ascertain the facts

underlying such actions, statements or recommendations and in the reasonable belief that the action, statement or recommendation is warranted by such facts.

b. Providing Information

Representatives of the Hospital, the Medical Staff and any third party shall have absolute release from any and all liability in any judicial proceeding for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of the Hospital or of the Medical Staff or to any other hospital, organization or health professionals, or other health-related organizations, concerning a practitioner who is or has been an applicant to or member of the Medical Staff, AHP Staff, or who did or does exercise privileges or provide specified services at this Hospital.

9.4 Activities and Information Covered

a. Activities

The provisions of this Article shall apply to acts, communications, reports, recommendations, or disclosures in connection with this or any other health-related institution's or organization's activities concerning, but not limited to:

1) Applications for appointment, Privileges. Membership, or specified services;

2) Periodic reappraisals for reappointment, Privileges, Membership, or specified services;

3) Disciplinary measures, including warnings and reprimands;

4) Corrective Actions;

5) Hearings and appellate reviews;

6) Performance Improvement and Professional Review activities including the creation and dissemination of performance profiles;

7) Peer Review activities, including external peer review;

8) Utilization and claims reviews; and

9) Other Hospital, Department or committee activities related to monitoring and maintaining of quality patient care and appropriate professional conduct

b. Information

The acts, communications, reports, disclosures and other information referred to in this Article may relate to a Practitioner's professional qualifications, clinical or procedural abilities, judgment, character, physical and mental health, emotional

stability, professional ethics, professional conduct or any other matter that might directly or indirectly affect patient care.

9.5 Cumulative Effect

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

ARTICLE X
CORRECTIVE ACTION AND FAIR HEARING

10.1 Investigations

a. When reliable information indicates that a Physician may have exhibited acts, demeanor, or conduct, reasonably likely to be:

1. detrimental to patient safety or to the delivery of quality patient care within the Hospital;

2. unethical or illegal;

3. contrary to the Medical Staff Bylaws or Rules, Regulations, or Policies;

4. harassing or intimidating to Hospital employees, Medical Staff colleagues, patients or their families;

5. disruptive of Hospital or Medical Staff operations;

6. below applicable professional standards for competency or as established by the Medical Staff; or

7. harmful to the reputation of the Hospital and/or Medical Staff,

a request for an investigation or action against such Physician may be initiated by the Board, President of Staff, MEC, Chief Medical Officer of the Hospital, or the Hospital CEO, such request must be submitted to the MEC.

b. If the MEC concludes an investigation is warranted, it shall direct an investigation to be undertaken by the Performance Improvement Committee or its designated subcommittee. In the event the Board believes the MEC has incorrectly determined an investigation unnecessary, it may request the Performance Improvement Committee directly to undertake an investigation.

c. The investigation shall proceed in a prompt manner and a written report of the investigation findings will be submitted to the MEC as soon as practicable. The MEC

will determine if it is complete and sufficient for the MEC to make a determination whether Corrective Action should be recommended.

The Medical Staff delegates to the MEC the authority to adopt associated detail elaborating on investigations. Such associated detail is located in the Corrective Action & Fair Hearing Manual.

10.2 Imposition of Adverse Actions.

a. Summary Suspension of Privileges

1. The President of Staff, a Department chair, the CMO of the Hospital, the Hospital CEO or the Board shall each have the authority to summarily suspend all or any portion of Physician's Privileges whenever it perceives a reasonable possibility that failure to do so may pose imminent danger to the health, safety and/or well-being of any individual. Such a suspension will not become effective until it is agreed to by one other individual (and one must be the CEO) having the authority to suspend. This suspension will take place immediately and the President of Staff, and the Hospital CEO or his designee will promptly inform the affected Physician.

2. The Physician will be afforded an interview with the MEC if such request is made within five (5) days of notification of the summary suspension. The imposition of the suspension will be affirmed by the MEC no later than fourteen (14) days of the summary suspension. The Physician shall be entitled to request a fair hearing if the suspension exceeds fourteen (14) days.

The Medical Staff delegates to the MEC the authority to adopt associated detail elaborating on summary suspensions. Such associated detail is located the Corrective Action & Fair Hearing Manual.

b. Automatic Suspensions/Limitations/ and Voluntary Relinquishments

Automatic suspensions and limitations on Medical Staff membership and Privileges and voluntary resignations/relinquishments of Medical Staff membership and Privileges may occur for failure to meet eligibility requirements of membership or compliance with requirements for Medical Staff membership or Privileges found in these Bylaws, Policies and Rules and Regulations. The following will result in either automatic suspension, limitations on Medical Staff membership or Privileges, or voluntary resignations/relinquishments of Medical Staff membership and Privileges:

- Revocation or suspension of license
- Conviction of a felony, a plea of no contest to a felony, or deferred adjudication for a felony
- Suspension for failure to complete medical records
- Failure to attend specially noticed committee or department meetings when requested unless good cause is shown
- Revocation or suspension of DEA number or State Controlled Substance Abuse Certification number

- Failure to maintain liability insurance
- Exclusion from federal or state health insurance programs or conviction for insurance fraud
- Failure to participate in an evaluation or assessment
- Failure to notify Hospital of disciplinary or final malpractice actions
- Failure to return from leave of absence

The reasons listed above are not based on determinations of competence or unprofessional conduct and are not considered Professional Review actions, and do not entitle the Physician to the procedural due process rights in these Bylaws. The Medical Staff delegates to the MEC the authority to adopt associated detail elaborating on automatic suspension, limitations and voluntary relinquishment of Privileges. Such associated detail is located in the Corrective Action & Fair Hearing Manual.

10.3 Fair Hearing and Appeal. The following steps describe the process for fair hearing and appeal. The Medical Staff delegates to the MEC the authority to adopt associated detail elaborating on the fair hearing and appeal process. Such associated detail is located in the Corrective Action & Fair Hearing Manual.

a. Grounds for a Hearing

A recommendation by the MEC for an Adverse Decision or the imposition of an Adverse Decision, if based on a determination of professional competency or professional conduct, shall constitute grounds for a hearing. The Physician, with respect to whom an adverse action shall have been recommended, shall promptly be given notice thereof by the President of Staff. The Physician shall have thirty (30) days following the date of receipt of such notice within which to request a hearing by means of written notice delivered either in person or by certified or registered mail to the Hospital CEO and the President of Staff.

b. Notice of Hearing

Upon receipt of a timely request for a hearing by a Physician, the Hospital CEO shall inform the President of Staff, MEC and Board. Except in cases of a summary suspension in which the hearing shall be expedited, within thirty (30) days after receipt of such request the CEO shall schedule and arrange for a hearing and provide notice to the Physician. The hearing date shall be not less than thirty (30) days nor more than sixty (60) days from the date of receipt of the request for a hearing, unless the parties mutually agree to an earlier days. If the date is already set, the parties may mutually agree to any change in the hearing date except that neither party may change the date more than once.

c. Appointment of Hearing Panel, Presiding Officer, Hearing Officer

1. The President of Staff, after consultation with the Hospital CEO shall submit to the MEC nominations for no fewer than three (3) proposed Hearing Panel Members, one alternate Panel Member and for a Presiding Officer or a Hearing Officer. The MEC shall consider such nominations for members of the Hearing Panel and for the Presiding Officer or Hearing Officer. From such nominations, the MEC shall appoint a Hearing

Panel consisting of no fewer than three (3) Panel Members, one (1) alternate Panel Member and a Presiding Officer or a Hearing Officer. The Presiding Officer will not have voting privileges on the panel.

2. Voting members of the Hearing Panel shall be licensed physicians who are Medical Staff Members at the Hospital and who shall not have previously participated in the deliberations involving the matter. However, knowledge of the matter involved shall not preclude a person from serving as a member of the Hearing Panel. No member of the Hearing Panel may be a direct competitor of the Physician under review.

3. The MEC may appoint a single Hearing Officer in lieu of a Hearing Panel where the issue triggering the hearing involves alleged unprofessional conduct rather than professional competency.

The Medical Staff delegates to the MEC the authority to adopt associated detail elaborating on the composition and responsibilities of the members of the Hearing Panel, Presiding Officer and Hearing Officer. Such associated detail is located in the Corrective Action & Fair Hearing Manual.

d. Hearing Procedures

1. The personal presence of the Physician who requested the hearing shall be required.

2. The Presiding Officer has the discretion to limit the role or legal counsel for either side during the hearing. However, this limitation does not deprive the Physician or Hospital of the right to utilize legal counsel in preparation for the hearing and such counsel may be present at the hearing, advises his client, and participate in resolving procedural matters.

3. The Presiding Officer shall ensure that all participants in the hearing have a reasonable opportunity to be heard and to present appropriate oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process. The Presiding Officer shall be entitled to determine the order of procedure during the hearing and shall have the authority to set reasonable time limits on the duration of the hearing, testimony of witnesses, or arguments by parties.

4. During the hearing, each party shall have the right to:

- Call and examine witnesses
- Introduce evidence and exhibits
- Cross-examine any witness on any matter relevant to the issues
- Impeach any witness
- Rebut any evidence

5. The body whose action or decision prompted the hearing (either the MEC or the Governing Body) shall have the burden to come forward initially with evidence in support of its action, proposed action, or decision. Thereafter, the burden shall shift to the Physician who requested the hearing to come forward with evidence in support of his case. In all cases in which a hearing is conducted, after all evidence has been submitted by both parties, the Hearing Panel shall rule against the Physician who requested the hearing unless it finds that such person has proved, by clear and convincing evidence, that the factual allegations against the Physician are untrue in total or substantial part, or unless it concludes, based on its findings of fact that the action of the entity whose decision prompted the hearing was arbitrary, unreasonable, or appears to be unfounded or unsupported by credible evidence.

6. Except in cases of summary suspension in which the Hearing Panel shall expedite the Hearing and decision, within thirty (30) days after the conclusion of the hearing, the Hearing Panel shall make a detailed written report signed by each committee member, which sets forth separately each charge against the Physician, a summary of the evidence that supports or rebuts such charges, its findings on each fact at issue, and recommendations based on such findings with respect to the matter. This report, together with the hearing record and all other documentation considered by it, will then be forwarded to the MEC. The MEC shall forward this report, along with all other documentation considered by the Hearing Panel, to the body whose decision prompted the hearing if not the MEC.

7. Within fifteen (15) days after receipt of the report of the Hearing Panel, the MEC, shall consider the same and affirm, modify or reverse its previous recommendation, decision or proposed decision in the matter. The MEC shall indicate its action in writing, and shall transmit a copy of its written recommendation together with the hearing record, the report of the Hearing Panel, and all other relevant documentation, to the Board. The Physician requesting the hearing shall be provided the Hearing Panel's recommendation by Special Notice and the decision of the MEC to accept and affirm the Hearing Panel's recommendation, modify or reverse its previous recommendation.

8. The Notice of the action taken shall be provided to the Performance Improvement Committee, President of Staff, Hospital CEO, and by Special Notice to the affected Physician.

e. <u>Appeal Procedures</u>

1. Except in cases of summary suspension in which the appeal will be expedited, within ten (10) days after receipt of the notice given, if the action of the MEC continues to be adverse to the Physician, he may request in writing an appellate review by the Board. Such request shall be delivered to the Hospital CEO/designee either in person or by certified or registered mail. The written request for an appeal shall also include a brief statement of the reasons for the appeal. The grounds for appeal shall be limited to the following:

- There was a substantial failure to comply with this Article X and associated details in the Medical Staff Bylaws/Corrective Action & Fair

Hearing Manual so as to deny basic procedural fairness or reasonable due process;

- The MEC's recommendations were made arbitrarily, capriciously, or with prejudice; or
- The recommendation of the MEC and/or Hearing Panel was not supported by the hearing record.

2. In the event of any appeal to the Board, the Board shall, within thirty (30) days after the receipt of such notice of appeal, schedule and arrange for an appellate review. The Board shall provide the Physician special notice of the time, place and date of the appellate review. The date of the appellate review shall be not less than fourteen (14) days or more than sixty (60) days from the date of the receipt of the request for appellate review from the Physician. If the Physician is still under a summary suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made but in no event more than thirty (30) days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the Board of the Hospital for good cause.

3. Upon completion of an appellate review, the Board or the Committee of the Board, may affirm, modify or reverse the action which is the subject of the appeal, or refer the matter back to the MEC for further review and recommendation.

4. If at any time after receipt of Special Notice of an adverse recommendation, action or result, the Physician fails to make a required request or appearance or otherwise fails to proceed with a fair hearing, he shall be deemed to have consented to such adverse recommendation, action, or result and to have voluntarily waived all rights to which he might otherwise have been entitled under these Medical Staff Bylaws then in effect.

10.4 Corrective Action and Fair Hearing Manual. The Medical Staff delegates to the MEC with the authority to adopt associated details elaborating on the corrective action and fair hearing process in this Article X. Such associated detail is located in the Corrective Action and Fair Hearing Manual which may be modified from time to time.

10.5 Mediation. Within ten (10) days of receipt of the Notice of Adverse Decision giving rise to hearing rights, an affected Physician may file a written request for mediation pursuant to the provisions of the Corrective Action and Fair Hearing Manual.

ARTICLE XI
GENERAL PROVISIONS

11.1 Medical Staff Ancillary Manuals, Rules, Regulations, and Policies

Subject to the procedures identified below, the MEC is delegated the authority to adopt new or change existing Ancillary Manuals, Rules, Regulations, or Policies, as may be necessary to more specifically implement the general principles found within these Bylaws and to carry out the responsibilities and functions of the Medical Staff and implement its operations.

a. MEC's Consideration of New or Amended Ancillary Manuals, Rules, Regulations, or Policies

Any proposed new or changed Ancillary Manual, Rule or Regulation under consideration by the MEC shall first be distributed to the Members of the Medical Staff for review and comment before the MEC may adopt it. The MEC may also, in its discretion, distribute a proposed new or changed Policy under its consideration to the Members of the Medical Staff for a courtesy review and comment before adoption.

b. Medical Staff Proposal of New or Amended Ancillary Manuals, Rules, Regulations, or Policies

The Medical Staff may propose new or changed Ancillary Manuals, Rules, Regulations, or Policies by first generating a written petition in support of such proposal signed by at least twenty five percent (25%) of the voting Members of the Medical Staff, second presenting such proposal to the MEC for review and comment, and third obtaining a majority vote of the voting Members of the Medical Staff in favor of such proposal. Any such new or changed Ancillary Manual, Rule, Regulation or Policy proposed by the Medical Staff shall be presented to the Board for approval along with any comments from the MEC.

c. Board Approval and Communication to the Medical Staff

Any new or changed Ancillary Manual, Rule, Regulation, or Policy adopted by the MEC or proposed by the Medical Staff shall become effective only after approval by the Board. Any new or changed Ancillary Manual, Rule, Regulation, or Policy approved by the Board shall be promptly communicated to the Medical Staff.

11.2 Conflict of Interest

All members of the Medical Staff are required to abide by any Conflict of Interest policies adopted by the MEC and approved by the Board. Members shall disclose any conflict of interest, as defined by the MEC or Board, or potential conflict of interest in any transaction, occurrence or circumstance which exists or may arise with respect to his participation on any committee or in his activities in Medical Staff affairs, including in departmental activities and in the review of cases. Where such a conflict of interest exists or may arise, the member shall not participate in the activity, or as appropriate, shall abstain from voting, unless the circumstances clearly warrant otherwise. If the member does not voluntarily remove himself from participation in the activity, or voting as the case may be, the President of Staff shall remove such member.

11.3 Joint Conference

Whenever the Board's proposed decision will be contrary to the MEC's recommendation, the Board shall submit the matter to a Joint Conference of an equal

number of Medical Staff and Board of Governor members for review and recommendation before making its final decision and giving notice of final decision. Individuals participating in a Joint Conference will be appointed by the President of Staff and Chair of the Board. The MEC or the Board may also request the convening of a Joint Conference to discuss any matter of controversy or concern that would benefit from enhanced dialogue between Medical Staff and Board leaders.

11.4 Histories and Physicals

A physician, oral maxillofacial surgeon, or other qualified licensed independent practitioner, each of whom is acting within the scope of their practice as determined by State law and holding appropriate Privileges at the Hospital, must complete a physical examination and medical history ("H&P") for each patient no more than thirty (30) days before or within twenty-four (24) hours after the patient's admission or registration, but prior to any surgery or procedure involving moderate sedation or anesthesia (excluding topical and local analgesia).

If the H&P was performed prior to admission or outpatient procedure, the patient must be re-examined and the H&P must be updated within twenty-four (24) hours after admission or registration, but prior to any surgery or procedure involving moderate sedation or anesthesia (excluding topical and local analgesia). The update should reflect any changes in the patient's condition or specify no changes from the previous H&P.

The MEC may, at its discretion, specify in Medical Staff Policies the outpatient procedures that require an H&P and additional Privileged Practitioners who may perform these required histories and physicals in accordance with state law and Hospital policy.

11.5. Conflict Management Process/Communication to Board.

The Medical Staff may require that the conflict management process in this Article be followed in the event twenty five percent (25%) of the voting Members of the Medical Staff sign a petition, stating the basis for the disagreement, or otherwise evidence disagreement with any action taken by the MEC, including but not limited to any amendment to these Bylaws, the Ancillary Manuals, Rules and Regulations, Policies and procedures pursuant to the following process:

a. The petition, along with the list of all petitioners, shall be sent to the MEC. Within thirty (30) days of receipt of the petition, a meeting between representatives of the MEC, appointed by the President of Staff, and the petitioners shall be scheduled. The parties shall act in good faith and take all reasonable steps to resolve the disagreement.

1) If the conflict is resolved, the proposed resolution shall be submitted to the voting Members of the Medical Staff. If approved by the voting Members, the proposal shall be forwarded to the Board for its review and consideration. If approved by the Board, the decision shall be final. If not approved by the Board, the MEC and/or the petitioners shall have the option to request a Joint Conference pursuant to Article XI.11.4.

2) If the parties fail to reach resolution or if the voting Members of the Medical Staff do not approve any proposed resolution, the petition shall be forwarded to the Board for its review and consideration. The decision of the Board shall be final.

b. Any individual Member of the Medical Staff may communicate directly with the Board on any Rules and Regulations or Policies adopted by the Medical Staff or MEC. Such communication shall be sent to the CEO of the Hospital who shall forward it to the Chair of the Board and to the President of Staff who shall forward it to the MEC. The Chair of the Board shall determine the manner and method of responding to any individual Member communicating to the Board in this manner.

11.6 Bylaws Not a Contract.

These Bylaws are not a contract and do not establish a contractual right between the Medical Staff and the Hospital.

ARTICLE XII
ADOPTION AND AMENDMENT OF MEDICAL STAFF BYLAWS

12.1 Formulating and Reviewing Bylaws Amendments

The Medical Staff shall have the responsibility to formulate, review at least biennially, and recommend to the Board any Medical Staff Bylaws, Rules, Regulations, or Policies, including amendments thereto, as needed, which shall be effective when approved by the Board. Neither the Board nor the Medical Staff shall unilaterally amend the Medical Staff Bylaws.

12.2 Methods of Adoption and Amendment to Bylaws

Unless any amendments to these Bylaws are being proposed directly to the Board by the Medical Staff, all proposed amendments to these Medical Staff Bylaws whether originated by the MEC, another standing committee or the Board must be reviewed and discussed by an ad hoc Bylaws committee appointed by the MEC prior to its formal adoption by the MEC. The MEC will consider input from the Bylaws committee and discuss the proposed amendment(s) prior to an MEC vote. The MEC may establish a fixed date for input from the ad hoc Bylaws committee.

Any amendment proposed directly by the Medical Staff shall first be sent to the MEC for its review and discussion prior to submission to the Board. The MEC shall submit any proposed amendments from the Medical Staff to the Board for its review and adoption, even if not approved by the MEC.

In the event the Medical Staff or the MEC do not approve of an amendment, either has the option to pursue the conflict management process set forth in Article XI.11.6 above. Any amendment shall only be effective pending the outcome of the conflict management process.

The MEC shall vote on proposed amendments at a regular meeting, or at a special meeting called for such purpose. Following an affirmative majority vote by the MEC, all active members of the Medical Staff shall receive a description of the proposed Bylaws amendment(s) at least thirty (30) days in advance of a meeting of the Medical Staff where the amendment will be discussed. Within thirty (30) days following their discussion at a meeting of the Medical Staff, the Active Members of the Medical Staff will be asked to vote on the proposed amendment to these Bylaws. This vote may be conducted via printed or electronic ballot in a manner determined by the MEC. Ballots marked in favor of amendment(s) or those that are not returned will be considered affirmative votes in support of the MEC recommendations for amendment(s). To be adopted, the proposed Bylaws amendment(s) must be affirmed by a majority of the Members of the Medical Staff in the Active category and subsequently ratified by the Board.

12.3 Provisional and Urgent Amendments

The MEC shall be delegated with the authority to provisionally adopt such amendments to these Bylaws, the Ancillary Manuals, Rules and Regulations, and Policies that are, in the MEC's judgment, technical or legal modifications to comply with law or clarifications, consist of reorganization or renumbering of material, or are needed due to punctuation, spelling, or other errors of grammar or expression, without any prior approval of the Medical Staff, and the Board shall provisionally approve such amendment. In such cases the entire Medical Staff will be notified by the MEC. Copies of any notice or materials requiring urgent amendment, if not otherwise confidential, will be submitted along with the written notice. The Medical Staff shall have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the MEC, the provisional amendment will remain in effect. If there is conflict over the provisional amendment, the process for conflict management set forth in Article 11 shall be implemented. If necessary a revised amendment will be submitted to the Board for its review and consideration. Such amendments must be ratified by the Board.

If the urgent change involves an amendment to the Ancillary Manuals, Rules and Regulations or Polices on matters already delegated by the Medical Staff to the MEC, the approval process in this section shall not apply but a copy of the change must be sent to all Members of the Medical Staff.