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MEDICAL STAFF BYLAWS
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PREAMBLE

Recognizing that the medical staff is responsible for the quality of medical care in the hospital and must accept and assume this responsibility, subject to the ultimate authority of the hospital's Board of Trustee's, and that the best interests of the patient are better protected by concerted effort, the practitioners of this hospital are organized in conformity with these bylaws and the medical staff rules and regulations. That the medical staff is a constituent part of the hospital and is not a separate entity and the medical staff and its members act on behalf of the hospital in peer review, quality insurance, credentialing, utilization review and other appropriate matters.

These bylaws were prepared for compliance, and are to be construed in conformity with applicable hospital licensing laws, applicable accreditation guidelines and regulatory requirements; they do not constitute an express or implied contract between or among any individual, committee or entity.

ARTICLE I - DEFINITIONS

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

1. Admitting Privileges: the right of members of the Medical Staff to admit their patients to the hospital.
2. Allied Health Professionals (AHP): individuals, other than a licensed physician, dentist, or podiatrist, who exercises independent judgment within the areas of his or her professional competence and the limits established by the Board of Trustee's, the Medical Staff, and the applicable State Practice Acts; or who is qualified to render direct or indirect medical care or assistance under the supervision or direction of a medical staff member possessing privileges and prerogatives in the conformance with the rules adopted by the Board of Trustee's, these bylaws, and the Medical Staff Rules and Regulations. Advanced Practice Registered Nurses and Physician Assistants shall be considered AHP's. AHP's are not eligible for medical staff membership.
3. Attending Physician: the Medical Staff member who is the physician of record for a given patient.
4. Authorized Representative or Hospital's Authorized Representative: The term "hospital's authorized representative" includes the Board of Trustee's, its individual members and committee members; the Chief of Staff, the medical staff, committee chairs and members having responsibility for collecting information regarding or evaluating the applicant's credentials.
5. Board Certified: specialty board recognized by the AMA (American Medical Association) or the AOA (American Osteopathic Association). Any other Board Certification shall be approved on an individual basis by the Board of Trustee's in consultation with the Medical Executive Committee.
6. Board of Trustee's: Board of Trustee's (BOT); the local governing body of the hospital, delegated authority and responsibility and appointed by the General Partner of the management subsidiary which operates the hospital. As appropriate in the context and consistent with the hospitals' bylaws, it may also mean any Board of Trustee's committee or individual authorized to act on behalf of the Board of Trustee's.
7. Chief 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 this hospital.
8. Clinical Privilege/Privilege: specified diagnostic and therapeutic services that may be exercised by authorized individuals on approval of the Board of Trustee's.
9. Completed Application: an application, either for initial appointment or reappointment to the medical staff or for clinical privileges, that has been determined by the applicable medical staff department(s), Credentials Committee, Medical Executive Committee and the Board of Trustee's to meet the requirements of the medical staff bylaws, rules and regulations.
10. Days: calendar days, unless otherwise noted in these bylaws.

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11. Dentist: an individual who has received a doctor of dental surgery or a doctor of dental medicine degree and has a current, unrestricted license to practice dentistry in this state.
12. Department: a clinical division of the medical staff, grouping members in accordance with their specialty or major practice interest, as specified in these bylaws.
13. Department or Service Chairman (Chief): the member of the active medical staff who is duly selected in accordance with these bylaws to serve as the head or director of a clinical department or service.
14. Designee: any reference to an individual holding a duly authorized office under these bylaws includes the designee of that individual.
15. Discrimination or Harassment includes, without limitation, sexual harassment and discrimination or harassment against any individual on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender or sexual orientation.
16. Disruptive Behavior: includes any aberrant behavior which may reasonably appear to compromise quality of care either directly or indirectly because it disrupts the ability of other professionals to provide quality care. Examples of Disruptive Behavior includes without limitation, (1) verbal abuse of any individual, (2) verbal abuse which is directed at large but is perceived by a member of a group to be offensive, (3) delaying the progress of surgery or other procedures to reprimand nurses or staff, (4) making bad faith, false accusations of unprofessional behavior against any individual, or (5) any other aberrant behavior which may reasonably appear to compromise quality of care either directly, or indirectly because it disrupts the ability of other professionals to provide quality care.
17. Emergency: for all individuals a medical condition such that the absence of immediate medical attention could reasonably be expected to result in either placing the health of the individual in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part; or for a pregnant woman having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery; or that the transfer may pose a threat to the health or safety of the woman or her unborn child.
18. Executive Committee/Medical Executive Committee/ (MEC): the executive committee of the medical staff which shall constitute the governing body of the medical staff as described in these bylaws.
19. Ex Officio: service as a member of a body, department or committee, by virtue of an office or position held, within the medical staff organization, and unless otherwise expressly provided, means without voting rights.
20. Fair Hearing Committee (FHC): the committee appointed pursuant to these bylaws for the purpose of evaluating the evidence and making findings in a medical staff hearing.
21. Good Standing: the term "good standing" means a medical staff member who, at the time the issue is raised, has met the attendance and committee participation requirements during the previous medical staff year, and has not received a restriction of membership or privileges in the previous twelve (12) months.
22. HIPAA Privacy Regulations: the federal privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996.
23. Hospital: Texas Health Harris Methodist Hospital Southlake
24. Hospital President: Administrator or CEO; the individual appointed by the hospital to act on its behalf in the overall management of the hospital.
25. Hospitalist: Physicians that only provide care of patients in a hospital setting.
26. Impaired Practitioner: Any individual who displays a physical, psychiatric or emotional illness which impacts on his or her medical/clinical judgment and which has or which with reasonable foresee ability could be expected to impact patient care.
27. Licensed Independent Practitioners: licensed independent practitioners provide medical care to patients, in accordance with state licensure laws, without supervision by a physician.
28. Medical Disciplinary Cause or Reason (MDCR): a basis for disciplinary action involving an aspect of a practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

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29. Medical Staff/Staff: the formal organization of the hospital that consists of all physicians (M.D. or D.O.), dentists, and podiatrists who hold an unrestricted license in this state and who are privileged to provide patient care services in this hospital within the scope of their licensure and approved clinical privileges. Only Practitioners as defined below can be members of the medical staff.
30. Medical Staff Year: the period from January 1 to December 31.
31. Member: a practitioner who has been granted and maintains medical staff membership and (except for honorary staff) clinical privileges and who is in good standing pursuant to these bylaws.
32. Peer: a practitioner holding the same license as another practitioner: (MD & DO equivalent; DDS for DDS; DPM for DPM; PhD for PhD; etc.)
33. Peer Review: the functions of evaluating the qualifications of Members or Allied Health Professionals or the quality of health care rendered by providers of health care service to provide intervention, support, or rehabilitative referrals or services, or to determine that health care services rendered were professionally indicated, or were performed in compliance with the applicable standard of care, or that the cost of health care rendered was considered reasonable by the providers of professional health care services in the area.
34. Peer Review Committee: the committee appointed pursuant to these bylaws for the purpose of evaluating the evidence and making findings in a medical staff hearing.
35. Physician: an individual who holds a current, unrestricted license as a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) in this state.
36. Podiatrist: an individual who has a doctor of podiatric medicine degree and a current, unrestricted license to practice podiatry in this state.
37. Practitioner: a physician or a dentist or a podiatrist, unless otherwise expressly limited, who is applying for medical staff membership and/or clinical privileges or who is a medical staff member and/or who exercises clinical privileges in this hospital.
38. Proctor: an Active member, in good standing, of the Medical Staff of the Hospital with privileges in the specialty area being proctored or a licensed physician or licensed independent practitioner of outstanding reputation that has been chosen by the Medical Executive Committee when a member of the staff cannot be identified.
39. Professional Review Activity: any activity of the hospital with respect to an individual practitioner (a) to determine whether an applicant or a member may have clinical privileges at the hospital or membership on the medical staff; (b) to determine the scope or conditions of such privileges or membership; or (c) to change or modify such privileges or membership.
40. Professional Review Body: shall mean and as appropriate to circumstances, the Board of Trustee's, Board of Managers, the Credentials Committee, any ad hoc investigation committee, any hearing committee, any Appellate Review Committee, Medical Executive Committee, President of the Hospital, the Chief of Staff, and department, division or service chairman and any other authorized representative having authority to make an adverse recommendation with respect to take or propose an action against applicant or member when assisting the Board of Trustee's in a professional review activity.
41. Resident: practitioners who are currently enrolled in a graduate medical education program approved by the Medical Executive Committee and the Governing Board.
42. Service: a subdivision of either the medical staff or a clinical department, grouping members in accordance with their specialty or major practice interest, as specified in these bylaws.
43. Sexual Harassment:
 - (a) includes, without limitation, unwelcome sexual advances, requests for sexual favors, and other verbal, visual, or physical of a sexual nature when: (1) submission to the conduct is made either explicitly or implicitly a term or condition of employment; (2) submission to or rejection of such conduct is used as a factor in decisions affecting hiring, evaluation, retention, promotion or other aspects of employment; or (3) such conduct has the purpose or effect of unreasonably interfering

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with an employee's work performance, or creating an intimidating, hostile, or offensive work environment;

- (b) examples of sexual harassment include, but are not limited to: (i) unwelcome sexual flirtations, advances, or propositions; (ii) offering employment benefits in exchange for sexual favors; (iii) subtle pressure or requests for sexual favors; (iv) making or threatening reprisals after a negative response to a sexual advance; (v) unnecessary touching of an individual; (vi) visual conduct such as leering, making sexual gestures, displaying of sexually suggestive objects or pictures, cartoons or posters; (vii) verbal conduct such as making or using derogatory comments, epithets, slurs and jokes; or (viii) verbal abuse of a sexual nature such as graphic verbal commentaries about an individual's body, sexually degrading words used to describe an individual, suggestive or obscene letters, notes, or invitations.

44. State: Texas

ARTICLE II - NAME

These are the bylaws of the medical staff of Texas Health Harris Methodist Hospital Southlake

ARTICLE III - PURPOSES AND RESPONSIBILITIES

SECTION 1 - PURPOSES

The purposes of the medical staff are to:

- A. Provide an organized body through which the benefit of medical staff membership (mutual education, consultation, and professional support) may be obtained by each medical staff member and the obligations of medical staff membership may be fulfilled.
- B. serve as the primary means for accountability to the Board of Trustees for the quality and appropriateness of the professional performance and ethical conduct of its members as well as of designated professional personnel, and to strive for achievable quality patient care, efficiently delivered and maintained consistent with available resources, to the degree reasonably possible as determined by the state of the healing arts and resources locally available.
- C. develop a structure, reflected in medical staff bylaws, rules and regulations, policies, protocols, and other applicable documents, that adequately defines the responsibility and when appropriate the authority and accountability of each medical staff component.
- D. Provide a means through which the medical staff may provide recommendations to the hospital's policy making and planning process.

SECTION 2 - RESPONSIBILITIES

The responsibilities of the medical staff are to account for the quality and appropriateness of patient care rendered by all practitioners and allied health professionals authorized to provide patient care services in the hospital by:

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- A. Processing credentials in a manner that matches verified qualifications, performance, and competence with clinical privileges for all medical staff applicants and members and practice prerogatives for all allied health professionals.
- B. Making recommendations to the Board of Trustee's with respect to medical staff appointments, reappointments, staff category, probationary status, clinical privilege delineation, and as appropriate, department, service and/or unit assignment and corrective actions.
- C. Participating in the hospital quality/performance management program by conducting objectively all required peer evaluation activities through medical staff and/or department/service review, specific (committee) monitoring processes, and a comprehensive occurrence screening program.
- D. Providing an effective utilization review program for allocation of medical services based upon patient-specific determinations of individual medical needs.
- E. Providing continuing education that is relevant to patient care provided in the hospital as determined, to the degree reasonably possible, from the findings of quality/performance related activities.
- F. Initiating and pursuing corrective action when indicated.
- G. Enforcing the medical staff bylaws, rules and regulations uniformly and consistently.

ARTICLE IV - MEDICAL STAFF MEMBERSHIP

SECTION 1 - MEMBERSHIP AS A PRIVILEGE

- A. Membership on the medical staff of this hospital and/or clinical privileges is a privilege that shall only be granted and maintained by those professionally qualified and currently competent practitioners who continuously meet the qualifications, standards, and requirements set forth in these bylaws, rules and regulations and the bylaws and policies of the hospital. Appointment to and membership on the medical staff shall confer on the member only such clinical privileges and rights as have been granted by the Board of Trustee's in accordance with these bylaws.
- B. No individual is automatically entitled to initial or continued membership on the medical staff or to the exercise of any clinical privilege in the hospital merely because he or she is licensed to practice in this or any other state, because he or she has previously been a member of this medical staff, because he or she had, or now has membership or privileges at this or another health care facility or another practice setting, or because he or she is a member of any professional organization.
- C. Medical staff membership does not create an employment or agency relationship between the practitioner and the hospital.

SECTION 2 - GENERAL CRITERIA FOR MEMBERSHIP

Subject to exceptions provided by law or stated in these bylaws, medical staff membership and/or clinical privileges shall not be denied on the basis of age, sex, religion, race, creed, color, disability, or national origin, but shall be related to professional ability and judgment, relevant training and experience, physical and mental health status

(subject to reasonable accommodation to the extent required by law), current competence; and to the hospital's purposes, needs, and non-exclusive capabilities. When the determination is based on the hospital's needs or its non-exclusive ability to provide the facilities, beds, and support staffing/services, consideration will be given, or as otherwise provided by law, to utilization patterns, and actual and planned allocations of physical, financial, and human resources, to general and specialized clinical and support services, and to the hospital's specific goals and objectives as reflected in the hospital's short and long range plans. It is recognized that some patient care services at the hospital may be provided exclusively by a limited number of practitioners selected by the hospital, and who have been properly processed and granted medical staff membership and/or clinical privileges.

SECTION 3 - QUALIFICATIONS AND OBLIGATIONS OF MEMBERSHIP OR PRIVILEGES

- A. Qualifications. In addition to the general criteria for membership, a physician must meet all of the following qualifications to hold membership on the medical staff:
1. have a current, unrestricted license to practice in the State;
 2. Be able to document his or her background, professional experience, worthy character, education, relevant training, and judgment; physicians will provide a minimum of 24 category 1 CME's including 1 hour of ethics training. All other practitioners will provide evidence of continuing medical education applicable to state licensure. All practitioners will provide a current picture, hospital ID card (optional) and a valid picture ID issued by a state or federal, agency (e.g., driver's license or passport).
 3. All applicants must meet board certification and eligibility requirements that are defined by each discipline within their respective departments and approved by the Medical Executive Committee and Board of Trustee's.
 4. demonstrate current competence, adherence to the ethics of their profession, good reputation, physical and mental health status (subject to any necessary reasonable accommodation to the extent required by law), the ability to work with others (staff members, members of other health care disciplines, hospital management and employees, visitors, patients, and the community in general);
 5. demonstrate an ability to refrain from Disruptive Behavior, Discrimination or Harassment;
 6. are not suspended, excluded, debarred, or sanctioned under the Medicare or Medicaid program or by any governmental licensing agency;
 7. never have been convicted of any offense related to health care, or listed by a federal or state agency as debarred, excluded or otherwise ineligible for federal or state program participation; and demonstrate to the medical staff and Board of Trustee's that any patient treated by them in the hospital or in any of its facilities will be given care of the professional level of quality and efficiency as established by the medical staff and hospital;
 8. Maintain professional liability insurance in the amount set by the Board of Trustee's which in no case shall be less than \$200,000 / \$600,000.
 9. Each member of the Medical Staff must arrange for patient coverage in the event that the physician is unavailable for the medical management of a patient. A call coverage form must be completed and signed by a physician who is currently a member of the medical staff and practices in the specialty/subspecialty in which the member has requested privileges.
- B. Obligations. In addition to the other obligations listed in these bylaws, each applicant, by applying for or being granted membership or clinical privileges (temporary or otherwise), thereby agrees to:

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1. Adhere to the generally recognized standards of professional ethics of his profession.
2. Not participate in fee-splitting or "ghost" surgical or medical care.
3. Participate as required in peer evaluation activities including Peer Review Committee.
4. Provide continuous care for his patients and delegate the responsibility for diagnosis or care of patients only to a member in good standing who has unrestricted clinical privileges to undertake that responsibility.
5. Obtain and document in the patient's medical record appropriate informed consent.
6. Abide by the medical staff bylaws, rules and regulations, and applicable hospital policies.
7. Provide documentation of annual TB skin test (TST) or furnish documentation of chest X-Ray done at regular intervals according to the HMSCDS Employee Health Policy. TB questionnaires will be done annually if there is a history of positive TST or BCG vaccine.
8. Complete adequately, and in a timely fashion, the medical and any other required records for all patients he admits or in any way provides care for in the hospital.
9. Seek consultation whenever medically indicated.
10. Maintain professional liability insurance in an amount and with a carrier approved by the Board of Trustee's and provide the hospital with a current certificate of insurance evidencing this coverage. The insurance must cover all of the privileges requested.
11. Reasonably assist the hospital in fulfilling its uncompensated or partially compensated patient care obligations in the areas of professional competence and privileges including service on emergency department call panels when required to do so by the medical executive committee.
12. Reasonably cooperate with the hospital in its efforts to comply with accreditation, reimbursement, and legal or other regulatory requirements.
13. Supply requested information and appear for interviews with regard to membership or privileges.
14. Immediately notify the Hospital President of the revocation or suspension of the applicant's professional license or the imposition of terms of probation or limitation of practice by any state licensing agency or the DEA, or of the commencement of any actions with regard to such adverse licensure activity; of the voluntary or involuntary loss of staff membership or clinical privileges at any health care institution; of the cancellation or restriction of professional liability coverage; of any adverse determination by a peer review organization or a third party payor reimbursement; of the commencement of a formal investigation or the filing of charges by the Department of Health and Human Services or any law enforcement agency or health regulatory agency of the United States or of any state; of the notice of intent to file or the filing of a claim alleging professional liability; or the filing of any criminal charges; or any investigational or other action taken by any governmental agency related to the Medicare or Medicaid program.
15. Maintain the confidentiality of all medical staff peer review matters, pursuant to these bylaws.
16. Maintain the confidentiality of all individual patient identifiable information in accordance with State and Federal regulations and Hospital's privacy policies.
17. Provide patients with care at the professional level of quality and efficiency as defined by the medical staff and Board of Trustee's.
18. Discharge staff, department, committee and hospital functions for which he or she is responsible by staff category assignment, appointment, and election or otherwise.
19. Authorize the hospital to consult with members of the medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on his or her competence, skill, character, ethical and other qualifications.
20. Consent to the hospital's inspection of all records and documents that may be material to an evaluation of his or her professional qualifications for the clinical privileges he or she requests as well as his or her moral and ethical qualifications for staff membership.

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21. Release from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with the investigation and evaluation of the applicant and his credentials.
 22. Release from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information.
 23. Consent to the disclosure to other health care entities, medical associations, licensing boards, and other organizations any information regarding his professional or ethical standing that the hospital or medical staff may have, and release the medical staff and hospital from liability to the fullest extent permitted by law.
 24. Refrain from disruptive behavior or discrimination or harassment against any individual.
 25. refrain from conducting their practice in such a manner as to cause suspension, exclusion, and debarment or sanction under the Medicare or Medicaid program or by any governmental licensing agency, the conviction of an offense related to health care, or listing by a federal or state agency as debarred, excluded or otherwise ineligible for federal or state program participation.
 26. Comply with all medical staff policies, rules and regulations including, without limitation, the medical staff Management of Disruptive Practitioner Policy.
 26. authorize hospital and any of its agents or employees to maintain information concerning the applicants or medical staff appointee's age, training, board certification, licensure and other confidential information in a centralized physician data base for the purpose of making aggregate physician information available for use by the hospital and its affiliates (although not required to be done by the hospital).
 27. To appear for a personal interview at any reasonable time requested by any hospital representative.
 28. consents to the reporting by any hospital representative of information to the National Data Bank established pursuant to the Healthcare Quality Improvement Act of 1986 which such hospital representative believes in good faith is required by law to be reported.
 29. releases from any liability (a) all hospital representatives for their acts performed in connection with evaluating his credentials or releasing information to other institutions for the purpose of evaluating his credentials, in compliance with the medical staff Bylaws; and (b) all third-parties who provide information, including otherwise privileged or confidential information, to the hospital and hospital representatives concerning his credentials, unless such information is false and the third-party providing it knew it was false.
 30. that, if any adverse decision is made with respect to him, (a) he will follow and exhaust the administrative remedies afforded by the medical staff bylaws as a prerequisite to any other action, and (b) he will have the burden of demonstrating that he meets the standards for appointment or continued appointment to the medical staff or for the clinical privileges requested.
 31. That the foregoing provisions are in addition to any agreements, understandings, covenants, waivers, authorizations or releases provided by law or contained in any application or request forms.
- C. On-Call Responsibilities. All Internal Medicine and Family Practice members of the medical staff shall be available on a rotational schedule to provide medical care or consultation to any patient in the Hospital who is found by the Attending physician on duty to require such care. These duties may be extended to any or all members of medical staff as a whole additional physician coverage is needed to meet the hospital's emergency care mission and obligations.

Specialty on-call coverage shall be available twenty-four (24) hours a day, seven (7) days a week. Schedules, names, and contact numbers for on-call physicians shall be available at all times in the hospital. Such records shall be retained in the hospital for one (1) year. All specialties with four or more physicians on active staff will

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be listed on the on-call rotation. Physicians 60 years or older will not be required to take specialty on-call. In the event an on-call physician cannot be contacted, the next listed on-call physician will be called.

A determination as to whether the on-call physician must physically assess the patient in the Hospital is the decision of the attending physician. The on-call physician shall come to the Hospital if requested by the Attending physician. If unavailable for any reason, he or she shall secure a satisfactory alternate from the medical staff to take call. Any physician refusing to render such service shall be subject to disciplinary action by Medical Executive Committee which may result in termination of medical staff membership and privileges.

SECTION 4 - CONDITIONS AND DURATION OF APPOINTMENT AND REAPPOINTMENT

All medical staff members will be appointed to an initial appointment process as active staff members by the Board of Trustees upon recommendation of Medical Executive Committee. Initial appointment and reappointments to the medical staff shall be made by the Board of Trustees upon a recommendation from the Medical Executive Committee, and shall be for a specific period up to, but not to exceed, two (2) years.

The Board of Trustees may act without or contrary to such recommendation on the basis of documented evidence of the applicant's or member's professional and ethical qualifications, obtained from reliable sources other than the medical staff but shall give great weight to the recommendation, if any, of the Medical Executive Committee. Prior to taking such action, however, the Board of Trustees shall notify the Medical Executive Committee of its intent and shall designate an action date prior to which the Medical Executive Committee may still fulfill its responsibility. Input shall be obtained and considered for all applicants for appointment and reappointment. The individual performance profile may also be used as input regarding performance required at the time of reappointment.

SECTION 5 - PROCEDURE FOR APPOINTMENT

- A. Application Fees. Applications for Initial Appointment and Reappointment to the Medical and Allied Health Staff shall be subject to an administrative processing fee.

Monies collected through the application process may be utilized for the expenditure of credentialing, resources and continuing education for the Medical Staff Services Department as well as the expenditure of other essential resources as determined by the Medical Executive Committee (MEC). The MEC shall have the power to recommend increases of applications fees, if any, for each category of medical staff membership, subject to the Governing Body's approval. All application fees shall be non-refundable.

- B. Application for Initial Appointment. Each application for appointment to the medical staff shall be in writing, submitted on the prescribed form, and signed by the applicant. When an applicant is provided an application, he shall also be given access to a copy of these bylaws, the medical staff and departmental rules and regulations, and applicable hospital policies.

- C. Applicant's Responsibility. The applicant shall have the burden of producing adequate information for a proper evaluation of his or her competence, character, skill, ethics, physical and mental health status (subject to any necessary reasonable accommodation to the extent required by law) ability to work with others, and other qualifications. Neither the Board of Trustees nor any medical staff committee shall have any obligation to review any application until the applicant completes it in all respects and submits all required information and supporting material and pays any application fee due. The applicant shall provide accurate, up to date information on the application. The applicant shall be responsible for resolving any doubts regarding the application and qualifications for membership and all privileges requested. The applicant agrees to report immediately to the Hospital President any change in the information which occurs after an application has been submitted. Any committee or its designee may request the applicant to appear for an interview with regard to the application. Failure to comply with any of these provisions, including failure to appear for any requested interview, may result in the application being deemed incomplete, or in the denial of membership or privileges, or may subject the practitioner to disciplinary action. The information shall include, but not be limited to:

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1. identifying information – A current picture hospital ID card and/or A valid picture ID issued by a state or federal, agency (e.g., drivers license or passport)
2. Undergraduate education.
3. Postgraduate education and professional degrees (need source verification).
4. Internship (need source verification).
5. Residency/fellowship.
6. All past and present hospital and other health care entity affiliations for the past ten (10) years.
7. Memberships in professional associations, societies, academies, colleges, and faculty/training appointments (need source verification).
8. Specialty board certification status (need source verification).
9. State licensure(s) with expiration date(s) (need source verification).
10. Drug Enforcement Administration (DEA) registration with expiration date.
11. professional references consisting of two (2) references from persons other than family or affiliated by marriage who must have personal knowledge of the applicant's recent professional performance, ethical character, current competence, health status (subject to any necessary reasonable accommodation to the extent required by law), and the ability to work cooperatively with others.
12. Previous practice data.
13. Continuing medical education for the past two years.
14. Curriculum Vitae.
15. Professional liability insurance, including carrier, amount and dates of coverage (need source verification) and past and present professional liability history.
16. responses to the following questions:
 - (a) Has any professional license of yours, in any jurisdiction, or your DEA registration ever been denied, limited (either voluntarily or involuntarily), suspended, revoked, voluntarily surrendered or otherwise acted against or is any such action pending?
 - (b) Have your clinical privileges (including, but not limited to temporary, locum tenens, admitting, consulting, and assisting) or membership at any health care facility ever been limited, suspended, reduced, denied, modified, revoked, not renewed, voluntarily relinquished or limited, or otherwise adversely acted upon, or is any such action pending?
 - (c) Have your clinical privileges or membership in any managed care organization, or medical or professional group (e.g., HMO, PPO, IPA, etc.) ever been (either voluntarily or involuntarily) limited, suspended, reduced, denied, modified, revoked, not renewed, voluntarily relinquished or otherwise adversely acted upon, or is any such action pending?
 - (d) Have you ever been denied or voluntarily relinquished membership, or renewal thereof, or had your membership or affiliation revoked or otherwise acted against, or been subject to disciplinary action at any health care facility, medical group, in any medical or professional group or organization, or is any such action pending?
 - (e) Have you ever been notified of an investigation or to appear before any licensing agency (State Board of Examiners, DEA, etc.) for a hearing or complaint with regard to your professional license or DEA registration?
 - (f) Have you ever been charged or convicted of a felony or misdemeanor (other than minor traffic offenses) or is any such action pending? Have you ever entered into a plea agreement to avoid conviction of a felony? On a separate piece of paper list the details and the court involved.

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- (g) Has any judgment or settlement been made against you in a professional liability case? If so, on a separate sheet, list the complete case name, the court in which the case was filed, the date of loss, the date you first received notice of the claim, the date of resolution, your insurance carrier and the amount of judgment or settlement paid by you or on your behalf for each judgment or settlement.
- (h) Has any professional liability insurance claim been filed against you or have you reported any malpractice claim to your insurance carrier or have you received any letter of intent to sue?
- (i) Are there any professional liability cases pending against you? If so, on a separate sheet, list the complete case name, court in which it was filed, date of loss, date you received notice of the claim, its current status, the name of your insurance carrier, and an explanation of the nature of the case.
- (j) Has any professional liability insurance carrier canceled, refused coverage, excluded specific procedures from your coverage, or has your insurance been rated up or has a surcharge been imposed by your insurance carrier, or is any such action pending?
- (k) Have you ever discontinued practice for any reason (other than for routine vacation or formal education/training) for one month or more?
- (l) Have you ever been sanctioned, suspended or otherwise restricted from participation in any private insurance plan?
- (m) Have you ever been suspended, excluded, debarred or sanctioned under the Medicare or Medicaid program or by any governmental licensing agency, convicted of an offense related to health care, or listed by a federal or state agency as debarred, excluded, or otherwise ineligible for federal or state program participation?
- (n) Do you have any physical and mental health issues which cannot be reasonably accommodated and which may inhibit or otherwise impact your ability to meet your obligations under these bylaws, and exercise the clinical privileges requested, safely and competently? On a separate sheet of paper, please specify any accommodations which you may require and the basis therefore.

- 17. A request for staff membership category and, if such exists, the department or clinical service assignment desired.
- 18. Clinical privileges desired.
- 19. A specific signed consent for immunity and release from liability for all individuals involved in and performing the credentialing function.
- 20. A list of cases treated or procedures performed if requested.
- 21. A small photo for identification purposes only.

D. Submission of the Application. The application shall be submitted to the Medical Staff Office or, if designated by the Hospital President, the medical staff coordinator or a credentials verification organization contracted by the hospital (a "CVO") for the purpose of assisting the Credentials Committee chairman, or designee, to have all information verified. The Medical Staff Office or, if designated by the Hospital President, a CVO, shall query the National Practitioner Data Bank (NPDB) and applicable state licensing board, if required, in compliance with existing laws and hospital policy, for all practitioners who are applying for privileges or membership. A civil court index search and criminal background check may be done. The applicant must immediately report to the Medical Staff Office any change in the information in the application that occurs after the application has been submitted. Once all information has been verified, the

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application will be considered complete and will be submitted by the Medical Staff Office to the Department and Credentials Committee for action in accordance with these bylaws.

- E. Significant Misrepresentation or Omission. If an applicant supplies information in the application process that contains any significant misrepresentation or omission, this may be grounds for termination of the application process, or if membership or privileges have been granted, for corrective action under these bylaws.
- F. Incomplete Application/Further Information/Application Withdrawn From Processing. Any committee or individual charged under these bylaws with the responsibility of reviewing an application for appointment, reappointment, or new clinical privileges, may, upon review of the application, deem any such application incomplete. The fact that an application is deemed complete by the Medical Staff Office or a department or committee does not preclude a committee or department which subsequently reviews the application from deeming it incomplete. If an application is deemed incomplete, it will not be processed. The committee or department that deems an application incomplete shall request further documentation or clarification from the applicant. Such committee or department requesting further documentation or clarification shall notify the applicant in writing and shall afford the applicant a set period of time to provide the requested information and clarification. Such period of time shall be as deemed appropriate by the committee or department requesting the information, but shall not exceed sixty (60) calendar days from receipt of the request to provide the requested information. Failure of an applicant to timely produce all of the requested information, documentation and clarification shall result in the application being deemed incomplete and voluntarily withdrawn. Such action will not result in the filing of a report with the applicable state-licensing agency nor with the National Practitioner Data Bank. Any subsequent application submitted by this practitioner shall be processed as an initial application under these bylaws. Notwithstanding any other provision of these bylaws, any practitioner whose application is discontinued from processing pursuant to this section shall not be entitled to the hearing and appeal rights under these bylaws.
- G. Credentials Committee Review Within sixty (60) days of receipt of the completed application, the Credentials Committee shall make a written recommendation to the Medical Executive Committee as to membership, and if membership is recommended, as to staff category, privilege delineation, service assignment, and any conditions attached to the appointment.
- H. Medical Executive Committee Review and Recommendation. At its next regular meeting after receipt of the recommendations of the Credentials Committee, the Medical Executive Committee shall submit its written recommendation to the Board of Trustee's relating to membership, and if appointment is recommended, to staff category, clinical privileges, and any special requirements or conditions. The recommendation shall be based on the review of all available information. The Medical Executive Committee may take action by recommending that the Board of Trustee's either: (a) defer making a recommendation, (b) appoint the applicant to a medical staff category in probationary status, clinical privileges, or (c) reject the applicant's request for membership and/or privileges.
1. The Medical Executive Committee may defer action on a complete application for a period not to exceed sixty (60) days except for good cause.
 2. When the recommendation of the Medical Executive Committee is favorable to the applicant, the Hospital President will forward it, together with all supporting documentation, to the Board of Trustee's for consideration at its next scheduled meeting.

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3. When the recommendation of the Medical Executive Committee is adverse to the applicant, the Hospital President shall so inform the applicant within five (5) working days advising him of his hearing and appeal rights under these bylaws.
4. Notice of an adverse recommendation shall be forwarded to the Board of Trustee's for its information, but shall not be acted upon until after the affected individual has exercised or waived the right to a hearing and appeal under these bylaws.

I. Action by the Board of Trustee's.

1. Unless subject to the provisions of Article VIII of these bylaws, the Board of Trustee's or its duly authorized committee shall act on the matter at its next regular meeting following receipt of the recommendation of the Medical Executive Committee.
2. Unless subject to the provisions of Article VIII of these bylaws, or as set forth below, a sub-committee of the Board of Trustee's consisting of at least two (2) members, may be delegated the authority to render decisions regarding the appointment, reappointment, and renewal and modification of clinical privileges in between regular meetings. This sub-committee shall report its actions at each regular Board of Trustee's meeting. An applicant or re-applicant shall be considered ineligible for the expedited process if at the time of appointment or prior reappointment any of the following has occurred:
 - (a) The applicant submits an incomplete application;
 - (b) The Medical Executive Committee makes a final recommendation (within 60 days) that is adverse or with limitation;
 - (c) There is a current challenge or a previously successful challenge to licensure or registration;
 - (d) The applicant has received an involuntary termination of medical staff membership at another organization;
 - (e) The applicant has received involuntary limitation, reduction, denial or loss of clinical privileges; or
 - (f) There has been a final judgment adverse to the applicant in a professional liability action.
3. In taking action under this Section, the Board of Trustee's shall give great weight to the recommendation of the Medical Executive Committee and shall not act arbitrarily or capriciously.
 - (a) If the Board of Trustee's adopts the recommendation of the Medical Executive Committee, it shall become the final action of the hospital.
 - (b) If the Board of Trustee's does not adopt the recommendation of the Medical Executive Committee, the Board of Trustee's may refer the matter back to the Medical Executive Committee with instructions for further review and recommendation and a time frame for responding to the Board of Trustee's. The Medical Executive Committee shall review the matter and shall forward its recommendation to the Board of Trustee's. If the Board of Trustee's adopts the recommendation of the Medical Executive Committee, it shall become the final action of the hospital.
 - (c) If the action of the Board of Trustee's is adverse to the applicant the Hospital President shall send written notice to the applicant within five (5) working days advising the applicant that he shall be entitled to the hearing and appeal.
 - (d) An adverse decision of the Board of Trustee's shall not become final until the applicant has exercised or waived his hearing and appeal rights under these bylaws. The fact that such

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adverse decision is not yet final shall not be deemed to confer membership or privileges when none existed before.

4. At its next regular meeting, after all of the affected individual's hearing and appeal rights under these bylaws have been exhausted or waived, the Board of Trustee's shall take final action. All decisions to appoint shall include a delineation of clinical privileges, staff category, and any applicable conditions and the applicant shall be so notified.
 5. Subject to any applicable provisions of Article VII, notice of the Board of Trustee's final decision shall be given in writing through the Hospital President to the applicant within five (5) working days of the final decision. The Chief of Staff shall give notice to the Medical Executive Committee and the Credentials Committee. In the event a hearing and/or appeal were held, the Fair Hearing Process shall govern notice of the Board of Trustee's final decision.
- J. Probationary Status. All initial appointments to any category of the medical staff shall be probationary for twelve (12) months. Each probationary appointee shall be monitored and reviewed by one or more appropriate member(s) as approved by the Medical Executive Committee unless such requirement is waived upon recommendation of the Medical Executive Committee and approval of the Board of Trustee's for initial appointments occurring during the first twelve (12) months from the date of the medical staff is first constituted at Hospital. The care observed shall be relevant to the privileges granted. The purpose of observation is to determine the individual's eligibility for advancement from probationary status and for exercising the clinical privileges provisionally granted. At the end of the probationary period the appointee must qualify for and be advanced to permanent staff status, or be extended on probationary status for an additional period not to exceed twelve (12) months, at the end of which time he will be reevaluated for advancement. No member may be on probationary status for a total period longer than twenty four (24) months.
- K. Previously Denied or Terminated Applicants. Notwithstanding any other provision of these bylaws, if an application is tendered by an applicant who has been previously denied membership and/or privileges, or who has had membership and/or privileges terminated, or whose prior application was deemed incomplete and withdrawn, and it appears that the application is based on substantially the same information as when previously denied, terminated, or deemed withdrawn, then the application shall be deemed insufficient by the Credentials Committee and returned to the applicant as unacceptable for processing. No such application shall be processed, and no right of hearing or appeal shall be available in connection with the return of such application. An individual who has previously resigned or voluntarily relinquished his or her privileges for failure to complete proctoring and/or probationary status may reapply but at four times the current application fee and will be subject to processing of the application as any new applicant and subject to the terms and conditions set forth in these bylaws for new applicants.

SECTION 6 - THE REAPPOINTMENT PROCESS

- A. Application. At least one hundred and eighty (180) days prior to the expiration of the Practitioner's current term of appointment, the medical staff office shall provide each member with an approved "Application for Reappointment" form which must be completed and returned with all required information within sixty (60) days to the medical staff office for review. The application shall be in writing on a form approved by the Board of Trustee's in consultation with the Medical Executive Committee, and it shall require detailed information concerning the changes in the applicant's qualifications since his or her last review. Information to be available for review shall include at least:

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1. objective evidence of the individual's clinical competence based on peer review activities.(e.g., QRC issues, complications, medical records issues, blood issues, tissue issues, utilization issues, mortalities)
2. Evidence of the individual's support of the medical staff and hospital (e.g., medical record deficiency/delinquency status, committee service, satisfaction of minimum patient care requirements to maintain staff category, compliance with the bylaws, rules and regulations, and applicable hospital policies).
3. Any request or recommendation for change in staff category or clinical privileges, citing the reasons and supporting information.
4. Evidence of consideration of the staff member's health status (subject to necessary reasonable accommodation to the extent required by law).
5. Information regarding any sanctions imposed by another health care facility, professional organization, or licensing authority.
6. information regarding any suspension, exclusion, debarment or sanction under the Medicare or Medicaid program or by any governmental licensing agency, or third party payor or the conviction of an offense related to health care, or listing by a federal or state agency as debarred, excluded, or otherwise ineligible for federal or state program participation.
7. malpractice claims experience since the last reappraisal, including at a minimum, final judgments and settlements against the applicant, identifying the case name, court, date of loss, date of disposition, amount paid in judgment or settlement and a description of the case.
8. Evidence of current licensure and DEA registration.
9. Evidence of professional liability coverage in the amounts required by the Board of Trustee's (carrier, type, policy number, amount, expiration date) and any limitations.
10. Information regarding previously successful or currently pending challenges to any licensure or registration (DEA) or the voluntary relinquishment of such licensure or registration.
11. Information regarding voluntary or involuntary termination of membership, or the voluntary or involuntary limitation, reduction, or loss of clinical privileges at another health care facility.
12. Evidence of a query sent to the National Practitioner Data Bank.
13. Information regarding any pending criminal charges or criminal convictions.
14. Information regarding termination from any professional liability program.
15. A letter of reference from the individual's current primary specialty facility.

The reapplication will be submitted to the Medical Staff Office for processing. The Medical Staff Office shall, in a timely manner, seek to verify the additional information made available on each reappointment application form and to collect any other material or information deemed pertinent.

- B. Failure to Complete Application/Incomplete Application. A practitioner who fails to return the form, to pay any application fees or to supply all of the required information within ninety (90) days prior to the expiration of the current appointment period or to respond in a timely manner to a request for information without good cause shall be deemed to have resigned his or her medical staff membership, effective as of the date of the expiration of his or her current appointment. A practitioner who is deemed to have resigned under this section shall not be entitled to the hearing and appeal rights under these bylaws. A practitioner whose privileges and membership have been deemed to be voluntarily relinquished for failure to complete the required application or timely submit the application may petition to appear before the Medical Executive Committee for the sole purpose of establishing "good cause." This shall not be deemed a hearing pursuant to these bylaws and shall not give rise to any other rights under these bylaws. The decision of the Medical Executive Committee shall be final.

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- C. Applicant's Responsibility. The applicant shall have the burden of producing adequate information for a proper evaluation of his or her current competence, character, skill, ethics, health status in terms of his ability to practice in the area in which privileges are sought (subject to necessary reasonable accommodation to the extent required by law), ability to work with others, and other qualifications. By applying for appointment or reappointment to the medical staff, or for clinical privileges, the practitioner agrees to comply with the medical staff bylaws, the medical staff rules and regulations, and applicable hospital and medical staff policies and procedures.
- D. Processing Delays. The time periods specified herein are to guide the parties in accomplishing their tasks but failure to meet the time periods suggested shall not be actionable.
- E. Credentials Committee Review. At least sixty (60) days prior to the final scheduled Board of Trustee's meeting in the medical staff term, the Credentials Committee shall review all pertinent information and within thirty (30) days make its written recommendation to the appropriate Medical Executive Committee concerning the member's reappointment and clinical privilege delineation. The reason for any change shall be documented.
- F. Medical Executive Committee Review and Recommendation. At least thirty (30) days prior to the last scheduled Board of Trustee's meeting in the medical staff term, the Medical Executive Committee shall meet and review all pertinent information and make its written recommendation to the Board of Trustee's through the Hospital President concerning each staff member's reappointment and clinical privilege delineation. When any change is recommended, the reason for such recommendation shall be stated and documented.

SECTION 7 - CLOSED STAFF; EXCLUSIVE CONTRACTS

- A. Exclusive Contracts. The Board of Trustee's may determine as a matter of policy and in accordance with State and Federal law that certain hospital clinical facilities may be used only on an exclusive basis in accordance with written contracts between the hospital and qualified professionals. These may include, but are not limited to, emergency care services, anesthesiology services, radiology services, pathology and clinical laboratory services. Applications for initial appointment or for privileges related to those hospital facilities and services specified in such contract(s) will not be accepted for processing unless submitted with confirmation from the Hospital President that they are from applicants that have an existing or proposed contract with the hospital.
- B. Contract Practitioners. A practitioner, who is providing contract services pursuant to Section 8A, must meet the same membership qualifications, must be processed for appointment, reappointment, and clinical privilege delineation in the same manner, and must fulfill all of the obligations for membership category and clinical privileges as any other applicant or member.
- C. Termination/Reduction of Privileges. Practice at the hospital is always contingent upon continued staff membership, and is also dependent on the clinical privileges granted. The right of a practitioner who is providing contract services to practice at the hospital is automatically terminated when his or her staff membership expires or is terminated. Similarly, his or her right to render services under the contract is automatically limited to the extent that his or her clinical privileges are reduced, restricted or terminated.

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- D. Expiration/Termination of Contract. The effect of expiration or other termination of a contract upon a practitioner's staff membership and clinical privileges will be governed solely by the terms of the practitioner's contract. If the contract is silent on the matter, then contract expiration or termination will not affect the practitioner's staff membership or clinical privileges, except that the practitioner may not thereafter exercise any clinical privileges for which the hospital has made exclusive contractual arrangements with another practitioner.

SECTION 8 - LEAVE OF ABSENCE FOR EDUCATIONAL, MEDICAL OR PERSONAL REASONS

- A. Request for Leave of Absence (LOA). A member may request a voluntary leave of absence from the medical staff by submitting a written request to the Hospital President who will transmit this request to the Credentials Committee and the Medical Executive Committee. The request shall state the reason for the request and the specific time period which may not exceed one year. All leaves must be approved by the Medical Executive Committee and the Board of Trustees. By requesting a leave of absence the member understands and agrees that he or she shall bear the burden of proof to demonstrate to the satisfaction of the Medical Executive Committee and the Board of Trustees that he or she is qualified for reinstatement. During the period of leave, the member's clinical privileges shall be inactive and he or she shall not be allowed to practice in the hospital without first requesting termination of the leave and reinstatement of privileges.
- B. Request for Reinstatement. At least thirty (30) days prior to termination of leave, or at any earlier time, the member may request reinstatement of privileges by submitting a written notice to that effect to the Hospital President, who will transmit this notice to the Credentials Committee and the Medical Executive Committee. The member must also submit a written summary, detailing his or her professional and patient care activities during the leave. The Credentials Committee shall evaluate the request and may deem it incomplete if any necessary information is not provided. The Medical Executive Committee, on receipt of the recommendation of the Credentials Committee, may deem the request incomplete, may request further information from the member, may defer action on the request, or may make a recommendation to the Board of Trustees concerning the reinstatement of the member's privileges and any conditions that should be attached. Thereafter, the procedure provided in Article III, Section 5 shall apply.
- C. Failure to Request Reinstatement. Failure without good cause to request reinstatement, to supply sufficient information for the request to be deemed complete, or failure to provide a summary of professional and other activities as above required shall constitute a voluntary resignation from the staff, effective at the end of the member's then 2 year appointment term or sooner if determined appropriate by the Medical Executive Committee. The Medical Executive Committee shall in its sole discretion, and after giving the practitioner an opportunity to address the Medical Executive Committee, determine whether good cause exists to continue the member's medical staff membership with leave. Such voluntary resignation shall not entitle the practitioner to the hearing and appeal rights under these bylaws. A request for staff membership subsequently received from this practitioner shall be treated and processed as an application for initial appointment.
- D. Routine Observation Requirements. In the discretion of the Medical Executive Committee, reinstatement may be made subject to an observation requirement for a period of time during which the practitioner's clinical performance is observed by one (1) or more designated medical staff members. Such routine

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observation shall not be considered disciplinary action and shall not entitle the practitioner to the hearing and appeal rights under these bylaws.

SECTION 9 - RESIGNATION FROM THE MEDICAL STAFF

Any practitioner who desires to resign from the medical staff must submit a letter of resignation, through the Credentials Review Chairman, to the Medical Executive Committee and the Hospital President. Such a practitioner's subsequent application for medical staff membership or clinical privileges will not be processed if he has any unfulfilled obligations under these bylaws or the rules and regulations, including, but not limited to, the need to complete delinquent medical records. Subsequent application for staff membership or clinical privileges will not be processed while outstanding obligations remain, and this status will be reported in response to any requests for references. Resignation while under investigation for any medical disciplinary cause or reason shall be reported to the appropriate agencies as required by State or Federal law.

SECTION 10 - HOSPITAL EMPLOYEES

The hospital may determine as a matter of policy that certain practitioners may be employed in accordance with a written contract between the hospital and the practitioner. An employed practitioner must meet the same membership qualifications, must be processed for appointment, reappointment, and clinical privilege delineation in the same manner, and must fulfill all of the obligations for membership category as any other applicant or member. The termination of the medical staff membership and privileges of an employed practitioner shall be handled in accordance with the provisions of Article VII, Section 11G.

SECTION 11 - HIPAA PRIVACY RULE COMPLIANCE

- A. Commitment to Privacy Rule Compliance. The use and disclosure of health information is governed by the Standards for Privacy of Individually Identifiable Health Information adopted by the U.S. Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time (the "Privacy Rule"), and other State and Federal law. Therefore, the Medical Staff and AHPs with service authorization at the Hospital shall protect the privacy of patients' health information as required by the Privacy Rule, other applicable law and the Hospital Privacy Policies and Procedures. Further, the Medical Staff and AHPs are committed to protecting the privacy of patient health information in a manner that reasonably minimizes disruption to quality patient care.
- B. Organized Health Care Arrangement.
1. General. The Privacy Rule permits multiple health care providers that are Covered Entities (as defined in the Privacy Rule) and provide health care in a clinically integrated care setting, such as the hospital setting, to declare themselves an "organized health care arrangement." Organized health care arrangement status generally permits its health care provider participants to use and disclose health information for purposes of treatment, payment and health care operations activities of the arrangement. As such, it protects patient privacy while minimizing disruption to quality patient care. Accordingly, the Hospital has organized an organized health care arrangement to facilitate the appropriate sharing of health information in the Hospital between and

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- among the Hospital, its workforce members and business associates, Practitioners and AHPs authorized to provide services at the Hospital (the "Hospital OHCA").
2. Agreement to Participate in OHCA. By applying for and exercising clinical privileges at the hospital each Medical Staff Member and AHP with service authorization agrees to participate in the Hospital OHCA.
- C. Joint Notice of Privacy Practices.
1. Agreement to Comply with Terms of Joint Notice. The Privacy Rule requires a health care provider that is a Covered Entity to deliver a notice of privacy practices to a patient no later than the provider's first date of service to the patient. Health care providers that participate in an organized health care arrangement may comply with this requirement by a joint notice. The implementation of a joint notice streamlines compliance with the Privacy Rule. Accordingly, with respect to Protected Health Information (as defined in the Privacy Rule) created or received by a Medical Staff member or an AHP in connection with his or her provision of services in the Hospital, the Medical Staff member or AHP agrees to abide by the terms of the joint Notice of Privacy Practices of the Hospital OHCA then in effect unless the Medical Staff Member or AHP has delivered a written notice to the Hospital specifying that he/she has opted out of the joint Notice of Privacy Practices.
 2. Revisions to Joint Notice. The Hospital may revise the Hospital OHCA's joint notice of privacy practices, in its reasonable discretion, upon thirty days notice of a revision (with a copy of the revised joint notice) to the MEC (unless the compliance date of a law necessitates a shorter notice period).
- D. Corrective Action. Whenever a Medical Staff member or AHP with service authorization uses or discloses health information in a manner inconsistent with the Privacy Rule, other applicable law, the Hospital Privacy Policies and Procedures or the Hospital OHCA's joint notice of privacy practices, such use or disclosure will be deemed disruptive to the operations of the Hospital and contrary to these Bylaws and Hospital policies. If the MEC determines that such an inconsistent use or disclosure has occurred, it may undertake such corrective action as it deems appropriate in accordance with these Bylaws and Hospital policies.

ARTICLE V - CATEGORIES OF THE MEDICAL STAFF

SECTION 1 - MEDICAL STAFF

The medical staff shall be divided into the following categories: active, courtesy, and consulting.

SECTION 2 - ACTIVE STAFF

The active staff category shall consist of practitioners who are located (primary or satellite office and temporary or permanent residence) within a reasonable distance to the hospital in order to provide continuous care to their patients. Active staff members assume the functions and responsibilities of membership including, when appropriate, emergency service care, disaster plan assignment, and consultation assignments. Members of the active staff shall be eligible to vote; serve on medical staff and Board of Trustee's committees; and shall attend not less than the number of medical staff and committee meetings required by these bylaws, rules and regulations. Active staff members shall participate in the quality/performance management activities required of the medical staff and shall serve, when qualified and required to do so, as proctors for other practitioners during any period of

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temporary privileges pending membership processing, during the initial membership probationary status period or for physician monitoring and education. Active staff members shall also provide on-call coverage for medical emergencies as provided in Article III, Section 3.C. When there is a bed shortage, regardless of the reason, active staff members will be granted priority over the members of all other medical staff categories for elective admissions subject of course to the needs of the patient in each case. Active staff members shall provide service to a minimum of 48 patients in their two year appointment period.

SECTION 3 - COURTESY STAFF

The courtesy staff category shall consist of practitioners who are located (primary or satellite office and temporary or permanent residence) within a reasonable distance to the hospital to provide continuous care for their patients. Courtesy staff members shall be members of the active or associate staff of another hospital in which their regular participation in quality/performance management activities is documented and their performance is evaluated. Courtesy staff applicants and members shall provide satisfactory evidence to the Credentials Committee of such membership, participation, and evaluation. Courtesy staff members are not eligible to vote on medical staff matters, or hold medical staff office. They may serve as voting members of designated hospital committees in which they may participate, except for the Credentials Committee and Medical Executive Committee. They shall not be required to attend medical staff meetings. At times of shortage of hospital beds or other facilities as determined by the Hospital President the elective patient admissions of courtesy staff members shall be subordinate to those of active staff members. Courtesy staff members shall provide service to a minimum of 6 patients in their two year appointment period.

SECTION 4 - CONSULTING MEDICAL STAFF

Qualifications/Prerogatives: The Consulting Medical staff shall consist of members who meet the general qualifications set forth in these Bylaws for active staff; who only provide limited services in this Hospital; who have satisfactorily completed one year in the probationary category including any proctoring requirements. Consulting Medical staff members are not eligible to admit patients to the hospital or exercise clinical privileges in the hospital unless they are able to demonstrate their current competence to do so. Consulting medical staff members may be required to practice with another fully privileged member of the medical staff. They cannot vote or hold office in this medical staff organization, but they may serve on committees with or without a vote, at the discretion of the Chairman of the Committee. Consulting Medical staff members may attend general staff meetings, including open committee meetings and educational programs. Consulting staff does not have a minimum patient requirement.

SECTION 5 – PROCTOR STAFF

The Proctor staff category shall consist of practitioners who meet the general qualifications set forth in these Bylaws for active staff. Proctoring staff members may provide their educational expertise to another fully privileged member of the medical staff. Proctoring staff will not provide professional services or care for patients in the hospital. Proctoring staff are not eligible to admit to the hospital and will not exercise any clinical privileges. They are not eligible to vote on medical staff matters, hold medical staff or departmental office or serve on committees.

SECTION 6 – RESIDENT STAFF

- A. The terms “residents” as used in these bylaws, refer to practitioners who are currently enrolled in a graduate medical education program approved by the Medical Executive Committee and the Governing

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Board. Residents shall be considered independent practitioners. In compliance with federal laws, it shall be necessary to submit a query to the National Practitioner Data Bank prior to permitting a resident to provide services at this hospital. Residents may render patient care services at the hospital only pursuant to defined privileging responsibilities.

- B.
- C. While functioning at this hospital, residents shall abide by all provisions of the medical staff bylaws, rules and regulations, and hospital and medical staff policies, and shall be subject to limitation or termination of their ability to function at the hospital at any time in the discretion of the Hospital President or the Chief of Staff. Residents may perform only those services set forth in the protocols developed by the applicable training program to the extent that such services do not exceed or conflict with the rules and regulations of the medical staff or hospital policies and to the extent approved by the Governing Board.
- D. Residents are distinguished from practitioners who, though currently enrolled in a graduate medical education program, provide services independently at the hospital (e.g., moonlighting or locum tenens coverage) and not as part of their educational program; such practitioners who provide independent services must meet the qualifications for medical staff membership and privileges and shall be credentialed in the same manner as a practitioner seeking initial appointment to the medical staff.

SECTION 7 - ALLIED HEALTH PROFESSIONALS

- A. General. All Allied Health Professionals working at this hospital must be under the supervision of a member of the medical staff or, for providers authorized by law and the hospital to work independently, an appropriate service. Allied Health Professionals are not members of the medical staff but may hold designated clinical privileges.
 - 1. Allied Health Professionals (AHPs) are health care providers who:
 - (a) hold a current, valid and unrestricted license, certificate, or other legal credential as required by this state which authorizes the AHP to provide patient care services or, if the State does not license or certify individuals performing the services for which privileges are requested, demonstrate current competence and ability to work under the direct supervision of a member of the medical staff;
 - (b) are in a category of AHPs designated by the Board of Trustee's to provide practice prerogatives under a defined degree of supervision and monitoring, and are individually designated by the Board of Trustee's of this hospital to exercise specific practice prerogatives in this hospital; and
 - (c) Meet the qualifications in these rules and regulations, in the referenced sections of the medical staff bylaws, in medical staff rules and regulations, and applicable medical staff and hospital policies.
 - 2. AHPs are not entitled to medical staff membership or prerogatives.
 - 3. AHPs are not entitled to the hearing or appeal rights in the Fair Hearing Process.
 - 4. Nothing in these bylaws is to be interpreted to construe AHPs as a separate or self-governing entity.
- B. Qualifications. To be eligible for, and to maintain practice prerogatives a AHP must at a minimum meet each of the following requirements in addition to any requirements recommended by the medical staff executive committee and required by the Board of Trustee's:

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1. hold a current, unrestricted license/certificate/appropriate legal credential in a category of AHPs that the Board of Trustee's has identified as eligible for practice prerogatives;
2. document his background, relevant training, education, experience, demonstrated current competency, judgment, character, and physical and mental health status (subject to reasonable accommodation if and to the extent required by law), with sufficient adequacy to demonstrate that patient care services will be provided by the AHP at the professional level of quality and efficiency established by the medical staff and Board of Trustee's;
3. submit an application for practice prerogatives on the form prescribed by the medical staff and Board of Trustee's, providing requested information and documentation;
4. provide written confirmation of the existence and extent of required supervision by a physician member of the medical staff as required by the Board of Trustee's;
5. document his strict adherence to the ethics of the medical staff and of the AHP's respective profession; his ability and agreement to work cooperatively with others in the hospital setting; and his willingness to commit to and regularly assist the hospital in fulfilling its obligations related to patient care within the areas of the AHP's professional competence and credentials; and
6. Maintain professional liability insurance in amounts, of a type, and with a carrier, as required by the Board of Trustee's.

C. Procedure for Granting Practice Prerogatives.

1. Each AHP must apply and qualify for practice prerogatives by submitting an application on the approved form, providing all necessary information, and agreeing to be bound by the applicable medical staff bylaws, rules and regulations, and medical staff and hospital policies. Applications for initial practice prerogatives, and at a minimum biennial renewal thereof, shall be submitted and processed in accordance with the procedures stated in the medical staff bylaws and the applicable provisions of the medical staff rules and regulations; however, AHPs shall not be entitled to the hearing or appeal rights in the medical staff bylaws. There must be verification that each AHP's required licensure/certification/registration is current and unrestricted, and documentation that each AHP has the required type and amount of professional liability insurance in full force.
2. Each AHP who is granted practice prerogatives must be under the supervision of a physician on the medical staff or purposes of supervision and reporting. The degree of supervision required, whether direct or remote, shall be clearly established for each AHP.
3. For each category of AHP it shall be determined whether or not they may make entries in the medical record and whether countersignatures are required and by whom.
4. Unless otherwise specified in the bylaws or medical staff rules and regulations, AHPs shall be subject to terms and conditions paralleling those in the bylaws as they apply to the more limited practice of AHP's.
5. A system for objectively evaluating the performance of each AHP on a periodic basis within the Quality/Performance Improvement Program shall be established. The findings of these evaluations shall be considered in any decision to renew "practice prerogatives."
6. All rules and qualifications shall be applied uniformly to all AHPs in a given category.
7. No AHP shall be entitled to exercise any practice prerogative at this facility without prior approval of the Board of Trustee's, because the individual previously was permitted to exercise that prerogative at this or any other institution or because the individual is permitted to perform that prerogative under state law. This hospital is not required to grant all or any prerogatives permitted by law or requested by an individual.

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- D. Responsibilities. As a condition of applying for, or being granted a practice prerogative, each AHP agrees to:
1. fulfill those responsibilities required by the medical staff bylaws, rules and regulations, and applicable medical staff and hospital policies;
 2. retain appropriate responsibility within the AHP's area of professional competence and within the scope of practice prerogatives granted, for the care of hospital patients;
 3. participate, as appropriate, in quality/performance review including but not limited to evaluations, and monitoring activities required of AHPs, in supervising initial appointees of the AHP's same profession, and in discharging such other functions as may be required from time to time;
 4. serve on medical staff and hospital committees to which the AHP is assigned;
 5. attend the meetings to which the AHP is assigned, as permitted by medical staff rules and regulations;
 6. attend educational programs in the AHP's field of practice as may be required by the hospital, by licensure, certification, registration, or the supervising practitioner;
 7. comply with the terms and conditions of the granting of practice prerogatives and all policies, procedures and protocols that may be implemented from time to time by the medical staff or hospital;
 8. maintain the confidentiality of all peer review related matters and waive any right under state law to voluntarily disclose such matters; and
 9. maintain the confidentiality of all individual patient identifiable information in accordance with State and Federal regulations, as well as with the Hospital Privacy Policies and Procedures.
- E. Termination of Practice Prerogatives. An AHP's practice prerogatives shall terminate automatically at the sole discretion of the Hospital President, Chief of Staff or supervising physician upon the occurrence of any of the following:
1. suspension, restriction, termination, voluntary relinquishment, or the imposition of terms of probation (whether voluntary or involuntary) on the medical staff membership or privileges of any supervising practitioner;
 2. termination of the supervisory/sponsoring relationship between the AHP and the supervising practitioner;
 3. suspension, revocation, expiration, voluntary or involuntary relinquishment or restriction, termination, or imposition of terms of probation by the applicable licensing or certifying agency of the AHP's license, certificate or other legal credential which authorizes the AHP to provide health care services;
 4. failure of the AHP to perform properly assigned duties including but not limited to medical record completion;
 5. conduct by the AHP which interferes with or is detrimental to the provision of quality patient care;
 6. failure of the AHP to maintain professional liability insurance as required;
 7. failure of the supervising physician to maintain professional liability insurance as required;
 8. failure of any supervising practitioner to maintain active staff membership and clinical privileges in good standing;
 9. termination of the supervising practitioner's professional services contract, if any, with the hospital.

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- F. Grievance Process. Nothing in the Medical Staff Bylaws shall be interpreted to entitle an AHP to the rights granted pursuant to the Fair Hearing Process. However, an AHP shall have the right to challenge any action that would constitute grounds for a hearing under these Bylaws by filing a written grievance with the Medical Executive Committee within fifteen (15) days of this action. Upon receipt of the grievance, the Medical Executive Committee shall conduct an investigation, not to exceed 60 days or at a time established by MEC, that affords the AHP an opportunity for an interview concerning the grievance. The interview shall not constitute a "hearing" as established by the Fair Hearing Process and need not be conducted according to the procedural rules applicable to those hearings. Before the interview, the AHP shall be informed of the specific circumstances giving rise to the action and the AHP may present relevant information at the interview. A record of the interview shall be made and a recommendation on the action shall be made by the Medical Executive Committee to the next scheduled Board of Trustee's meeting. The Board of Trustee's shall review the recommendation and the supporting material and shall make a decision on the action, which decision shall be final.
- G. Hospital Employees. Nothing in these rules and regulations shall be construed to interfere with the hospital's right to terminate hospital employees in accordance with hospital personnel policies.

ARTICLE VI - CLINICAL PRIVILEGES

SECTION 1 - EXERCISE OF PRIVILEGES

Every practitioner providing direct clinical services including but not limited to telemedicine services, at this hospital, by virtue of membership or otherwise, shall, in connection with such practice and except as provided in Sections 3 and 4 below, be entitled to exercise only those privileges specifically granted to him by the Board of Trustee's. The privileges must be within the scope of the license authorizing the practitioner to practice in this state. Regardless of the privileges granted, each practitioner must obtain consultation when necessary for the safety of his patients or when required by these bylaws, the medical staff rules and regulations and other policies of the medical staff and the hospital.

SECTION 2 - DELINEATION OF CLINICAL PRIVILEGES

- A. Application. Clinical privileges may be granted only upon formal request on forms provided by the hospital with subsequent processing and approval. Telemedicine Practitioners must submit an application for telemedicine privileges. Every application for staff appointment and reappointment must contain a request for the specific clinical privileges desired by the applicant. A request by a practitioner for a modification of privileges must be supported by documentation of additional training and/or experience supportive of the request.
- B. Basis for Privilege Determination. Requests for clinical privileges shall be evaluated on the basis of the practitioner's current licensure, relevant training, experience, education; demonstrated current competence; any required references; the ability to perform the privileges requested and other relevant information and health status (subject to necessary reasonable accommodation to the extent required by law). In granting privileges, consideration must be given to objective information received from sources outside the hospital, to the need for an adequate ongoing successful experience to maintain proficiency, to the hospital's ability to support such patient care services, and to the objective findings of patient care evaluation and peer review activities. Peer input shall be obtained and considered in determining clinical privileges.

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- C. Procedure. All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article IV for medical staff membership. The Medical Executive Committee shall develop criteria for determining an applicant's ability to provide patient care services within the scope of clinical privileges requested. These criteria are in addition to the medical staff criteria for medical staff membership and clinical privileges.
- D. Special Conditions for Clinical Privileges. Requests for clinical privileges for dentists and podiatrists shall be processed in the manner specified in this Article for other practitioners. The granting of privileges shall be based on their training, experience, education, health status in terms of the applicant's ability to practice in the area in which privileges are sought, demonstrated current competence, and the need for their services in the hospital. Surgical procedures that each dentist and podiatrist may perform shall be under the overall supervision of the Medical Executive Committee. An adequate history and physical examination on all dental and podiatric patient admissions shall be performed and recorded in the medical record by a physician member of the medical staff, or, in some cases by a physician approved by the medical staff. The dentist or podiatrist shall be responsible for completing the part of the history and physical examination related to any dental or podiatric problem justifying the reason for admission. A physician member of the medical staff must be assigned the responsibility for the care of any medical problem present at the time of admission or that arises during hospitalization.
- E. Unavailable Clinical Privileges. Notwithstanding any other provisions of these bylaws, to the extent that any requested clinical privilege is not available at the hospital (whether because of exclusive contract, lack of facilities, policy decision of the Board of Trustees, or otherwise), the request shall be rejected without the necessity of processing pursuant to Section 2C above. Because such a rejection is unrelated to the applicant's qualifications, an applicant whose request is so rejected shall not be entitled to the hearing and appeal rights under these bylaws.

SECTION 3 - TEMPORARY PRIVILEGES

- A. Qualifications for Temporary Privileges. There is no right to temporary privileges. Prior to temporary privileges being granted, a practitioner must demonstrate that he or she has appropriate professional qualifications, an unrestricted, current state license, a current and unrestricted DEA registration, documentation of professional liability insurance coverage as required by the Board of Trustees, and no subsection to involuntary limitation, reduction denial or loss of clinical privileges, and a query must be submitted as required by federal law to the National Practitioner Data Bank. By applying for temporary privileges all practitioners agree to be bound by the medical staff bylaws, rules and regulations, and applicable medical staff and hospital policies.
- B. Authority to Grant Temporary Privileges/Conditions.
1. The Hospital President or his or her designee, with the written concurrence of the Chief of Staff, or in his or her absence, the Credentials Review chairman, may grant temporary privileges under the circumstances noted below. In all cases, temporary privileges shall be granted for a specific period of time, not to exceed thirty (30) days. After that period of time the practitioner may request a renewal of temporary privileges for another specific period of time. Under no circumstances shall temporary privileges be extended for more than ninety (90) consecutive days. Temporary privileges shall terminate automatically at the end of the specific period for which they were

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granted, without the hearing and appeal rights set forth in these bylaws. Special requirements of supervision and consultation may be imposed upon the granting of temporary privileges.

2. In all cases, if temporary privileges are granted prior to the medical staff and Board of Trustee's receipt and review of a report from the National Practitioner Data Bank (NPDB), the practitioner agrees, as a condition of applying for or being granted temporary privileges, that such privileges are strictly conditioned upon the receipt and review of a response from the NPDB deemed favorable by both the Medical Executive Committee and the Board of Trustee's. In the event that a response is received which the Medical Executive Committee or the Board of Trustee's believes warrants further investigation, then the practitioner's conditional temporary privileges shall automatically and immediately expire and his or her application for temporary privileges shall be deemed incomplete. Irrespective of any other provision of these bylaws, any practitioner whose temporary privileges automatically expire under this provision shall not be entitled to the hearing and appeal rights under these bylaws.
3. Temporary privileges may be granted for:
 - (a) Care of a Specific Patient. Temporary privileges may be granted to a practitioner who is not an applicant for staff membership but whose services are required for the care of a specific patient who is not transportable and the required expertise is not available through the medical staff membership.
 - (b) Locum Tenens. Temporary privileges may be granted to a qualified practitioner serving as locum tenens for a member of the medical staff. Such privileges shall be limited based on the locum tenens practitioner's individual training, experience and qualifications. The locum tenens practitioner will not be granted privileges in excess of those granted to the practitioner being temporarily replaced, unless an exception is granted by the medical staff and the Board of Trustee's.
 - (c) Pending Appointment to the Medical Staff. In addition to the requirements noted in Section 3A above, the applicant's professional degree must be verified (e.g., M.D., D.O.) as well as his current license, current DEA registration and/or state drug license, any specialty training claimed, at least two (2) references relating positively to professional and ethical status and ability to perform the privileges requested, documentation of the required professional liability insurance coverage and the endorsement of the chairman of the Credentials Committee. Temporary privileges may be granted for no more than three (3) separate and successive thirty (30) day periods at which time they automatically expire without the right to a hearing or appeal under these bylaws. The applicant shall be under the supervision of the Chief of Staff. All of the care provided by the practitioner shall be reviewed during this period. Special consultation requirements and reporting may be imposed by the supervising practitioner.
 - (d) Participant in a Peer Review Committee. In the situation where there are no members of the medical staff who are qualified or available to act as a member of a Peer Review Committee, temporary privileges may be granted to a qualified individual for the limited purpose of participating as a member of a Peer Review Committee as defined under Article VII of these bylaws.
 - (e) Participate as a Consultant on Peer Review Matters. In those cases where a peer review committee deems it necessary to obtain a review of a practitioner's practice by an outside consultant who is not a member of the medical staff, the outside consultant may be

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granted temporary privileges for the limited purpose of conducting the review, reporting to the peer review committee and for testifying at a hearing or appeal with regard to that review.

- C. Denial, Termination or Restriction of Temporary Privileges. Temporary privileges, unless acted upon pursuant to other provisions of these bylaws, shall terminate automatically at the end of the specific period for which they were granted, without the hearing and appeal rights under these bylaws. The Hospital President, Chief of Staff or their designees may terminate or restrict temporary privileges, for any reason, including in the event of the discovery of negative information, questionable qualifications/ability or false information provided by the practitioner, or when the life or health of a patient could be endangered by the treatment by that practitioner or for disruptive, unprofessional, unethical or inappropriate behavior or for similar reasons. No practitioner is entitled to the hearing and appeal rights set forth in these bylaws for the denial, non-renewal, restriction or termination of temporary privileges, unless such action must be reported pursuant to State or Federal requirements. In the event a practitioner's temporary privileges are terminated or restricted, the practitioner's patients then in the hospital shall be assigned to another practitioner by the by the Chief of Staff. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

SECTION 4 - DISASTER PRIVILEGES

In the event that the hospital has activated its emergency management plan and is unable to meet patient's needs, any member of the Medical Staff, to the degree permitted by his license and regardless of the Service or Staff status or lack of it, shall be permitted and assisted to do everything possible in event of any emergency involving a patient, using every facility of the Hospital necessary or desirable. The Hospital President, the Chief of Staff or their respective designee(s) shall have the right to grant disaster privileges to physicians who are not members of the medical staff upon presentation of any of the following: (1) a current picture ID card, (2) a current license to practice medicine and valid picture ID issued by a state, federal or regulatory agency, (3) identification indicating that the individual is a member of a Disaster Medical Assistance Team, (4) identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances by a federal, state or municipal entity or (5) presentation by current hospital or medical staff member(s) with personal knowledge regarding the individual's identity. Provided, however, that each person authorized to grant disaster privileges shall not be required to grant such privileges to any person and shall make such decisions on a case-by-case basis at his or her discretion. Verification of the individual's credentials as required for the granting of temporary privileges shall be a high priority, beginning as soon as the immediate situation is under control. When an emergency situation no longer exists, such physician, or dentist must request the privileges necessary to continue to treat the patient. In the event such privileges are denied, or if he does not desire to request privileges, the patient must be referred to an appropriate member of the Medical Staff.

SECTION 5 - CHANGE IN MEMBERSHIP, PRIVILEGES OR STAFF CATEGORY

A staff member may request a change of staff category or privileges by submitting a written request to the medical staff office. Criteria used for a change of status will be based on the staff category requested and will only be reviewed annually. Criteria for a change in privileges or additional privileges shall be processed in the same manner as an initial or reappointment application. All changes or additions must be recommended by the Credentials Committee to the Medical Executive Committee for approval and is subject to approval by the Board of Managers.

SECTION 6 - EXPEDITED PROCESS FOR INITIAL APPOINTMENT

In exceptional circumstances, an expedited processing of a particular application may be necessary to satisfy a demonstrated patient care or Hospital need. In such exceptional circumstances, the evaluation of an application on an expedited basis shall be performed pursuant to the following criteria. If the application is deemed incomplete, or if at any step of the approval process, a review is unfavorable to the Practitioner, the application may be sent through the customary application process and will no longer be eligible for expedited processing.

A. Criteria for expedited processing:

1. satisfaction of all the qualifications to be considered for Medical Staff membership as delineated in these Bylaws, the Rules and Regulations and any applicable Hospital and Section policy or procedure;
2. proof of acceptable malpractice claims history activity (including past and current malpractice claims, settlements or judgments) in light of the Practitioner's specialty;
3. demonstration of acceptable practice history (e.g. the Practitioner has no unexplained gaps in chronological school, training or practice history);
4. receipt of unanimously favorable peer recommendations;
5. absence of any disciplinary actions or special conditions during medical school, residency and/or fellowship training;
6. absence of any investigations, denials, restrictions, lapses, probations suspensions or limitations on the DEA certificate or DPS registration;
7. absence of any investigations, denials, restrictions, lapses, probations, suspensions or limitations on any current or previous professional license in Texas or in any other jurisdiction;
8. absence of any restrictions, limitations, probations, withdrawals, special conditions, reductions or denials of medical staff membership or clinical privileges by any hospital or health care entity;
9. absence of any sanctions, exclusions or limitations imposed by any medical organization or professional review organization;
10. no criminal history or felony convictions;
11. no past or pending sanctions, limitations or exclusions from participation in any governmental or private third party agency, reimbursement program, including participation in the Medicare and Medicaid programs;
12. no history of substance abuse or health conditions that may adversely affect the practitioner's ability to perform clinical privileges requested; and

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13. recommendation by for expedited review of practitioner's request for membership and clinical privileges.

All information on the application shall be verified via facsimile and/or mail in accordance with these Bylaws.

B. Expedited processing will include:

1. Email request for Dictation and patient registration system numbers from the Medical Staff Services office for the following:
 - Office address
 - Phone number
 - Fax number
 - License number
 - NPI
 - DEA and DPS numbers (if required for clinical practice)
 - Date of Birth
 - Social Security Number
2. The Credentials Chairman, on behalf of the Credentials Committee, shall review the expedited application, supporting documentation and shall determine if the Practitioner has satisfied the minimum eligibility criteria for appointment to the Medical Staff and for the requested clinical privileges.
3. The Chairman of the Credentials Committee shall forward a recommendation in writing to the Chief and/or Vice Chief of Staff and the Hospital President for action.
4. The Chairman of the MEC and the Hospital President, or their designees, shall take action on the application and request for clinical privileges. To the extent membership on the Medical Staff and clinical privileges are so granted, such membership and privileges shall take effect immediately upon the signature of the Hospital President, subject to ratification at the next Board of Managers meeting.
5. If the Board of Managers does not ratify the grant of Medical Staff membership or clinical privileges, then such membership or privileges shall be deemed immediately revoked and the Practitioner shall be entitled to a right to a hearing under these Bylaws.

ARTICLE VII - CORRECTIVE ACTIONS

SECTION 1 - ALTERNATIVES TO CORRECTIVE ACTION

Under certain circumstances, routine monitoring and education of a practitioner in accordance with Medical Staff procedures, may be an appropriate alternative to corrective action.

SECTION 2 - CORRECTIVE ACTION

- A. Grounds: Initiation. Except as otherwise provided in Article IV above, whenever the conduct of any medical staff member ("affected practitioner") is considered to be lower than the standards of the medical staff; or to be disruptive to the operations of the hospital; or to constitute Disruptive Behavior, Discrimination or Harassment; or to constitute fraud or abuse or other criminal conduct; or to be detrimental to the quality of patient care at the hospital; or to be detrimental to the hospital's licensure or accreditation; or to be detrimental to hospital or medical staff efforts to comply with any professional review organization, third-party payor (private or governmental), or utilization review requirements; or in violation of patient or peer review confidentiality; or to be in violation of the medical staff bylaws, rules and regulations, or policies of the hospital, medical staff or committee thereof; or to be in violation of the ethics of their profession; or if any affected practitioner has been suspended, excluded, debarred or sanctioned under the Medicare or Medicaid program or by any governmental licensing agency, or convicted of any offense related to health care, or listed by a federal or state agency as debarred, excluded or otherwise ineligible for federal or state program participation, then corrective action may be requested against such practitioner by the requesting party who may be any member of the Active medical staff or the Board of Trustee's, or the Hospital President. All requests for corrective action shall be in writing, shall be submitted to the Medical Executive Committee through its chairman, and shall set forth the specific conduct constituting the basis for the request.
- B. Investigation. The Medical Executive Committee, before taking action on the request, shall conduct such investigation as it deems necessary, which may, in its discretion, include informal interviews with the requesting party and the affected practitioner (each out of the presence of the other), informal interviews with or reports from other persons including external consultants, any required chart reviews, if applicable. Neither the investigation nor any other activities of the Medical Executive Committee in acting upon a request for corrective action shall constitute a hearing; they shall be informal, and none of the hearing and appeal rights under these bylaws shall apply during the investigation. In the event the affected practitioner resigns his or her medical staff membership or privileges during the course of an investigation undertaken pursuant to this section, such resignation shall be reported to the required agencies in accordance with State and Federal laws.
- C. Time for Taking Action; Notice; Right to Hearing. Within sixty (60) days after receipt by the Medical Executive Committee of a request for corrective action, or within such reasonable additional time as the Medical Executive Committee deems necessary, the Medical Executive Committee shall take action upon the request. If that action is adverse to the practitioner, the Medical Executive Committee, within five (5) days after taking action, shall give written notice to the affected practitioner and the Board of Trustee's stating which of the actions set forth in this Section the Medical Executive Committee has taken or recommended. If the action is of a type requiring notice as described Article VIII, Sections 2 or 4, the notice shall comply with the applicable Sections of Article VIII. In no event shall the practitioner be entitled to the rights under Article VIII when the only action of the Medical Executive Committee was to issue a letter of admonition or reprimand.
- D. Possible Actions. The action of the Medical Executive Committee on a request for corrective action may be to: (1) reject the request; (2) issue a letter of admonition or reprimand; (3) impose terms of probation or recommend mandatory proctoring, co-admitting, or consultation; (4) recommend reduction, suspension, or revocation of clinical privileges; (5) recommend that an already imposed summary suspension of

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membership or clinical privileges be terminated, modified, or sustained; (6) recommend that the practitioner's membership be suspended or revoked; or (7) take or recommend other actions deemed appropriate by the Medical Executive Committee.

- E. Notice to Hospital President. The chairman of the Medical Executive Committee shall promptly notify the Hospital President in writing of each request for corrective action received by the Medical Executive Committee and the date of its receipt, and shall keep the Hospital President fully informed of all communications, meetings, and actions in connection with each request.
- F. Board of Trustee's Action. If, after receiving either written notice of alleged conduct constituting grounds for corrective action, or a written request for corrective action, the Medical Executive Committee fails or declines to investigate or initiate corrective action, the matter shall be forwarded to the Board of Trustee's. If the Board of Trustee's reasonably determines that the Medical Executive Committee's action or inaction is contrary to the weight of the evidence presented, the Board of Trustee's or its designee shall consult with the Chief of Staff. Thereafter the Board of Trustee's or its designee may direct the Medical Executive Committee to conduct an investigation or otherwise initiate corrective action. In the event the Medical Executive Committee fails to take action in response to a direction from the Board of Trustee's (or its designee), then the Board of Trustee's (or its designee) after written notification to the Medical Executive Committee, may conduct an investigation or otherwise initiate corrective action proceedings. If applicable, such proceedings shall afford the affected practitioner the hearing and appeal rights described in these bylaws.
- G. Use of Membership/Privileges. The affected practitioner shall retain the use of his membership and privileges pending final action by the Board of Trustee's unless such membership and/or privileges are otherwise suspended as provided in this Article.

SECTION 3 - SUMMARY SUSPENSION OR SUMMARY RESTRICTION

- A. Grounds; Authority. All or any portion of a practitioner's clinical privileges may be summarily suspended or restricted where the failure to take summary action may result in imminent danger to the health or safety of any individual. The following persons are authorized by the medical staff to take summary action: the Medical Executive Committee or the Hospital President with contact to Chief of the Medical Staff as soon as possible. Suspension or restriction pursuant to this paragraph shall be temporary and effective only until further action is taken by the Medical Executive Committee pursuant to Section 2 D. When no person or committee referenced above is available to impose a summary suspension or restrict clinical privileges, the Board of Trustee's, or its designee, may take such action if a failure to do so would be likely to result in an imminent danger to the health or safety of any individual. Prior to exercising this authority, the Board of Trustee's, or its designee, must make reasonable attempts to contact the Chief of Staff, as the designee of the medical staff, another medical staff officer or the chairman or designee. Summary action by the Board of Trustee's which has not been ratified by the Chief of Staff, as the designee of the medical staff, or by the Medical Executive Committee within two (2) working days, excluding weekends and holidays, shall terminate automatically without prejudice to further summary action as warranted by the circumstances.
- B. Effective Date; Notice. A summary suspension or restriction shall become effective immediately upon imposition and the person or body imposing same shall promptly give written or oral notice of the suspension or restriction to the suspended practitioner, stating by whom it was imposed and the reasons for same. The notice shall be deemed to have been given on the date on which it is either personally

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delivered or mailed to the suspended practitioner, whichever occurs first. The notice, or a written confirmation of it, shall inform the suspended practitioner: (1) of his or her right to an informal interview upon his or her written request under Section 2 C; (2) whether the action is reportable pursuant to any State or Federal Statute; (3) if the suspension could be reportable to the National Practitioner Data Bank; and (4) that even if the suspension or restriction is terminated when the Medical Executive Committee takes further action under 2 D, the practitioner will be entitled to hearing at which the sole issue will be whether there was probable cause for the summary suspension or restriction. A copy of the notice shall promptly be delivered to the Hospital President, the Medical Executive Committee, and the Board of Trustee's.

- C. Investigation. The Medical Executive Committee, before taking further action, shall conduct such investigation within 14 days, which shall include at least one (1) meeting of the Medical Executive Committee and/or a designated sub committee of the MEC; and may include an informal interview with the suspending party. An informal interview with the affected practitioner (out of the presence of the suspending party, if other than the Medical Executive Committee) may be held if the affected practitioner delivers a request for an informal interview in writing within seven (7) days after notice of the suspension was given to him. The Medical Executive Committee's or designated sub committee's investigation may include chart reviews, if applicable, and informal interviews with or reports from other persons or relevant committees. Neither the investigation nor any other activities of the Medical Executive Committee in taking its further action shall constitute a hearing; they shall be informal, and none of the hearing and appeal rights under these bylaws shall apply. In the event the affected practitioner resigns his or her medical staff membership or privileges during the course of an investigation pursuant to this section, such resignation shall be reported to the required agencies in accordance with State and Federal law.
- D. Further Action; Time. Within fourteen (14) days after the date of the suspension, the Medical Executive Committee shall take further action with respect to the suspension, and may modify, continue for a definite or indefinite period, or terminate the summary suspension or restriction. Such further action shall remain in effect unless and until altered or terminated pursuant to other provisions of these bylaws. If the Medical Executive Committee upholds a summary suspension, it shall also decide if the affected practitioner's medical staff membership and clinical privileges should be terminated. The Medical Executive Committee shall promptly give written notice of its further action to the suspended practitioner, the Hospital President and the person or body who imposed the suspension or restriction (if other than the Medical Executive Committee).
- E. Rights to Hearing. Following the decision of the Medical Executive Committee regarding further action, the provisions of Article VIII shall govern the mediation, hearing and appeal rights under these bylaws.
- F. Alternate Patient Coverage. Immediately upon the imposition of a summary suspension or restriction, the Chief of Staff shall provide for alternate medical coverage by a member of the medical staff for the patients of the suspended practitioner remaining in the hospital at the time of such suspension, if the privileges to provide such coverage were suspended. The wishes of the patients shall be considered in the selection of such alternate coverage.

SECTION 4 - AUTOMATIC SUSPENSION; TERMINATION

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The following shall result in the automatic suspension and possible termination of medical staff membership and/or clinical privileges and shall not entitle the affected practitioner to the hearing and appeal rights specified in these bylaws, unless otherwise expressly provided.

- A. Medical Records; Suspension. Practitioners must complete their patients' medical records within thirty (30) days of each patient's discharge, or within such time as the Board of Trustee's requires. Medical records that the practitioner fails to complete within the required period will be considered delinquent. The Medical Records Department shall send a written notice, including all records that are at or near delinquent status, to a practitioner indicating that his or her clinical privileges will be automatically suspended if such records are not completed. The first (1st) letter will be sent on the 14th day. Notice shall be sent by either fax, personal delivery or by certified mail, or return receipt requested. If the practitioner does not complete the medical records, a second (2nd) letter will be sent on the 21st day. If the practitioner does not complete the medical records within 30 days of patient's discharge, a temporary suspension of all privileges shall be automatically imposed by the Hospital President after consultation with the Chief of Staff with regard to whether the delinquency is based upon a medical disciplinary cause or reason. Such suspension shall be effective until the medical records in issue are satisfactorily completed. The suspension may be terminated by the joint action of the Hospital President and the Chief of Staff if they, or their designees, determine that failure to timely complete the records was justified (e.g., illness or other circumstances beyond the control of the affected practitioner) or, upon the request of the suspended practitioner, the Hospital President may temporarily lift the suspension only if it is determined that an emergency exists in which the health and safety of any patient will be jeopardized by failure to allow the practitioner to treat that patient. With the exception of emergency care approved by the Hospital President, with the approval of the Chief of Staff if needed, and the care of patients already hospitalized at the time of the suspension, such temporary suspension shall include all admitting and clinical privileges, as well as the scheduling of elective operations, assisting at elective operations, and deliveries. Unverified emergency admissions shall not be used to bypass such suspension. Failure to complete the medical records within three (3) months from the date of such suspension shall constitute a voluntary relinquishment of all clinical privileges and resignation from the Medical Staff. Reapplication to the Medical Staff can be made following completion of all incomplete records. The application process shall proceed in the same fashion as any new application to the Medical Staff. Suspensions for delinquent medical records do not preclude physicians from participating in the emergency room call panel.

Practitioners whose clinical privileges are automatically suspended or who have been deemed to have voluntarily resigned from the staff pursuant to this Section, shall only be entitled to the hearing and appeal rights set forth in Article VIII if the Medical Executive Committee, determines in conformity with applicable state law, that the medical record delinquencies are based on a medical disciplinary cause or reason, and if it is reportable under any State or Federal regulations. In all other instances, no hearing and appeal rights are available to any practitioner whose clinical privileges are automatically suspended or deemed resigned due to incomplete medical records. Such affected practitioner may petition to appear before the Medical Executive Committee for the sole purpose of establishing good cause for failure to complete medical records. The decision of the Medical Executive Committee following this appearance shall be final.

- B. Licensure. Whenever a practitioner's license to practice in this state is revoked, not renewed, restricted, suspended, voluntarily relinquished or made subject to any probationary provisions by the licensing agency, the practitioner's staff membership and clinical privileges shall automatically terminate upon receipt by the hospital of notice thereof. If a practitioner's license to practice is made subject to probationary terms by the licensing agency, the practitioner's privileges and membership shall automatically become subject to

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the terms of probation, subject to review by the Medical Executive Committee and approval by the Board of Trustee's. Action automatically imposed under this Section does not entitle the practitioner to the mediation, hearing and appeal rights provided under Article VIII of these bylaws.

- C. Drugs/Medication. A temporary automatic suspension of a practitioner's privileges to prescribe or obtain controlled substances or other medications at or through the hospital or any of its facilities shall be immediately imposed by the Hospital President upon the receipt by the hospital of notice that such practitioner's right or license to prescribe or obtain controlled substances or medications has been suspended, revoked or otherwise restricted by the applicable governmental agency. Such automatic suspension shall include only those controlled substances or medications suspended or revoked by the governmental agency and shall be effective until the governmental agency reinstates the practitioner's right or license in question, unless the Medical Executive Committee determines otherwise and so notifies the affected practitioner. If a practitioner's right or license to prescribe or obtain controlled substances or medications is subject to an order of probation, the practitioner's privileges to prescribe or obtain controlled substances or other medications at or through the hospital or any of its facilities shall automatically become subject to the terms of the probation effective upon and for at least the term of the probation. An affected practitioner shall not be permitted to prescribe medications under the hospital's DEA number. Action imposed under this Section does not entitle the practitioner to the hearing and appeal rights under these bylaws.
- D. Loss of Malpractice Insurance. If a practitioner fails to maintain professional liability insurance in the amounts as required by the Board of Trustee's, or fails to provide evidence of such coverage, the practitioner's membership and clinical privileges, shall be automatically suspended and shall remain so suspended until the practitioner provides evidence to the Medical Executive Committee that he or she has secured the required professional liability coverage. Failure to provide such evidence within six (6) months after the date the automatic suspension became effective shall be deemed a voluntary resignation from the medical staff. A practitioner whose clinical privileges are automatically suspended or who has been deemed to have voluntarily resigned from the medical staff pursuant to this Section may request a meeting to discuss the matter informally with the Medical Executive Committee or its designee, but the practitioner shall not be entitled to the hearing and appeal rights under these bylaws.
- E. Felony Conviction. A practitioner who has been convicted or pled "guilty" or "no contest" or its equivalent to a felony in any jurisdiction shall be automatically suspended. Such suspension shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed. Such suspension shall remain in effect unless and until the matter is resolved by subsequent recommendation by the Medical Executive Committee and action by the Board of Trustee's or through corrective action, if necessary.
- F. Suspension, Exclusion, Debarment or Sanction under any Federal or State Health Care Agency. Any affected practitioner who has been suspended, excluded, debarred or sanctioned under the Medicare or Medicaid program or by any governmental licensing agency, or convicted of any offense related to health care, or listed by a federal or state agency as debarred, excluded or otherwise ineligible for federal or state program participation shall be automatically suspended. Such suspension shall become effective immediately upon such debarment, exclusion, sanction, conviction or listing regardless of whether an appeal is filed. Such suspension shall remain in effect unless and until the matter is resolved by subsequent recommendation by the Medical Executive Committee and action by the Board of Trustee's or through corrective action, if necessary.

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- G. Quality/Performance Management and Peer Review Inquiries. Practitioners have an obligation to timely and satisfactorily respond to inquiries from medical staff committees and their designees on issues relating to the practitioner's qualifications, character, behavior, ethics, health status in terms of the practitioner's ability to practice in the area in which privileges are sought or have been granted, case management, current competence, performance and the practitioner's compliance with the bylaws, rules and regulations, and policies of the medical staff and hospital. Prompt responses allow the committee to deal with these issues expeditiously, which is the best interests of good patient care and the record of the physician in question. The member must respond, in writing, within 14 days of receipt of one certified letter from the Committee requesting this information. The response should be a letter explaining all issues or questions raised by the committee. Failure to respond within 14 days will result in the case scored without physician input. It is the Committee's policy to allow an appeal process of a score within the time frame of 30 days from the receipt of the score letter. The appeal must be in writing and only additional pertinent information not previously reviewed by QRC may be included. The review process of a case is determined closed, if no appeal letter is received. Action taken pursuant to this Section shall not entitle the affected practitioner to the hearing and appeal rights of these bylaws unless the Medical Executive Committee, determines that the suspension was based on a medical disciplinary cause or reason and if it is reportable under any State or Federal statute.
- G. Duty of Practitioner. Each practitioner shall be responsible for delivering proof of current insurance, licensure and right to prescribe medications to Hospital. Any effort by Hospital to secure this evidence directly shall not relieve the practitioner of his or her responsibility. A practitioner who does not furnish current evidence of insurance, licensure or right to prescribe shall be subject to automatic suspension as if he or she failed to maintain these items without regard to whether he or she holds these current credentials. Any automatic suspension that remains uncured for a period greater than thirty (30) days shall be deemed a voluntary resignation of medical staff membership, absent a showing of good cause for the delay in cure which is satisfactory to the Medical Executive Committee and the Board of Trustee's. Action automatically imposed and voluntary resignation under this Section does not entitle the practitioner to the mediation, hearing and appeal rights provided under Article VIII of these bylaws.
- H. Loss of Exclusive Contract. In the event that the practitioners staff membership and clinical privileges are conditioned upon the exclusive contract for such services at the hospital, and in the event that the exclusive contract is terminated, then the practitioner's privileges shall be automatically terminated. Any action automatically imposed under this section does not entitle the practitioner to the hearing and appeal rights under Article VIII of these Bylaws.

SECTION 5 - NOTICE

Unless otherwise specified in this Section, the Hospital President shall immediately notify the affected practitioner and the Chief of Staff in writing, either by personal delivery or mail, of any suspension or termination under Article VII, Section 4. Such notice shall set forth the effective date and the reason for the suspension or termination.

SECTION 6 - APPLICATION TO MEDICAL STAFF AFTER TERMINATION

Unless reinstated by the Medical Executive Committee and the Board of Trustee's, any practitioner who is terminated from membership or who has clinical privileges terminated and who desires to be admitted to the medical staff or granted clinical privileges shall be required to apply for membership and privileges and such application shall be processed as for an initial applicant. Notwithstanding the foregoing statement, no such application shall be made or processed within twenty-four (24) months after the effective date of the practitioner's

termination, unless the practitioner makes a written request for consideration by the Medical Executive Committee and can demonstrate to the Medical Executive Committee good cause for why he or she should be permitted to apply at an earlier time. Any previously imposed conditions must be satisfied in full in order for the individual to be eligible to reapply for medical staff membership or privileges.

SECTION 7 - OTHER INVESTIGATIONS

Notwithstanding anything in these bylaws to the contrary, the Medical Executive Committee in its sole discretion may investigate any matter or any practitioner brought to its attention by anyone and may take or recommend any action it deems appropriate, subject to review by the Board of Trustees. Such investigation shall not be deemed a hearing and may be substantially as described in Section 2B above. The Medical Executive Committee shall act with reasonable promptness and shall give notice of any action thus taken or recommended within five (5) days there from, to any affected practitioner and the Hospital President. The practitioner shall only have a right to request a hearing if the action or recommendation falls into one or more of the grounds for a hearing specifically set forth in Article VIII; in such cases the notice to the affected practitioner shall comply with the notice requirements of Article VIII.

ARTICLE VIII - MEDIATION, HEARING AND APPELLATE REVIEW PROCEDURES

SECTION 1 - GENERAL PROVISIONS; DEFINITIONS; SETTLEMENT

- A. Duty to Exhaust Remedies. The purpose of this Article is to permit the medical staff and hospital to resolve issues related to professional practice and qualifications for medical staff membership and clinical privileges fairly, expeditiously and with due regard for both the need to protect patients and the interest of practitioners. Each applicant and member agrees to follow and complete the procedures set forth in this Article, including appellate procedures, before attempting to obtain judicial relief related to any issue or decision which may be subject to a hearing and appeal under this Article. The absence of an interlocutory appeal process for reviewing any alleged violation of the bylaws or the affected practitioner's fair procedure rights does not warrant judicial intervention.
- B. For the purposes of this Article, the following definitions shall apply.
1. Affected Practitioner: means the medical staff member or applicant for membership with respect to whom any of the actions specified in Section 2B below have been taken or recommended, and whose membership or privileges may be affected thereby.
 2. Body Who's Decision Prompted the Hearing: means the person, committee, or body (which will generally be the Medical Executive Committee) that, pursuant to these bylaws, took the action or made the recommendation that resulted in a hearing being requested.
 3. Parties or party: means, unless clearly indicated otherwise by particular context, collectively or individually as the case may be, the affected practitioner, the Medical Executive Committee, and/or the body whose decision prompted the hearing (if other than the Medical Executive Committee).
 4. Notice: means a written communication delivered personally to the required addressee or sent by United States Postal Service, first-class postage prepaid, certified or registered mail, return receipt requested, addressed to the required addressee at his address as it appears in the records of the hospital. Copies shall be as effective as the original for the purpose of giving notice. Any such

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notice shall be deemed effective on the date it was first received or five (5) working days after it was mailed first-class postage prepaid, whichever occurs first.

- C. Settlements. At any time following receipt of notice of a recommendation or action which would entitle a practitioner to request a hearing under this Article, the practitioner may ask the body whose decision prompted the hearing to discuss voluntary settlement or resolution of the matter. Upon such request and subject to the practitioner's waiver of time requirements in order to allow such discussions to proceed, the Medical Executive Committee may authorize one or more of its members to conduct confidential discussions with the practitioner; provided, that the Medical Executive Committee shall not be obligated to conduct such discussions if it concludes that the request is interposed primarily for delay or that a settlement is not feasible. If the practitioner and the body whose decision prompted the hearing reach a written agreement which could settle the matter, the body whose decision prompted the hearing shall promptly notify the Hospital President, Chief of Staff and the Board of Trustees. Any such proposed settlement shall be subject to Board of Trustees approval.

SECTION 2 - THE HEARING PROCESS

- A. Notice of Adverse Action or Recommended Action; Request for Hearing. Whenever any of the actions constituting grounds for a hearing as set forth in Section 2B below has been taken or recommended, the person, committee, or body causing same to occur shall give notice to the affected practitioner.

The notice shall:

1. describe what action has been taken or recommended.
2. state the reasons for the action (a statement of charges will be provided in the event a hearing is properly requested).
3. Advise that the practitioner has the right to request a hearing and, that such request be in writing and received by the Hospital President within thirty (30) days after the affected practitioner's receipt of the Notice of Adverse Action or Recommendation.
4. contain a summary of the practitioner's rights in the hearing and enclose a current copy of the Medical Staff Bylaws.
5. state that the action, if finally adopted, will be reported to the appropriate licensing entity and to the National Practitioner Data Bank (NPDB).

Whenever the Medical Executive Committee has given notice of action that constitutes grounds for a hearing as described in Section 2B below, the affected practitioner shall have thirty (30) days following the date such notice was given within which to request a hearing. A request for a hearing must be in writing and delivered to the Hospital President within the applicable time period set forth above. Failure of the affected practitioner to request a hearing within the time and in the manner set forth in this subsection shall be deemed an acceptance by the practitioner of such action or recommendation and a waiver by such party of all hearing and appeal rights under these bylaws. The matter shall thereupon be forwarded to the Board of Trustees for its final decision in accordance with Article VIII, Section 8F. The Hospital President shall give notice to all parties of any such waiver and acceptance.

- B. Grounds for Hearing. Except as otherwise provided in these bylaws, or other than in compliance with a policy decision of the hospital (e.g., closing a service or physical plant changes), the taking or recommending of any one or more of the following actions by the Medical Executive Committee when based on the member's professional conduct or competence, shall constitute grounds for a hearing pursuant to this Article:

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1. denial of staff reappointment.
2. suspension of staff membership or clinical privileges for thirty (30) days or more.
3. termination of staff membership.
4. denial or termination of clinical privileges, including temporary privileges.
5. reduction in clinical privileges.
6. summary suspension of clinical privileges for more than fourteen (14) consecutive days.
7. significant consultation or co-admitting requirements other than in compliance with the medical staff bylaws, rules and regulations or Hospital policies.

C. Notice of Hearing.

1. Upon receipt of a proper request for hearing, the Hospital President shall deliver the request to the Medical Executive Committee, stating the date it was received by the Hospital President, then
2. the Medical Executive Committee shall, within thirty (30) days after receipt by the Hospital President of the request, schedule a date for a hearing, then
3. the Medical Executive Committee shall, not less than thirty (30) days prior to the date of the hearing, give notice to the parties of the time, place, and date thereof, and shall deliver a copy of these bylaws and a Statement of Charges as provided in the following paragraph, to the affected practitioner. The date of commencement of the hearing shall not be less than thirty (30) days from the date of the notice of hearing nor more than sixty (60) days from the date of receipt of the request for a hearing by the Hospital President, except that when the request is received from a member who is under suspension, the hearing shall commence as soon as reasonably practicable, but not later than thirty (30) days from the date of receipt by the Hospital President of the request for hearing unless a later date is agreed to by all parties. In such instances where the member is under suspension, the notice of hearing shall be provided within a reasonable time prior to the date of commencement. The parties and the Peer Review Committee shall cooperate with each other in scheduling additional hearing sessions, as necessary, to complete the process as soon as practicable.

- D. Statement of Charges. As a part of, or together with, the Notice of Hearing referred to in the previous paragraph of these bylaws, the Medical Executive Committee shall state the acts or omissions with which the affected practitioner is charged, including, if applicable, a list of chart numbers under question (if any), a list of witnesses (if any) expected to testify at the hearing on behalf of the professional review body and the reasons for the action or recommendation. Amendments to the statement of charges may be made from time to time, but not later than the close of the case by the medical staff representative at the hearing. Such amendments may delete, modify, or add to the acts, omissions, charts, or reasons specified in the original notice. Notice of each amendment shall be given to the affected practitioner, the hearing officer, and each party. If the affected practitioner promptly gives written request to the medical review hearing committee, he or she shall be entitled to a reasonable postponement of the hearing to prepare a response or defense to any such amendment that adds acts, omissions, charts, or reasons to the original notice. The medical review hearing committee shall give prompt notice to the parties of each such postponement.

- E. Peer Review Committee or Arbitrator: Appointment, Removal, and Qualifications. Promptly after a hearing has been properly requested, the Chief of Staff as a designee of the Medical Executive Committee shall determine if the hearing shall be held before: (1) an arbitrator or arbitrators selected by a process mutually acceptable to the practitioner and the Medical Executive Committee; or (2) before a panel referred to as a

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Peer Review Committee. Should the Hospital President as a designee of the Medical Executive Committee determine that a Peer Review Committee shall be used; the Chief shall promptly appoint such a Peer Review Committee and its chairman to act as the peer review group in the hearing. The Peer Review Committee shall consist of not less than three (3) or more than seven (7) members, at least the majority of whom shall be physicians who shall be licensed to practice medicine but need not be members of the medical staff. When feasible, the Peer Review Committee shall include at least one (1) individual practicing in the same specialty as the affected practitioner. They may have knowledge of the matters to be heard, but each shall be willing to hear the matters objectively and without prejudice. They shall not have acted as accusers, investigators, fact finders or initial decision makers in connection with the same matter; shall gain no direct financial benefit from the outcome; and shall not be in economic competition with the affected practitioner.

- F. Hearing Officer; Chairman of Peer Review Committee. The Hospital President may appoint a hearing officer to conduct the hearing. The hearing officer may be a member of the state bar and should be familiar with the law applicable to hospital administrative proceedings. The hearing officer shall conduct the hearing impartially such that the proceeding will be, to the extent reasonably possible, fair, efficient, and protective of the rights of all parties and witnesses. The hearing officer shall gain no direct financial benefit from the outcome of the hearing and shall not act as a prosecuting officer or advocate. The hearing officer shall act as advisor to the Peer Review Committee as to procedural matters, including the drafting of its decision and report, but he or she shall not be entitled to vote. In the alternative, the Hospital President, after consulting the Medical Executive Committee, may appoint a medical hearing officer to conduct the hearing. The medical hearing officer may be a member of the medical staff but may not be in direct economic competition with the affected practitioner. He should be familiar with the applicable medical issues and with medical staff administrative proceedings. He shall conduct the hearing impartially such that the proceeding will be, to the extent reasonably possible, fair, efficient, and protective of the rights of all parties and witnesses. He shall decide all procedural matters. All references to the "hearing officer" shall refer to the medical hearing officer if one is appointed. If a hearing officer is not appointed, the chairman of the Peer Review Committee shall conduct the hearing and rule on procedural matters, and all references to the "hearing officer" shall be deemed to refer to the chairman of the Peer Review Committee or the arbitrator, as appropriate.
- G. Postponements and Extensions. After the appointment of the Peer Review Committee and before the commencement of the hearing, postponements beyond the times required by these bylaws may be requested by any of the parties, and shall be granted upon agreement of the parties or by the arbitrator or presiding officer on a showing of good cause. The Peer Review Committee shall promptly give notice to the parties of each such postponement.
- H. Medical Staff Representative. After a hearing has been properly requested, the Hospital President shall promptly appoint a medical staff member to present the case on behalf of, and otherwise represent the body whose decision prompted the hearing. The Hospital President may, in its sole discretion, remove or replace the medical staff representative at any time.

SECTION 3 - THE HEARING PROCEDURE

- A. Pre-hearing Exchange of Information and Discovery.

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1. The practitioner shall have the right to inspect and copy at the practitioner's expense any documentary information relevant to the charges which the Medical Executive Committee has in its possession or under its control, as soon as practicable after the receipt of the practitioner's request for a hearing. The Medical Executive Committee shall have the right to inspect and copy at its expense any documentary information relevant to the charges which the practitioner has in his possession or control as soon as practicable after receipt of the Medical Executive Committee's request. The failure of either party to provide access to this information at least thirty (30) days before the hearing shall constitute good cause for a continuance or for the hearing officer to bar or otherwise limit the introduction of any documents not provided to the other party. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable practitioners, other than the affected practitioner. This exclusion may also pertain to any practitioner involved in reporting information in the act of administering his or her duty. The hearing officer shall consider and rule upon any dispute or controversy concerning a request for access to information. The hearing officer may impose any safeguards, including the denial or limitation of discovery to protect the peer review process and justice. When ruling upon requests for access to information and determining the relevancy thereof, the hearing officer shall, among other factors, consider the following:
 - (a) whether the information sought may be introduced to support or defend the charges.
 - (b) the exculpatory or inculpatory nature of information sought, if any, i.e., whether there is a reasonable probability that the results of the hearing would be influenced significantly by the information if received into evidence.
 - (c) the burden imposed on the party in possession of the information sought, if access is granted.
 - (d) any previous requests for access to information submitted or resisted by the parties to the same proceeding.
 2. At the request of either party, the parties must exchange at least ten (10) days before the hearing:
 - (a) lists of witnesses expected to testify at the hearing; and
 - (b) copies of all documents expected to be introduced at the hearing.Failure of a party to produce these materials, or to update them, at least ten (10) days before the commencement of the hearing, shall constitute good cause for the hearing officer to grant a continuance, or to bar or otherwise limit the introduction of any documents not provided to the other party or testimony from witnesses not identified pursuant to this provision. The hearing officer may decide to exclude irrelevant information that he or she feels is used only to delay the due process.
 3. It shall be the duty of the practitioner and the body whose decision prompted the hearing to exercise reasonable diligence in notifying the hearing officer of any pending or anticipated procedural irregularity or any objection to the hearing panel or to the hearing officer, as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may expeditiously be made. Objection to any such pre-hearing decisions shall be raised on the record at the hearing and when so raised shall be preserved for consideration at any appeal.
- B. Failure to Appear. Failure of the affected practitioner to appear at the hearing shall be deemed to constitute the affected practitioner's voluntary acceptance of the recommendation or action and waiver of all hearing and appeal rights under these bylaws, unless the Peer Review Committee finds good cause for such failure, based upon written request by the affected practitioner or his representative.

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- C. Representation. The hearings provided for in these bylaws are for the purpose of intra -professional resolution of matters bearing on conduct or professional competency. Accordingly, either the affected practitioner or the body whose decision prompted the hearing shall be represented in any phase of the hearing by an attorney at law. Any request for legal representation shall be made at the time the hearing request is made. In no event shall the body whose decision prompted the hearing be represented by legal counsel if the affected practitioner is not so represented. The affected practitioner shall be entitled to be accompanied by and represented at the hearing by a physician licensed to practice in this state and who is not also an attorney at law and who preferably, is a member in good standing of the medical staff. The body whose decision prompted the hearing shall appoint a representative from the medical staff to present the evidence in support of the recommendation or actions. Any party may obtain legal counsel at their expense for the purpose of preparing for the hearing. A representative may also be a witness.
- D. Record of the Hearing. The Peer Review Committee proceedings shall be taken and transcribed by a court reporter, and a copy of the transcript of each session shall be available for purchase by either party. Each party shall be responsible for payment of all costs and charges associated with any transcript that it requests.
- E. Oath of Witness. The Peer Review Committee may, in its discretion, order all testimony at the hearing to be under oath administered by a person authorized to administer oaths.
- F. Organization and Conduct of Hearing Process. Unless otherwise expressly provided in these bylaws, the hearing shall be conducted as follows:
1. The parties shall have a reasonable opportunity to voir dire the Peer Review Committee members and the hearing officer, and the right to challenge the appointment of any Peer Review Committee member or the hearing officer. The hearing officer shall establish the procedure by which this right may be exercised, which may include requirements that voir dire questions be proposed in writing in advance of the hearing and that the questions be presented by the hearing officer. The hearing officer shall rule on any challenges in accordance with applicable legal principles defining standards of impartiality for hearing panels and hearing officers in proceedings of this type.
 2. The medical staff representative shall present an opening statement summarizing the background of the matter, the notices given, any administrative decisions rendered to date, and, if he chooses, the salient general conclusions the representative expects to prove.
 3. The medical staff representative shall then present the facts upon which he is relying, by calling the witnesses and presenting the documentary evidence to support the case. He may call any person or opposing party, who is present, in support of the case.
 4. At the close of the medical staff representative's case, unless the Peer Review Committee believes that the action or recommendation being reviewed was clearly not supported by the medical staff representative's presentation (in which case the hearing may terminate by such a ruling at this point), the affected practitioner or his representative shall make an opening statement and shall make a case presentation of evidence and testimony. He may call any person or opposing party, who is present, in support of the case.
 5. Upon the close of the initial presentations of the opposing parties, each party shall be entitled to present evidence to rebut the presentation of the other, subject to reasonable limitations by the hearing officer as to order, time, relevance, and repetition.

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6. Upon the close of all presentations and evidentiary rebuttals, the parties shall be entitled, subject to reasonable limitation by the hearing officer, to submit a written statement and give closing statements and argument.
 7. Upon the close of all presentations, rebuttals, statements, and argument, the hearing officer shall declare the hearing finally adjourned, and all persons other than the Peer Review Committee and hearing officer shall thereupon leave the hearing. The Peer Review Committee shall thereafter, at the convenience of its members but subject to the provisions of Section 6 below, deliberate in order to reach its decision.
 8. Liberality may be exercised in accommodating the schedules of witnesses, Peer Review Committee members, parties, and representatives, in allowing modification of required notices, in allowing recesses or extensions of time upon a reasonable showing of need, and in allowing changes in the order of the proceedings or the presentation of evidence. The decision of the hearing officer after consultation with the Peer Review Committee regarding such matters shall be final, subject to later reconsideration for good cause only.
 9. No person shall disrupt any hearing. Any person in attendance (whether a party or any other person) who disrupts a hearing after being warned by the hearing officer to cease such disruption on penalty of indefinite exclusion, shall, at the direction of the hearing officer, leave the hearing. Unless directed otherwise for good cause by the hearing officer, the hearing shall proceed in the absence of such excluded person. If such excluded person is the affected practitioner or a witness, he shall have the right to submit to the Peer Review Committee, not later than ten (10) days after such exclusion (unless extended by the hearing officer for good cause), a written affidavit of his testimony or other evidence, with copies thereof to the other parties.
 10. Except as otherwise provided in these bylaws and subject to reasonable restriction by the hearing officer, the following shall be permitted to attend the entire hearing in addition to the Peer Review Committee, the hearing officer, court reporter, and parties, the Hospital President or designee, one (1) person designated by the Hospital President (or his designee), the medical staff coordinator or assistant, one (1) key consultant for each party, and one (1) or more representatives of the entity that owns the hospital.
- G. Burden of Proof. A practitioner who is challenging a recommendation to deny an application for reappointment to the medical staff or an application for additional clinical privileges shall have the burden of proving, by a preponderance of the evidence, that he is sufficiently qualified to be awarded such membership or privileges at this hospital. This burden requires the production of information which allows for the adequate evaluation and resolution of reasonable doubts concerning his current qualifications. The affected practitioner shall not be permitted to introduce information not produced upon the request of any committee or person on behalf of the medical staff during the application process, unless the person establishes that the information could not have been previously produced in the exercise of reasonable diligence. In all other cases involving members who already are granted privileges, the Medical Executive Committee shall bear the burden of persuading the Peer Review Committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.
- H. Admissible Evidence and General Procedures. Except as otherwise provided in these bylaws, the following rules shall apply in the hearing.
1. The general rule of evidence shall be that any relevant matter, whether written or oral, upon which responsible individuals would be expected to rely in the conduct of serious affairs, shall be admitted, regardless of its admissibility in a court of law. The Peer Review Committee shall have

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- the discretion to recognize any matters, either technical or scientific, including statistical data, relating to the issues under consideration, which are common knowledge in the general medical community and/or any medical specialty.
2. Parties or their representatives shall have the right to:
 - (a) a reasonable opportunity to voir dire the Peer Review Committee members and the hearing officer, and the right to challenge the impartiality of any Peer Review Committee member or the hearing officer. Such challenges shall be ruled upon by the hearing officer.
 - (b) be provided with all information made available to the Peer Review Committee.
 - (c) call and examine witnesses on relevant evidence and to cross-examine witnesses.
 - (d) introduce relevant documentary evidence.
 - (e) present evidence that tends to impeach any witness on relevant matters, provided that, to prevent abuse of this right, the hearing officer may, in his discretion, require a prior offer of proof summarizing such evidence any may in his discretion reject such evidence if the party fails to submit such offer of proof or if the offer of proof reasonably justifies such rejection.
 - (f) submit a written statement at the close of the presentation of evidence.
 3. Evidence of relevant activities or practices at any location or facility shall be admissible unless limitations are imposed by the hearing officer upon a showing of good cause.
 4. The Peer Review Committee may receive and consider any brief or memorandum presented by any party.
 5. Any relevant material contained in medical staff files regarding the affected practitioner is admissible, including but not limited to applications, references, and accompanying documents.

SECTION 4 - DECISION AND REPORT OF PEER REVIEW COMMITTEE; NOTICE

After adjournment of the final session of the hearing, the Peer Review Committee shall begin its deliberations. Within thirty (30) days after closure of the deliberations of the Peer Review Committee, the Peer Review Committee shall render and deliver to the Hospital President a written report and decision. The Peer Review Committee may recommend that the Board of Trustee's affirm, terminate or modify the action or recommendation that prompted the hearing. If the recommendation is to modify, the Peer Review Committee must identify the modifications recommended. The decision and report shall be based on evidence produced at the hearing, including any recognized matters and reasonable inferences that may be drawn. The decision and report shall include findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the decision reached. It shall include sufficient detail to enable the parties and the Board of Trustee's to determine the basis for the Peer Review Committee's decision on each issue contained in the statement of charges. It shall also contain a description of the rights in the appeal process under these bylaws. The Hospital President within five (5) working days after receiving the decision and report shall send a copy to the parties.

SECTION 5 - BOARD OF TRUSTEE'S ACTION AFTER PEER REVIEW COMMITTEE DECISION

The Board of Trustee's shall take no action regarding the underlying matter or the decision and report of the Peer Review Committee, until after the expiration of the time for requesting the appeal under Section 8, however, if an appeal is requested under Section 8, the Board of Trustee's shall take no action except in compliance with the

procedures and provisions of this Article. If the appeal process is not timely requested, the Board of Trustee's shall make its final decision in accordance with Section 8.

SECTION 6 - APPEAL TO BOARD OF TRUSTEE'S

- A. Time for Requesting Appeal. Within thirty (30) days after receipt of notice of the decision of the Peer Review Committee, either the affected practitioner or the body whose decision prompted the hearing may request an appeal process according to these bylaws. The request shall be in writing and must be received by the Hospital President within the applicable time period set forth above. The Hospital President shall immediately deliver copies of the request to the Board of Trustee's and to the other parties. The request shall set forth the ground(s) for appeal as noted under Section 8C. If an appeal is not requested as set forth in this paragraph, all parties shall be deemed to have waived all rights to appeal.
- B. Nature and Effect of Appeal Process. The appeal process shall be conducted by the Board of Trustee's or a committee thereof and all references to the "Board of Trustee's" shall include such committees. The appeal process for the purpose under these bylaws shall consist of a review of the prior proceedings and decision, at least one meeting of the appeal committee and the parties, deliberations, review of any further recommendations, and a final decision. The Board of Trustee's shall give great weight to the Peer Review Committee decision, and shall not act arbitrarily or capriciously. The appeal body may however, exercise its independent judgment in determining whether a practitioner was afforded a fair hearing, whether the decision is reasonable and warranted, and whether any bylaw, rule or policy relied upon by the hearing committee is unreasonable or unwarranted. In its final decision the Board of Trustee's may affirm, modify or reverse the decision of the Peer Review Committee. The decision shall specify the reasons for the action taken and provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal (if any), and the decision reached, if such findings and conclusions differ from those of the Peer Review Committee. No person or entity that participated in bringing the charges or in officially reviewing the matter shall participate in the appeal process, even if such removal leaves the Board of Trustee's with less than a quorum.
- C. Grounds for Appeal. The grounds for appeal are limited to: substantial and prejudicial failure of the Peer Review Committee or the Medical Executive Committee to comply with these bylaws or to afford due process or a fair hearing; the action or recommendation that prompted the hearing, or any substantial part was arbitrary or capricious; the Peer Review Committee's decision or any substantial part was clearly contrary to the weight of the evidence; or that a medical staff bylaw, rule or regulation relied on by the Peer Review Committee in reaching its decision lacked substantive rationality.
- D. Notice of Time, Date, Place of Appellate Review Meeting. The Board of Trustee's shall, within thirty (30) days after receipt by the Hospital President of a timely request for appeal, schedule a date for an appellate review meeting. The Board of Trustee's shall, not less than ten (10) days prior to the date of the appellate review meeting, give the parties written notice of the time, place, and date. The date thereof shall be not less than ten (10) days, nor more than thirty (30) days from the date of receipt by the Hospital President of the request for appellate review, except that when a request for appellate review is from a member who is then under suspension, the meeting shall be held as soon as reasonably practicable but not later than thirty (30) days from the date of receipt of the request. The date for the meeting may be extended by the chairman of the Board of Trustee's for good cause.

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E. Appellate Review Proceedings. The appellate review shall be conducted as follows:

1. The Board of Trustee's shall limit its review to the record of the hearing before the Peer Review Committee, the Peer Review Committee decision and report, and any written briefs submitted by the parties. The Board of Trustee's may, however, in its sole discretion, accept additional issues or oral or written evidence subject to the same rights of cross-examination and rebuttal provided for Peer Review Committee hearings. Such acceptance of additional issues or evidence may be based on the Board of Trustee's own motion, or upon the request of a party if, not less than seven (7) days prior to the appellate review meeting date, the party desiring to present such additional issues or evidence makes written request to the Board of Trustee's to do so, specifying the nature and relevance of the issues or evidence, and gives notice of such request to all other parties. The Board of Trustee's shall give notice of its decision in such matters to all parties as soon as reasonably possible.
2. The Board of Trustee's may, in its sole discretion, appoint a hearing officer to conduct the appellate review meeting, rule on procedural matters, act as advisor to the Board of Trustee's as to procedural matters, and without voting rights, participate in its deliberations and assist in the preparation of its decision.
3. Each party shall have the right to submit a written brief in support of his position on appeal; provided that copies of such brief shall be given to all other parties at such time as may be directed by the Board of Trustee's.
4. Each party or his representative who may be an attorney, shall have the right to appear personally and make oral argument at the meeting following a hearing. If a personal appearance is made, the parties and representatives present shall answer any questions posed by any member of the Board of Trustee's.
5. The Board of Trustee's may, from time to time, adjourn and continue the appellate review to another date or dates if it decides, in its sole discretion, that such action is necessary or desirable in order to conduct a fair and thorough appeal in the matter. The Board of Trustee's shall give notice to the parties of any such date and time, unless the parties were present when such date and time were announced by the Board of Trustee's.
6. At the conclusion of the appellate review, the Board of Trustee's shall, at a time convenient to itself, conduct deliberations outside the presence of the parties and their representatives, in order to determine whether to affirm, modify, or reverse the decision of the Peer Review Committee.
7. The Board of Trustee's shall, in its sole discretion, decide the order of procedures to be followed in the appellate review, as well as answers to questions not otherwise addressed in these bylaws, to the end that the appellate review, including the appellate review meeting, shall be thorough, orderly, efficient, and fair.
8. No person shall disrupt any appellate review proceeding. Any person in attendance (whether a party or any other person) who disrupts such a meeting after being warned by the chairman of the Board of Trustee's (or hearing officer) to cease such disruption on penalty of indefinite exclusion, shall, at the direction of such chairman (or the hearing officer), leave the meeting. Unless directed otherwise for good cause by the chairman (or the hearing officer), the meeting shall proceed in the absence of such excluded person.

F. Final Decision; Effective Date. The appeal process shall conclude with the Board of Trustee's final decision in the matter which shall be made in accordance with the following rules:

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1. Within thirty (30) days after either the waiver of appellate rights or the conclusion of the appellate review meeting, the Board of Trustee's shall render its final decision, unless it refers the matter to the Peer Review Committee for further review and recommendation. The Board of Trustee's shall give great weight to the decision of the Peer Review Committee and shall not act arbitrarily or capriciously. The Board of Trustee's, however, may exercise its independent judgment in determining whether the hearing procedures in these bylaws were followed.
2. If the Board of Trustee's refers the matter to the Peer Review Committee for further review and recommendation, such referral may include instructions such as that the Peer Review Committee arrange for further hearings on specific issues. The Board of Trustee's shall give notice of such referral to the parties. The Peer Review Committee shall conduct such review in accordance with any such instructions, and shall deliver its written recommendation to the Board of Trustee's within forty-five (45) days after the receipt of the referral from the Board of Trustee's. Within forty-five (45) days after receipt of such recommendation, the Board of Trustee's shall render its final decision.
3. The Board of Trustee's final decision shall be in writing and shall include a statement of the Board of Trustee's basis for its decision. The decision shall be effective immediately and not subject to further hearing or appeal. As soon as the final decision is effective, a copy of it shall be delivered to the affected practitioner, the Hospital President, and each party, in person or by mail.

SECTION 7 - RIGHT TO ONLY ONE PEER REVIEW COMMITTEE HEARING AND APPELLATE REVIEW

No party shall be entitled to more than one (1) evidentiary hearing and one appellate review on any matter that may be the subject of a Peer Review Committee hearing or appeal.

SECTION 8 - INFORMAL INTERVIEWS

Nothing in these bylaws shall be deemed to prevent any committee, or person contemplating any action or recommendation set forth in Section 2B, from, at its sole discretion, inviting the affected practitioner to participate in an informal discussion of the contemplated action or recommendation. Such discussion shall not be deemed to constitute a hearing under this Article.

SECTION 9 - RESIGNATION OR WITHDRAWAL OF APPLICATION

Notwithstanding any other provision of these bylaws, whenever the affected practitioner unconditionally: (a) resigns from the medical staff; (b) resigns and relinquishes the privileges that are the subject matter of a hearing; (c) withdraws the application that is the subject matter of hearing; (d) amends an application or request with regard to the items that are the subject matter of the hearing; or (e) consents in writing to the action or recommendation that prompted the hearing, and there are no other issues before the hearing, all hearing and appeal proceedings with respect to the practitioner, his privileges or application, as the case may be, shall terminate as of the first day after such resignation, withdrawal, amendment, or consent. Once so terminated, the proceedings shall not be reopened except when ordered by the Board of Trustee's, after receiving a written request from, or giving notice to, the affected practitioner, and determining that good cause exists for such reopening. Reporting of any such resignation, withdrawal or consent to the action or recommendation will be in conformance with State and Federal regulations.

SECTION 10 – CONFIDENTIALITY

In addition to the provisions provided in Article XII of these bylaws, all medical staff applicants and members, committee members and committee guests, peer review consultants, persons involved in any peer review activity at this hospital, as well as parties, participants, and attendees at a medical staff peer review hearing, shall keep all peer review investigations as well as all hearing and appeal proceedings and the contents thereof confidential. No one shall disclose or release any information from or about the proceedings to any person or the public. Information about patients shall be kept confidential in accordance with State and Federal regulations, as well as with the Hospital Privacy Policies and Procedures.

SECTION 11- EXCEPTIONS TO HEARING AND APPEAL RIGHTS

In addition to other exceptions set forth in these bylaws, the hearing and appeal rights under these bylaws are not applicable under the following circumstances:

- A. Exclusive Contracts. The hearing and appeal rights under these bylaws do not apply to a practitioner whose application for medical staff membership and privileges was denied on the basis that the privileges he seeks are granted only pursuant to a closed staff or exclusive use policy.
- B. Medico-Administrative Practitioner. The hearing and appeal rights under these bylaws do not apply to those persons serving the hospital in a medico-administrative capacity. Termination of such persons' rights to practice in the hospital shall instead be governed by the terms of their individual contract with the hospital. However, the hearing and appeal rights of these bylaws shall only apply to the extent that membership status or clinical privileges, which are independent of the practitioner's contract, are also removed or suspended, unless the contract includes a specific provision establishing alternative procedural rights applicable to such decisions.
- C. Automatic Suspension or Termination of Privileges. The hearing and appeal rights under these bylaws are not granted if a member's medical staff membership or clinical privileges are automatically suspended or terminated in accordance with these bylaws.
- D. Allied Health Professionals. Except as required by State law for clinical psychologists, Allied Health Professionals are not entitled to the hearing and appeal rights set forth in Articles V and VIII of these bylaws. Allied Health Professionals shall be afforded an opportunity to address the Medical Executive Committee in accordance with the procedures set forth in these bylaws.
- E. Removal from Emergency Room Call Panel. Emergency Room call panel participation is not a benefit or privilege of staff membership, but rather it is an obligation. No hearing or appeal rights under these bylaws are available for any action or recommendation affecting a practitioner's emergency room call panel obligation(s) unless such action is based upon a medical disciplinary cause or reason.
- F. Hospital Policy Decision. The hearing and appeal rights of these bylaws are not available if the hospital makes a policy decision (e.g., closing service or physical plant changes) that adversely affects the staff membership or clinical privileges of any member or applicant.

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- G. Termination of Hospital Employed Practitioners. The privileges and staff membership of any practitioner employed by the hospital shall be subject to termination in accordance with the terms of the practitioner's contract. Such practitioner shall not be entitled to the hearing and appeal rights under these bylaw, except to the extent that the practitioner's staff membership or privileges which would otherwise exist independent of the contract are to be limited or terminated, or unless otherwise provided in the practitioner's contract.
- H. Failure to Meet Minimum Activity Requirements. Hearing and appeal rights under these Bylaws do not apply to a practitioner whose membership or privileges are denied, restricted, terminated or deemed resigned, or whose Medical Staff category is changed or not changed because of a failure to meet the minimum activity requirements set forth in the Medical Staff Bylaws or Rules and Regulations. In these cases, the only review shall be provided by the Medical Executive Committee, which may decide to act through a subcommittee of Medical Executive Committee members. The Medical Executive Committee or its subcommittee shall give the member notice of the basis of the intended action. The member shall have the right, within thirty (30) days after receipt of such notice, to request an interview. If an interview is requested, the Medical Executive Committee or its subcommittee shall schedule an interview to occur no less than thirty (30) or more than (60) days after the date the interview was requested. At this interview, the member may present evidence to dispute whether or not the member complied with the minimum activity requirements. Within thirty (30) days after this interview, the Medical Executive Committee or its subcommittee shall render a decision. A copy of the decision shall be sent to the member. If the interview is conducted by a subcommittee of the Medical Executive Committee, a copy of the decision also shall be sent to the Medical Executive Committee. The Medical Executive Committee may modify or reverse the decision of the subcommittee. The decision of the Medical Executive Committee shall be forwarded to the Board of Trustee's for its review. The Board of Trustee's decision on the matter shall be final.

ARTICLE IX - OFFICERS OF THE MEDICAL STAFF

SECTION 1 - OFFICERS

Officers of the medical staff shall be the:

- A. Chief of Staff.
- B. Vice Chief of Staff
- C. Immediate Past Chief of Staff.
- D. Secretary-Treasurer.

SECTION 2 - QUALIFICATIONS

Officers must be members of the active staff at the time of their nomination and election and must remain in good professional and ethical standing during their term of office. Because of the peer responsibilities of their offices, the Chief of Staff and the Vice Chief of Staff shall be physicians, with demonstrated competence in their fields of practice and ability to direct the medico-administrative aspects of medical staff activities. Officers must have demonstrated good interpersonal relationships with medical staff members and hospital staff, and have indicated a willingness to accept the responsibilities of the office.

SECTION 3 - NOMINATION AND ELECTION OF OFFICERS

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- A. Officers shall be elected for a three (3) year term by the active staff members at the final meeting of the designated medical staff term. Election shall be by written ballot unless there is only one (1) candidate. The candidate must be elected by a majority vote of the active staff members present at the meeting. When three (3) or more candidates are running and a majority is not obtained, the candidate with the least votes will be eliminated each time until a candidate receives a majority vote. Voting by proxy shall not be permitted.
- B. Nominations may be made in the following ways, provided that written consent to serve is obtained from the proposed nominee prior to placing the nominee's name into nomination:
 - 1. By a nominating committee. The nominating committee shall consist of three (3) members of the active medical staff appointed by the Chief of Staff subject to approval of the Medical Executive Committee. The nominating committee shall convene at least thirty (30) days prior to the final meeting of the medical staff term and shall submit to the medical staff secretary one (1) or more qualified nominees for each office at least twenty (20) days prior to the meeting. The nominees shall be for the office of Chief of Staff, Vice Chief of Staff and Secretary-Treasurer.
 - 2. By ballot. Nominating may be done by ballot to the Chief of Staff.

SECTION 4 - TERM OF OFFICE/VACANCIES

- A. Term of Office. Each officer shall serve a three (3) year term, beginning the first day of the medical staff year following their election. Each officer shall serve until the end of his term or until a successor is elected, unless he shall sooner resign or be removed from office. Officers may be re-elected for a second three year term. Notwithstanding the foregoing or any provision of these bylaws to the contrary, no officer shall serve more than two (2) consecutive terms in the same Office.
- B. Vacancies in Office. Vacancies in office during the medical staff term, except for the Chief of Staff, shall be filled by the medical staff MEC. If there is a vacancy in the office of Chief of Staff, the Vice Chief of Staff shall serve out the remaining term. A vacancy in the office of Immediate Past Chief of Staff will not be filled.

SECTION 5 - REMOVAL OF ELECTED OFFICERS FROM OFFICE

- A. Removal. Removal of a medical staff officer for cause may be initiated by a two-thirds (2/3) majority vote of the active medical staff. Removal shall also require approval of the Medical Executive Committee and the Board of Trustees. The Board of Trustees may remove any officer for cause as described in Section 5B, below.
- B. Grounds for Removal. Each of the following conditions in itself constitutes cause for removal of a staff officer from office:
 - 1. revocation of professional license by the authorizing state agency.
 - 2. suspension from the medical staff membership.
 - 3. failure to perform the required duties of the office.
 - 4. failure to adhere to professional ethics.
 - 5. failure to comply with or support enforcement of the hospital and medical staff bylaws, rules and regulations, and policies.

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6. failure to maintain adequate professional liability insurance.
7. failure to maintain active staff membership.

SECTION 6 - RESPONSIBILITIES, DUTIES AND AUTHORITY OF OFFICERS

A. Chief of Staff. The responsibilities, duties, and authority of the Chief of Staff are to:

1. call, preside at, and determine the agenda of all general and special meetings of the medical staff.
2. serve as chairman of the Medical Executive Committee, with tie-breaking vote prerogative only, and as ex officio member of all other medical staff committees without vote.
3. enforce medical staff bylaws, rules and regulations and appropriate hospital rules and policies; implement sanctions when they are indicated; and enforce the medical staff's compliance with procedural safeguards in all instances in which corrective action has been requested or initiated against a practitioner.
4. appoint the chairman and all medical staff members of medical staff standing and ad hoc committees, except the Medical Executive Committee; appoint the medical staff members of hospital and Board of Trustee's committees when these are not designated by position or by specific direction of the Board of Trustee's.
5. represent the views, policies, concerns, needs, and grievances of the medical staff to the Board of Trustee's and administration; serve ex officio as a non-voting member of the Board of Trustee's.
6. advise the Board of Trustee's on the effectiveness of the quality/performance management program and the overall quality of patient care in the hospital.
7. advise the Board of Trustee's, administration, and the Medical Executive Committee on matters that impact on patient care and clinical services, including the need for new or modified programs/ services, for recruitment and training of professional and support staff personnel, and for staffing patterns.
8. serve as spokesman for the medical staff in its external professional and public relations.

B. Vice Chief of Staff. The responsibilities, duties, and authority of the Vice Chief of Staff are to:

1. assume the responsibilities, duties, and authority of the Vice Chief of Staff during the latter's absence whether the absence is temporary or permanent.
2. serve as a voting member of the Medical Executive Committee.

C. Immediate Past Chief of Staff. The responsibilities, duties, and authority of the Immediate Past Chief of Staff are to:

1. serve as a voting member of the Medical Executive Committee.
2. advise the Chief of Staff and Medical Executive Committee on matters concerning the medical staff.
3. perform other functions at the request of the Chief of Staff.

D. Secretary-Treasurer. The responsibilities, duties, and authority of the Secretary-Treasurer are to:

1. serve as a member of the Medical Executive Committee with a vote.
2. maintain accurate and complete minutes of all medical staff meetings.

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3. give proper notice of all medical staff meetings on order of the Medical Staff Chief of Staff.
4. take steps so that an answer is rendered to all official medical staff correspondence.
5. maintain a record of medical staff fees, collections, and accounts, and sign checks for medical staff fund expenditures pursuant to his authority.
6. assume the responsibilities, duties, and authority of the Medical Staff Chief of Staff when both the latter and the Vice Chief of Staff are temporarily absent.

ARTICLE X - COMMITTEES AND FUNCTIONS

SECTION 1 - GENERAL CONSIDERATIONS

- A. Standing and Special Committees. There shall be standing and special (ad hoc) committees of the medical staff. Unless stated otherwise in these bylaws, the committees of this Article shall be standing committees of the Medical Staff and shall be formed and functioning by the expiration of the twelve (12) months following the date that the first medical staff of Hospital is constituted. Special/ad hoc committees may be created by the Medical Executive Committee to perform specified tasks as and when needed
- B. Appointment and Removal. Unless otherwise specified, the chairman and members (except the Medical Executive Committee and its chairman) of all committees shall be appointed and may be removed by the Chief of Staff after consultation with and approval of the Medical Executive Committee.
- C. Minutes. Unless stated otherwise in these bylaws, each committee shall submit a copy of its minutes to the Medical Executive Committee and the quality/performance management committee, and shall maintain a permanent record of its proceedings, including pertinent discussion and any conclusions, recommendations, and actions.
- D. Participation of Non-Medical Staff Members. Persons who participate/attend committees/ functions who are not medical staff members shall be selected by the Hospital President with the concurrence of the committee chairman or Chief of Staff. Non-medical staff members shall not be entitled to vote, but may participate if invited in discussions.
- E. Ex officio members. Ex officio committee members shall serve without vote.
- F. Performance of Functions. Whenever these bylaws require that a function be performed by:
 1. a medical staff committee but no committee has been specified, the Medical Executive Committee shall perform the function or designate a subcommittee to perform it.
 2. the Medical Executive Committee but a standing or special committee has been formed to perform the function, the committee so formed shall act in accordance with the authority delegated to it.
- G. Vacancies. Unless stated otherwise in these bylaws, vacancies on any committee shall be filled in the manner of original appointment to the committee; provided, however, that if an individual obtains membership by virtue of these bylaws and is removed for cause, a successor may be selected by the Medical Executive Committee.

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- H. Confidentiality. All committee participants/attendees, including members and invited guests, are required as a condition of attending/participating in a medical staff peer review committee, to sign and date a medical staff peer review confidentiality statement acknowledging that each agrees to maintain the confidentiality of committee matters, including but not limited to, patient-identifiable information.
- I. Committee Responsibilities, Duties, and Authority. Medical Staff Committees functions and duties are delineated in the Medical Staff Organization Chart.

SECTION 2 - MEDICAL EXECUTIVE COMMITTEE (MEC)

- A. Composition. The Medical Executive Committee shall be a standing committee of the medical staff and shall consist of the officers of the medical staff, other medical staff members as designated the Immediate Past Chief of Staff, the chairman of the Quality Improvement Committee, the chairman of the Credentials Committee, and the Hospital President, or that individual's designee, who shall be an ex officio member without vote. The Chief of Staff shall be chairman of the committee and shall vote only to resolve a tie vote. Each voting Medical Executive Committee member, regardless of other committee positions held shall have only one (1) vote.
- B. Responsibilities, Duties, and Authority. The Medical Executive Committee shall:
 - 1. represent and act on behalf of the medical staff, subject to such limitation as may be imposed by these bylaws.
 - 2. recommend to the Board of Trustee's on all matters relating to appointments, reappointments, clinical privileges, staff category and service assignments, and corrective action. When allied health professionals provide or are recommended to provide services in the hospital, the committee shall make recommendations to the Board of Trustee's on their qualifications to provide those services and on the degree of supervision required.
 - 3. receive and act upon reports and recommendations from medical staff committees, all clinical services, and staff officers concerning quality/performance management activities and the discharge of their delegated administrative responsibilities.
 - 4. cause, through evaluation by this committee or the Quality/Performance Management Committee, each medical staff peer evaluation and quality/performance assessment and improvement activity to be performed effectively.
 - 5. coordinate the activities of the staff, services, and committees.
 - 6. develop, adopt, and implement policies of the medical staff.
 - 7. fulfill the medical staff's accountability to the Board of Trustee's for the medical care rendered to patients in the hospital.
 - 8. initiate and pursue corrective action, when warranted, in accordance with these bylaws.
 - 9. take all reasonable steps to help provide for professional ethical conduct, competence, and clinical performance on the part of all staff members.
 - 10. make recommendations to the Board of Trustee's on medico-administrative and hospital management matters as requested, particularly as they relate to patient care, through the Hospital President and Chief of Staff.
 - 11. submit recommendations to the Board of Trustee's for changes in the medical staff bylaws, rules and regulations and other organization documents pertaining to the medical staff.

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12. provide and promote effective liaison among the medical staff, administration, and the Board of Trustee's.
 13. participate in identifying community health needs and in setting hospital goals and implementation of programs to meet those needs.
 14. actively promulgate effective medical staff participation in the hospital's occurrence screening program.
 15. promote in house medical staff continuing education activities that are relevant to the care and services provided in the hospital and, in particular, to the findings of medical staff peer evaluation and quality/performance management activities.
- C. Meetings. The Medical Executive Committee shall meet as often as necessary to accomplish its functions, but at least six (6) times per year.

SECTION 3 - CREDENTIALS COMMITTEE

- A. Composition: The Credentials Committee reports to the Medical Executive Committee and shall consist of at least four (4) members of the medical staff nominated by the Chief of Staff and/or his designee.
- B. Duties: The Credentials Committee shall review and evaluate applications for appointment, reappointment and clinical privileges for all categories of the staff and make appropriate recommendations to the Medical Executive Committee.
- C. Meetings: The Credentials Committee shall meet as often as necessary to accomplish its functions, but at least six (6) times per year and maintain a permanent record of its proceedings.

SECTION 4 - BYLAWS COMMITTEE

- A. Composition: The Bylaws Committee shall be a subcommittee of the Medical Executive Committee and shall consist of at least two (2) members nominated by the Chief of Staff and/or his designee. Representatives from Administration and Medical Staff Services shall be ex-officio members.
- B. Duties: To review as necessary the Bylaws and Rules and Regulations of the Medical Staff and to propose any revisions necessary to comply with current practices and standards.
- C. Meetings: The Bylaws Committee will meet at the call of the Chairman and will maintain a permanent record of its proceedings.

SECTION 5 - MEDICAL STAFF PHYSICIAN ASSISTANCE COMMITTEE

- A. Composition. The Medical Staff Physician Assistance Committee shall be composed of no less than three (3) but no more than seven (7) active members of the medical staff, a majority of whom, including the chairman, shall be physicians. The Chairman will be appointed by the Chief of Staff with members appointed on an ad hoc basis, that may include: distinguished senior medical staff members; an addictionist; a psychiatrist; a high-risk area representative (anesthesiology, surgery, emergency medicine), and a physician with substantial personal recovery—experience. For purposes of confidentiality and avoidance of conflict, the committee generally should not include: any hospital board members, the

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President of Staff, any medical executive committee members, any CEO or nurse, QI / RM committee member or legal counsel. Each member shall serve a term of three (3) years. The Chief of Staff shall have the option of sustaining the composition of the Committee in order to maintain continuity.

- B. Responsibilities, Duties and Authority. It is the medical staff's responsibility to enhance quality care and protect patients from harm. It is this committee's goal to act as physician advocate by providing valuable resources to assist medical staff members in dealing with these unique stresses in a confidential and compassionate manner which is separate and apart from the medical staff disciplinary process. This committee shall keep all information confidential. This committee shall address issues of practitioner health to include physical, psychiatric or emotional illness. It shall be responsible for facilitating confidential diagnosis, treatment and rehabilitation of practitioners who suffer from a potentially impairing condition. The committee shall focus on assistance and rehabilitation, rather than discipline, to aid a practitioner in retaining or regaining optimal professional functioning, consistent with the protection of patients. If at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that a practitioner is unable to safely perform the privileges he or she has been granted, the matter shall be forwarded to the Chief of Staff or his or her designee for appropriate corrective action. Reporting of such corrective action shall be in accordance with State and Federal reporting requirements. The committee shall be empowered to rule whether the disciplinary process or the physician health route best addresses a physician problem.

The committee may receive reports, through self-referrals or referrals by hospital staff or medical staff, related to the health, well-being or impairment of medical staff members. The committee may, as it deems appropriate, investigate such reports for the credibility of the complaint, allegation, or concern. With respect to matters involving individual medical staff members, the committee, or a designee of the committee, may confront the individual and provide advice, counseling, or referrals to the appropriate professional internal or external resources for the diagnosis and treatment of the condition or concern. Such activities shall be confidential to the extent that the affected practitioner voluntarily participates in any recommended programs and monitoring. In the event that the affected practitioner refuses such referral and the committee determines that further action is necessary, then the committee may forward its recommendation to the Chief of Staff for corrective action. To assure patient safety, the committee shall monitor the participating practitioner and the care provided to the patients he or she diagnoses or treats, until the rehabilitation or any disciplinary process is complete.

The committee shall also consider general matters related to the health and well being of the medical staff and develop educational programs or related activities about illness and impairment recognition issues specific to medical staff members for the hospital and medical staff. Education may include but not be limited to: medical staff presentations, training of nurses, and regular ongoing publicity through bulletin boards, newsletters and staff notices.

The committee shall report to the Medical Executive Committee on at least an annual basis the following summary information:

1. The number of referrals received for evaluation in the current reporting period;
2. The number of those referrals accepted for monitoring;
3. The total number of individuals currently being monitored;
4. The number of individuals released from monitoring in the current reporting period;
5. The number of individuals referred for corrective action in the current reporting period.

- C. Meetings. The committee shall meet as often as necessary to accomplish its functions. It shall maintain only such record of its proceedings as it deems advisable but any records regarding individual practitioners shall be kept strictly confidential and maintained independently from any general records of the committee

and the credentials file. In the event that a referral for corrective action is deemed necessary, the committee may submit any documents necessary to support the referral.

SECTION 6 - QUALITY REVIEW COMMITTEE

- A. Composition: The Quality Review Committee shall consist of those members of the medical staff that shall be appointed from time to time to serve on such committee in accordance with the Bylaws of the Medical Staff and shall also have as a non-voting member the Director of Quality Management to carry out support functions. The chairman of this committee shall be appointed in accordance with the Bylaws of the Medical Staff.
- B. Responsibilities, Duties, and Authority: This Committee addresses peer review issues that may be identified, but not limited to chart reviews, quality indicators, data from hospital committees, patient or family complaints, and variance report forms. It reviews and acts upon, on a regular basis, factors affecting the quality and safety of patient care provided in the hospital. It is a standing committee of the Medical Staff and it reports to the Executive Committee. In order to facilitate the successful operation of the Quality Plan, which at times mandates change through corrective action, the Quality Review Committee is authorized and empowered to affect the following procedures:
- Recommendation of specific corrective action for the solution of concerns.
 - Submission of reports detailing problem resolution or specific concerns.
 - May initiate the Behavioral Event Review Committee responsible for evaluating and investigating reports of disruptive behavior and determining the appropriate disposition of the issue. The Behavioral Event Review Committee (BERC) will function as an ad hoc committee of the Quality Review Committee. It will meet at the direction of the Committee Chair and will include additional ad hoc members. The BERC will report its activities and findings to the Quality Review Committee.
- C. Meetings: The Quality Review Committee shall meet monthly or as needed to carry out its functions and duties; shall record minutes of its findings, proceedings and actions; and shall make such recommendations to the appropriate hospital committees as deemed necessary.

ARTICLE XI - MEETINGS

SECTION 1 - GENERAL STAFF MEETINGS

- A. Regular Meetings. Regular meetings of the medical staff shall be held at least annually. The annual general medical staff meeting shall be the last meeting before the end of the designated medical staff term. The agenda of such meetings shall include cumulative reports by staff officers and by committee chairman of the review and evaluation of the work done. Elections for staff office will be held at this meeting. The Chief of Staff shall preside at all general meetings of the medical staff. This meeting will be a mandatory meeting unless member is excused by the Chief of Staff.
- B. Order of Business and Agenda. The order of business and agenda of a general staff meeting will be determined by the Chief of Staff. Except under the provisions of new business, no additional agenda items requiring a vote will be permitted unless they have been requested in writing with justification at least five (5) days prior to the meeting and approved by the Chief of Staff.

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- C. Special Meetings. Special meetings of the medical staff may be called at any time by the Chief of Staff and shall be called at the written request of the Hospital President, Board of Trustees, the MEC, or at least one-fourth (1/4) of the active staff members. The Chief of Staff shall call a special meeting within seven (7) days of his receipt of written request for same.
1. Written or printed notices stating the place, day, and hour of any special meetings of the medical staff shall be delivered, either personally or by mail, to each member of the active staff not less than five (5) nor more than ten (10) days before the date of such meetings, by or at the direction of the Chief of Staff. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail, addressed to each staff member at his address as it appears in the records of the hospital. Notice may also be sent to members of other medical staff groups who have so requested. The attendance of a member of the medical staff at a meeting shall constitute a waiver of notice of such meeting.
 2. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

SECTION 2 - COMMITTEE MEETINGS

- A. Medical staff committees and clinical services may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall then be required.
- B. A special meeting of any committee may be called by or at the request of the chairman or chief thereof, by the Chief of Staff, or by one-third (1/3) of the group's current members. No business shall be transacted at any special meeting except that stated in the meeting notice.
- C. Notice of Meetings.
1. Notice of regular meetings may be given orally or in writing.
 2. For any special meeting or any regular meeting not held pursuant to resolution, written or oral notice stating the place, day, and hour of the meeting shall be given to each member not less than five (5) days before the time of such meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at his address as it appears on the records of the hospital, with postage prepaid.
- D. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

SECTION 3 - QUORUM

- A. General Staff Meetings (Regular or Special).
1. 25% of the active medical staff members present shall constitute a quorum. Except as otherwise specified, the action of a majority of the total of those Active Medical Staff members who vote at any regular or special meeting shall constitute the action of the group. A majority shall be defined as one member over half of the total of those Active Medical Staff members who are present and voting and any members who may have submitted written ballots.

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2. In the absence of a quorum, the Chief of Staff may direct a ballot by mail with the approval of the majority present.

B. Committee.

The presence of at least two (2) voting members shall be required for all committee meetings to constitute a quorum with the exception of the Medical Executive Committee. The presence of fifty percent (50%) of the members of the Medical Executive Committee shall constitute a quorum for any regular or special meeting of that committee.

SECTION 4 - MANNER OF ACTION

- A. Except as otherwise specified in these bylaws, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group.
- B. Action may be taken without a meeting of a committee by a writing setting forth the action so taken and signed and dated by a majority of the members entitled to vote thereat.

SECTION 5 - MEETING MINUTES

Minutes of all meetings shall be prepared by the secretary of the meetings and shall include a record of attendance and the vote taken on each matter. The minutes shall record a brief discussion of all problems discussed, indicating any recommendations made and forwarded, conclusions reached, and actions taken. The minutes shall be signed by the presiding officer, approved by the attendees, and forwarded to the MEC and the quality/performance management committee. A permanent file of the minutes of each meeting (and the actions taken without an actual meeting) shall be maintained.

SECTION 6 - NONVOTING EX OFFICIO MEMBERS

Individuals serving under these bylaws as nonvoting ex officio members of a committee shall, unless otherwise specified, have all other rights and privileges of regular members, except they shall not be counted in determining the existence of a quorum.

SECTION 7 - MEETING AS A COMMITTEE OF THE WHOLE

Notwithstanding any other provision of these bylaws, whenever the medical staff meets, it shall be considered to be meeting as a committee of the whole medical staff, respectively.

SECTION 8 - CONDUCT OF MEETINGS

All meetings shall follow an acceptable form of parliamentary procedure, such as The Standard Code of Parliamentary Procedure (unless otherwise stated in these bylaws, in which the bylaws will overrule the procedure), in the conduct of meeting business.

ARTICLE XII - CONFIDENTIALITY/IMMUNITY FROM LIABILITY

SECTION 1 - CONFIDENTIALITY OF INFORMATION

- A. General. Records and proceedings of the medical staff, the Board of Trustee's, and all hospital and medical staff committees with responsibility for evaluating and improving quality of care, patient safety or provider performance in this hospital (to include information regarding any member or applicant to the medical staff or for clinical privileges or practice prerogatives), shall be confidential, subject to release only in accordance with policies of the medical staff and shall be privileged to the fullest extent permitted by federal and state laws. Furthermore, each committee (whether medical staff, Board of Trustee's, ad hoc, subcommittee, or joint committee), as well as the general medical staff and the Board of Trustee's when meeting as a whole, shall be constituted and operate as a medical peer review committee/medical committee/professional review body, as such terms are defined by law, and each is hereby authorized by the Board of Trustee's to function as a committee for purposes of peer review.
- B. Agreement to maintain confidentiality. All individuals participating or attending such committees or who are entitled to access such information shall execute an agreement to keep all of the proceedings, minutes, discussions and documents related to any peer review, clinical performance or quality management matter confidential and subject to disclosure only in accordance with policies of the medical staff.
- C. Patient Records. All patient records that contain individual patient identifiable information shall be kept confidential in accordance with State and Federal regulations, as well as with the Hospital Privacy Policies and Procedures.
- D. Breach of confidentiality. Inasmuch as effective peer review, credentialing and quality/performance management activities must be based on free and candid discussions, any breach of confidentiality of the discussions, deliberations or records of any medical staff meeting, or committee is outside appropriate standards of conduct for this medical staff and will be deemed disruptive to the operation of the hospital and as having an adverse impact on the quality of patient care. Such breach or threatened breach shall subject the individual to disciplinary action under the medical staff bylaws, rules and regulations and applicable hospital policies; any individual, committee or entity which may be damaged by such violation may seek enforcement by a court order for injunctive or other appropriate relief.

SECTION 2 - PRIVILEGES/IMMUNITY

- A. Privileges. Any act, communication, report, recommendation, or disclosure with respect to any applicant or member of the medical staff, committee member, or practice prerogatives performed or made for the purpose of assessing patient care or achieving and maintaining quality patient care in this or any other health care facility shall be privileged to the fullest extent permitted by law.
- B. Application. Such privileges shall extend to all individuals participating in the process of assessing patient care or achieving and maintaining quality patient care and practitioner performance including, but not limited to, members of the medical staff or Board of Trustee's, allied health professionals, the Hospital President and designees and to third parties who supply information to any of the individuals or committees authorized to receive, release or act upon such information. For the purpose of this Article the term "third parties" means both individuals and organizations from which information has been requested and/or

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received by an authorized representative of a health care facility, its Board of Trustees, the medical staff, or any committee or component thereof.

- C. Immunity. The Hospital, Medical Staff and any representatives, agents or consultants of either the Hospital or the Medical Staff will have absolute immunity from civil liability for any act, communication, report, recommendation or disclosure to the maximum extent permitted by law.
- D. Professional Review Privileges and Immunities. The Board of Trustees, any committees of the Medical Staff and/or of the Board of Trustees who conduct professional review activities and any individuals within the hospital authorized to conduct professional review activities, hereby constitute themselves as professional review bodies as defined in the Healthcare Quality Improvement Act of 1986. Each professional review body hereby claims all privileges and immunities afforded to it by such federal statute and any other state statutes which may be applicable. Any action taken by a professional review body pursuant to these Medical Staff Bylaws or the membership procedure shall be in the reasonable belief that it is in the furtherance of quality healthcare (including the provision of care in a manner that is not disruptive to the delivery of quality medical care at the hospital) only after a reasonable effort has been made to obtain the true facts of the matter, after adequate notice and hearing procedures are afforded to any applicant or medical staff member, and only in the reasonable belief that the action is warranted by the facts known after a reasonable effort has been made to obtain the facts.

SECTION 3 - RELEASES

All applicants and members shall execute a release of liability and of confidential information pursuant to these bylaws.

ARTICLE XIII - AMENDMENT AND ADOPTION OF BYLAWS

SECTION 1 - MEDICAL STAFF RESPONSIBILITY

The medical staff (through its bylaws committee and the Medical Executive Committee) shall have the initial responsibility to formulate, adopt and recommend to the Board of Trustees, medical staff bylaws and amendments thereto which shall be effective when approved by the Board of Trustees. Such responsibility shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally recognized professional level of quality and efficiency and of maintaining a harmony of purpose and effort with the Board of Trustees and with the community.

SECTION 2 - METHODOLOGY

Medical staff bylaws must be adopted, amended, or repealed by the following process:

- A. the affirmative vote of the Bylaws, Rules and Regulations Committee;
- B. the affirmative vote of the MEC;
- C. the affirmative vote by the majority of the Active status medical staff and eligible to vote on this matter by written ballot or by action; and
- D. the approval of the Board of Trustees, which shall not be unreasonably withheld.

The Medical Staff Bylaws must be adopted by the Medical Staff and approved by the Board of Trustees before becoming effective. Neither body may unilaterally amend the medical staff bylaws. Any manuals adopted as a part

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of these Bylaws may be adopted or amended by the approval of both the Medical Executive Committee and the Board of Trustee's.

ARTICLE XV – MISCELLANEOUS PROVISIONS

SECTION 1 – PHYSICAL EXAMINATION AND HISTORY

A medical history and physical examination be completed no more than 30 days prior to or within 24 hours after inpatient admission. For a medical history and physical examination that was completed within 30 days prior to inpatient admission, an update documenting any changes in the patient's condition is to be completed within 24 hours after inpatient admission or prior to surgery.

ARTICLE XVI – RULES AND REGULATIONS

SECTION 1 - MEDICAL STAFF RULES AND REGULATIONS

The medical staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these bylaws. The rules and regulations shall relate to the proper conduct of medical staff organizational activities and will embody the specific standards and level of practice that are required of each medical staff member and other designated individuals who exercise clinical privileges or provide designated patient care services in the hospital. Rules and regulations may be added, amended or repealed at any regular meeting of the Medical Executive Committee. All such changes in the rules and regulations shall not become effective until approved by the Board of Trustee's.

SECTION 2 - RULES AND REGULATIONS

The Medical Staff established through these bylaws shall formulate and implement rules and regulations which will become effective upon approval of the Medical Executive Committee and the Board of Trustee's. Rules and regulations shall be consistent with these bylaws, with the medical staff rules and regulations, and with established hospital policies, and will include standards of performance for members.

RELATIONSHIP TO BYLAWS

In the event there is a discrepancy between the bylaws and any rules and regulations, the bylaws shall supersede the rules and regulations.

These Medical Staff bylaws are adopted by the Medical Staff:

By: Michael Pettibon, MD Date: July 11, 2007
By: O. David Taunton, MD Date: December 18, 2008
By: O. David Taunton, MD Date: July 1, 2009

Approved by the Board of Trustee's

By: Mary Brian, MD Date: July 18, 2007
By: Mary Brian, MD Date: December 18, 2008
By: David Rothbart, MD Date: July 1, 2009

CHANGES MADE TO BYLAWS

Revisions approved on 12/05/2007:

Page 20: Resident Staff added to Article V – Categories of the Medical Staff

Page 34: Change to verbiage of Quality/Performance Management and Peer Review Inquiries.

Revisions approved on 12/17/2008:

Page 6: TB testing requirement added to Section 3 - Qualifications and Obligations of Membership or Privileges

Page 9: ID requirement added to Procedure for Appointment

Pages 50 – 52: Article X – Clinical Divisions deleted

Page 53: Section 2 – Medical Executive Committee (MEC) addition of “other medical members as designated”. Deletion of “the department chairmen and vice chairmen of medicine and surgery.”

Page 54: Section 2 – Medical Executive Committee (MEC) change of meeting requirement from ten (10) to six (6) times per year.

Page 55: Section 5 – Medical Staff Health/Well Being Committee changed to Behavioral Event Review Committee (BERC).

Page 56: Addition of Section 6: Quality Review Committee

Revisions approved 7/01/2009:

Article II – Name: Change from Harris Methodist Southlake Center for Diagnostics & Surgery to Texas Health Harris Methodist Hospital Southlake.

Article IV – Medical Staff Membership, Section 3 – Qualifications and Obligations of Membership or Privileges, Section B, number 26: Change to name of policy from “Disruptive Behavior, Discrimination, or Harassment to *“Management of Disruptive Practitioner”*

Article IV – Medical Staff Membership, Section 3 – Qualifications and Obligations of Membership or Privileges, Section C: On Call Responsibilities: Change from Emergency Medicine to *Family Practice*; removed “established by the Board of Trustee’s in consultation with the MEC”; removed “or on a department or service basis by vote of the board of Trustee’s; it determines, after consultation with the MEC, that”; added - *Specialty on-call coverage shall be available twenty-four (24) hours a day, seven (7) days a week. Schedules, names, and contact numbers for on-call physicians shall be available at all times in the hospital. Such records shall be retained in the hospital for one (1) year. All specialties with four or more physicians on active staff will be listed on the on-call rotation. Physicians 60 years or older will not be required to take specialty on-call. In the event an on-call physician cannot be contacted, the next listed on-call physician will be called.*

Article V – Categories of the Medical Staff, Section 7 – Allied Health Professionals, Paragraph B: Removal of Categories of AHP’s Eligible for Practice Prerogatives

Article V – Categories of the Medical Staff, Section 7 – Allied Health Professionals, Paragraph D, number 2: added “must be under the supervision of a”; deleted – shall be assigned a supervising, if appropriate, Practitioners who desire to supervise or direct AHPS who provide dependent services must apply and qualify for privileges to supervise approved AHP’s.

Article X – Committees and Functions, Section 5: Change name of committee from Behavioral Event Review Committee (BERG) to Physician Assistance Committee. Paragraph B: removal of verbiage: It is recognized that medical staff members face unique stresses involving professional or personal matters that may affect all aspects of their lives, and accordingly may impact the quality of care they render. . (i.e., not accessible to either the hospital administration or the medical staff.) The goal is to gain the trust of the medical staff members, impaired or not; including the prevention of. Additional verbiage – *to include*

Article X – Committees and Functions, Section 6 – Quality Review Committee: Addition of Behavioral Event Review Committee as an ad hoc committee of the QRC.