Hendrick Medical Center Brownwood

Medical Staff Bylaws

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BYLAWS OF THE MEDICAL STAFF OF HENDRICK MEDICAL CENTER BROWNWOOD

PREAMBLE

The primary aim of the Medical Staff is to achieve the highest quality of patient care that is possible with the available resources. Cooperation between the Medical Staff, Hospital management and the Board of Trustees is necessary to fulfill the Hospital's aims and obligations. The Medical Staff is an essential component of the Hospital and is subject to the ultimate authority of the Board of Trustees of Hendrick Medical Center Brownwood.

No Practitioner shall be entitled to Staff appointment and privileges at this Hospital solely by reason of education, licensure, or appointment to the Staff of another Hospital. The Medical Staff is directly accountable to the Board of Trustees for assessing and verifying the qualifications and competence of its members.

The following Bylaws have been established and approved by the Medical Staff and the Board of Trustees to facilitate the aims and purposes outlined above.

DEFINITIONS

1. **"Allied Health Professional" or "AHP"** means an individual, other than a licensed physician/ practitioner as approved by the Board of Trustees, whose patient care activities require that his or her authority to perform specified patient care services be processed through the usual Staff channels delineating his or her qualifications, status, clinical duties, and responsibilities. The Allied Health Professional Policy is incorporated into these Bylaws.

2. **"Administration"** means executive members of the Administration of the Hospital, including the CEO.

3. **"Admission"** refers to all admissions and observation stays in the acute care Hospital, the skilled nursing unit and day surgery.

4. ***"Board Certification"*** shall mean certification by a member board of the American Board of Medical Specialties, the American Osteopathic Board, American Board of Dentistry, American Board of Podiatric Surgery, and their approved sub-specialty Boards, and other Boards recognized by the Texas Medical Board.

5. **"Board of Trustees" or "Trustees"** means the local governing board of Hendrick Medical Center Brownwood.

6. **"Chief Administrative Officer" or "CAO"** means the individual appointed by Hendrick Medical Center to act on its behalf in the overall management of the Hospital. Whenever the word Administrator is used in these Bylaws, it shall mean CAO.

7. **"Chief of Medicine" and "Chief of Surgery"** mean the Medical Staff member duly appointed or elected in accordance with these Bylaws to serve as the head of each Department.

8. **"Clinical Privileges" or "privileges"** mean the Trustees' recognition of the physicians'/practitioners' competence and qualifications to render specific professional, diagnostic, therapeutic, medical, dental, podiatric, or surgical services.

9. **"Credentials Policy"** means the procedure adopted by the Medical Staff with the approval of the Board to investigate and consider each application for appointment or reappointment to the staff and each request for modification of staff membership status or privileges. The Credentials Policy is incorporated into these Bylaws as Appendix B.

10. **"Data Bank"** means the National Practitioner Data Bank (or any state designee), established pursuant to the Health Care Quality Improvement Act of 1986.

11. **"Department"** means the group of Practitioners who have Clinical Privileges in one of the general areas of medicine or surgery.

12. **"Ex Officio"** means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

13. **"Fair Hearing Plan"** means the Fair Hearing Plan incorporated into these Bylaws as Appendix A.

14. **"HCQIA"** means the Health Care Quality Improvement Act of 1986, 42 U.S.C.A. 11101 et seq., and any amendments to this Act.

15. **"Hospital"** means Hendrick Medical Center Brownwood, 1501 Burnet, Brownwood, Texas, 76801.

16. **"Medical Executive Committee" or "MEC"** means the Executive Committee of the Medical Staff.

17. **"Medical Staff" or "Staff"** means all duly licensed Physicians, Dentists, and Podiatrists who have been appointed to the Medical Staff and granted Clinical Privileges by the Trustees to attend patients in the Hospital.

18. **"Peer",** for credentialing purposes, means a Practitioner in the same professional discipline as the applicant.

19. **"Physician"** means an individual who is properly licensed to practice medicine in the state of Texas.

20. **"Policies"** means the Policies attached to these Bylaws, which govern the overall conduct of patient care and may affect the Medical Staff, Nursing Staff and Hospital personnel.

21. **"Practitioner"** means, unless otherwise limited, any Physician, Dentist, Podiatrist, or Allied Health Professional (AHP) applying for or possessing Clinical Privileges at Hendrick Medical Center Brownwood.

22. **"Prerogative"** means a participatory right granted, by virtue of Staff category or otherwise, to a Staff appointee or Allied Health Professional and exercisable subject to the conditions imposed in these Bylaws and in other Hospital and Staff Policies.

23. Pronouns used in the masculine refer to both male and female Practitioners.

24. **"Rules and Regulations"** means the Rules and Regulations attached to these Bylaws, which govern the actions of the Medical Staff.

25. **"Special Notice"** means written notification sent by certified or registered mail, return receipt requested or hand-delivered with signature requested on receipt.

26. **"Staff year"** means the period from January 1st through December 31st.

27. **"Telemedicine"** means the use of electronic communication or other communication technologies to provide or support clinical care at a location remote from Hospital.

1 NAME

The Practitioners granted Medical Staff appointment and Clinical Privileges to practice in this Hospital shall be collectively known as the Medical Staff of Hendrick Medical Center Brownwood, Brownwood, Texas.

2 PURPOSE AND RESPONSIBILITIES

2.1 PURPOSE: The purpose of the Medical Staff organization is to promote the objective that its members provide the highest quality care possible with the available resources for all Hospital patients.

2.2 **RESPONSIBILITIES:** The responsibilities of the Medical Staff are:

2.2.1 To account and to report to the Trustees regarding the quality of patient care by the Medical Staff and Allied Health Professional Staff. This will be facilitated by:

2.2.1.1 An ongoing peer review process of Medical Staff patient care activities that can be used by the Trustees in their oversight of patient care;

2.2.1.2 A utilization review program to allocate inpatient medical, surgical, and health-related services; and

2.2.1.3 Retrospective review and evaluation of the quality of patient care through a valid and reliable Performance Improvement Plan, including data compilation, medical record administration, review and evaluation of cost effectiveness and other such functions necessary to meet accreditation and licensure standards, as well as federal and state law requirements.

2.2.2 To maintain appropriate rules, regulations, and policies to achieve Section 2.1.

2.2.3 To recommend to the Trustees action with respect to appointments, reappointments, Medical Staff category, and Clinical Privileges. The credentialing program will include detailed mechanisms and criteria for appointment and reappointment to the Medical Staff Clinical privileges to be exercised or of specified procedures to be performed will be matched with the verified credentials and demonstrated current competence of the applicant or Medical Staff member.

2.2.4 To initiate and implement corrective actions with respect to Practitioners and AHP's when warranted, in adherence with the attached Policies.

2.2.5 To maintain a continuing medical education program directed at least in part by needs demonstrated by peer review processes, patient care audits, utilization review, or other quality assurance programs.

2.2.6 To exercise the authority granted by these Bylaws as necessary to adequately fulfill the foregoing responsibilities.

2.2.7 Implement a process to identify and manage matters of individual physician health that is separate from the Medical Staff disciplinary function in accordance with the Impaired Practitioner Policy as incorporated into these Bylaws. (Appendix L) **(Revision from Appendix D to L approved by BOT 8/26/2015)**

2.2.8 Maintain confidentiality with respect to the medical records of the Hospital, except as disclosure is required by law.

2.3 **REPORTING AND OBTAINING REPORTED INFORMATION:** The Medical Staff shall comply with all legal and accreditation requirements applicable to the Hospital. Any reports required of the Medical Staff or a Medical Staff committee shall be made by the CEO or his designee in consultation with the Chief of Staff.

2.4 **RELATIONSHIP WITH THE BOARD OF TRUSTEES:** The Medical Staff, as an integral component of the Hospital, shall coordinate its activities with the Trustees. The Medical Staff shall, in such activities, develop, adopt, and annually review these Bylaws and Rules and Regulations, to ensure they are consistent with the current Hospital practice and with applicable legal and other requirements. The Medical Staff shall review the Medical Staff Policies, as needed, but at a minimum of every three (3) years to ensure they are consistent with the current Hospital practice and with applicable legal and other requirements. **(Revision approved by the BOT on 8/16/2017)** These Bylaws, Rules and Regulations, and Policies, and any amendments or modifications thereto, are subject to, and effective upon, approval by the Trustees. Neither the Medical Staff nor the Trustees may unilaterally amend these Bylaws. By approval of these Bylaws, the Trustees acknowledge that any approvals will not be unreasonably withheld.

2.5 **CONFLICT RESOLUTION COMMITTEE:** The Conflict Resolution Committee shall provide an ongoing process for managing conflict among leadership groups. The Committee shall meet, as needed, specifically when a conflict arises that, if not managed, could adversely affect patient safety or quality of care. When such a conflict arises, the Committee shall meet with the involved parties as early as possible to resolve the conflict, gather information regarding the conflict, work with the parties to manage and, when possible, resolve the conflict, and to protect the safety and quality of care.

2.6 **PARTICIPATION IN ORGANIZED HEALTH CARE ARRANGEMENT:** Patient information will be collected, stored and maintained so that privacy and confidentiality are preserved. The Hospital and each member of the Medical Staff will be part of an Organized Health Care Arrangement ("OHCA"), which is defined as a clinically-integrated care setting in which individuals typically receive healthcare from more than one healthcare provider. The OHCA allows the Hospital and the Medical Staff members to share information for purposes of treatment, payment and health care operations. Under the OHCA, at the time of admission, a patient will receive the Hospital's Notice of Privacy Practices, which will include information about the Organized Health Care Arrangement between the Hospital and the Medical Staff.

3 MEDICAL STAFF MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP: Medical Staff appointment is a privilege extended by the Hospital, and is not a right of any Practitioner. Appointment to the Medical Staff or the exercise of temporary privileges shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. Appointment to the Medical Staff shall confer on the appointee only such Clinical Privileges and Prerogatives as have been granted by the Trustees in accordance with these Bylaws.

No aspect of Medical Staff appointment or particular Clinical Privileges shall be denied on the basis of sex, race, creed, color, national origin, or handicap; except that disability may be considered to the extent that it affects the delivery of quality patient care. Credentialing criteria that are specified in the Bylaws shall be applied uniformly to all applicants.

3.2 QUALIFICATIONS FOR MEMBERSHIP

3.2.1 Only Practitioners legally licensed to practice medicine, dentistry, or podiatry in the state of Texas shall be qualified for membership in the Medical Staff. Applicants must:

3.2.1.1 Document their background, training, experience, and current competence to perform the privileges requested;

3.2.1.2 Document any physical, mental, or emotional condition that would affect their ability to performed the privileges requested in accordance with accepted professional standards to fulfill the essential functions of the Medical Staff membership;

3.2.1.3 Document their good reputation, their ability to work cooperatively with others and their adherence to the legally enforceable ethics of their profession;

3.2.1.4 Practitioners must not be excluded by sanction from Federal government healthcare programs including Medicare and Medicaid, and may not be under a program suspension of any type.

3.2.2 The documentation mentioned above must be sufficient to assure the Medical Staff and the Trustees that the Practitioner has the necessary qualifications and competency to provide patients with quality patient care and meet the obligations of Medical Staff membership and that the Practitioner is qualified to provide a needed service within the hospital;

3.2.3 The burden shall be on the applicant to establish that he is professionally competent and worthy in character, professional ethics and conduct. Acceptance of appointment to the Medical Staff shall constitute the appointee's certification that he has in the past, and agrees that he will in the future, strictly abide by the lawful ethical principles of his profession; and

3.2.4 No Practitioner shall be entitled to membership in the Medical Staff or to the exercise of particular Clinical Privileges in the Hospital merely by virtue of the fact that he is duly licensed to practice medicine, dentistry, or podiatry in this or in any state, or that he is certified by any clinical board, or that he is a member of any professional organization, or that he had in the past, or presently has, such privileges at this Hospital, another healthcare facility, or in another practice setting.

3.2.5 Evidence of professional liability insurance with a minimum of one hundred thousand dollars per occurrence and three hundred thousand dollars per aggregate ($100,000/ $300,000) coverage. Such insurance shall be with a carrier reasonably acceptable to the Board of Trustees and shall comply with Section 2.3.2.3 of the Credentials Policy (Appendix B).

3.2.6 Such insurance shall be on an occurrence basis or a claims-made basis. The practitioner shall agree to obtain coverage with appropriate prior acts coverage for his/her specialty. At a minimum the policy should cover the two prior years. This may be either in the form of a tail coverage from the previous insurance carrier or prior acts coverage by the current insurance carrier. Each practitioner shall inform the Medical Staff Office of the details of such coverage at the time of policy renewal, and shall also be responsible for immediately advising the Medical Staff Office of any change(s) in such professional liability coverage.

3.3 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP: Each member of the Medical Staff shall:

3.3.1 Provide patients with care at the generally recognized standard of professional quality and efficiency;

3.3.2 Abide by the current Medical Staff Bylaws and by all other lawful and accreditation standards as well as all applicable State and Federal statutes;

3.3.3 Abide by applicable Hospital policies and the Hospital's Corporate Compliance program, current Policies and rules of the Hospital;

3.3.4 Participate as requested by the MEC in the delivery of emergency services;

3.3.5 Cooperate in any performance improvement activities or other medical peer review activities as requested;

3.3.6 Discharge such Medical Staff, committee, and Hospital functions for which he is responsible by appointment, election or otherwise;

3.3.7 Prepare and complete in a timely fashion and in adequate detail the medical and other required records for all patients he admits or in any way provides care to in the Hospital;

3.3.8 Refuse to engage in improper inducements for patient referrals which violate ethical and regulatory standards;

3.3.9 Comply with all state and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act of 1996, as amended, and its associated regulations; and

3.3.10 It is the responsibility of all Medical Staff members to immediately notify the Chief of Staff of the following:

3.3.10.1 Revocation, suspension, adverse action/Agreed Order, or limitation of professional license in any state,

3.3.10.2 Involuntary loss of medical staff membership or privileges at any hospital,

3.3.10.3 Loss of professional liability insurance,

3.3.10.4 Filing of criminal charges by any law enforcement agency, and

3.3.10.5 Sanction or suspension from Federal or State government healthcare programs including Medicare and Medicaid.

3.3.10.6 Currently either voluntarily or involuntarily participating in any rehabilitation or impairment program, or ceases participation in such a program without successful completion.

3.3.10.7 Being named as a defendant, or being subject to a final judgment or settlement, in any court proceeding alleging that the member committed professional negligence or fraud.

Full disclosure of the events leading to the actions taken is required.

3.4 CONDITIONS AND DURATION OF APPOINTMENT

3.4.1 The Trustees shall grant initial appointments and reappointment to the Medical Staff. The Trustees shall act on appointments and reappointments only after there has been a recommendation from the MEC as provided in these Bylaws and the Credentials Policy (Appendix B). In the event of unwarranted delay on the part of the Medical Staff, the Trustees may act without such recommendation on the basis of documented evidence of the applicant's or Medical Staff member's professional and ethical qualifications obtained from reliable sources other than the Medical Staff.

3.4.2 Initial and Additional Privileges: All initial appointments and grants of new or additional privileges to existing members of the Medical Staff shall be subject to a period of focused professional practice evaluation for a period of not less than six (6) months. The period of review may be renewed for additional period up to the conclusion of the member's period of initial appointment or initial grant of new or additional privileges. Results of the focused professional practice evaluation conducted during the period of focused review shall be incorporated into the practitioner's evaluation of reappointment.

3.4.3 Initial appointments for all categories of the Medical Staff, and the Allied Health Professional Staff, shall be for a period of one year. Reappointments shall be for a period of not more than two years commencing on the anniversary date of the initial appointment.

3.4.4 Appointment to the Medical Staff shall confer on the appointee only such Clinical Privileges as have been granted by the Trustees, in accordance with these Bylaws, and the Bylaws of the Board of Trustees.

3.4.5 Every application for Medical Staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgement of his obligations as set forth in Section 3.3.

3.4.6 A Practitioner who relocates with no in-house activity for a period up to 2 years might not be eligible for reappointment.

3.5 LEAVE OF ABSENCE

3.5.1 INITIATION OF LEAVE STATUS: A Medical Staff member may obtain a voluntary leave of absence from the Medical Staff by submitting written notice to the MEC and the CEO stating the exact period of time of the leave, which may not exceed one year.

When an active or provisional/active Medical Staff member has not admitted a patient to the Hospital or has not provided medical, dental, or podiatric services to any patient in the Hospital for twelve (12) months, he shall be given Special Notice that in thirty (30) days he shall automatically be deemed to be in a leave-of-absence status for the subsequent six-month period. During the period of a leave, the Medical Staff member's privileges and prerogatives shall be suspended without any procedural rights being afforded to the affected Practitioner.

3.5.2 REINSTATEMENT FOLLOWING LEAVE: At least sixty (60) days prior to the termination of the leave, or at any earlier time, the Medical Staff member may request reinstatement of his privileges and prerogatives by submitting a written notice to that effect to the CEO for transmittal to the MEC.

The Medical Staff member shall submit a written summary of his relevant activities during the leave, if the MEC so requests. A Medical Staff member placed automatically on leave status as provided in the leave status Section 5A shall also, if requested by the MEC, account in a written summary for his relevant activities during the entire period in which he did not admit patients to or practice in the Hospital. A medical clearance by a Physician will be required prior to being reinstated for a medical leave of absence.

MEC shall make a recommendation to the Trustees concerning the reinstatement of the member's privileges and prerogatives. Failure to request reinstatement or to provide a requested summary of activities as above provided shall result in automatic termination of Medical Staff membership, privileges and prerogatives without right of hearing or appellate review.

A request for Medical Staff membership subsequently received from a Medical Staff member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

If a member requests leave of absence status for the purpose of obtaining further medical training in his own or another field of medical practice, reinstatement will become automatic upon request for same. However, any new privileges requested will be acted upon and monitored as if the member were a new applicant.

Reinstatement will be automatic if leave of absence if for service in any branch of the armed forces. If leave of absence occurs with no medical activity for twelve (12) or more months, the MEC may require proof of competence by either further education, i.e. a refresher course, and/or appropriate monitoring for a period of time to ensure continuing competence.

4 CATEGORIES OF THE MEDICAL STAFF

4.1 THE MEDICAL STAFF

The Medical Staff shall be divided into active, courtesy, consulting, and honorary categories. Members in their first year of service shall be considered provisional members of each category.

4.2 THE ACTIVE MEDICAL STAFF

4.2.1 QUALIFICATIONS: The active Medical Staff shall consist of Practitioners who regularly admit patients to or are otherwise regularly involved in the care of patients in the Hospital and whose office and residence are close enough to the Hospital to provide continuous care to their patients. "Close enough" is defined as within 30 minutes of the hospital with exceptions considered only in extraordinary circumstances. The Trustees shall make the final determination of "close enough". For purposes of determining whether a practitioner is "regularly involved" in the care of the requisite number of patients, a patient encounter or contact shall be deemed to include any of the following:

4.2.1.1 admission;

4.2.1.2 consultation with active participation in the patient's care;

4.2.1.3 provision of direct patient care or intervention in the hospital setting;

4.2.1.4 performance of any outpatient or inpatient surgical or diagnostic procedure; and

4.2.1.5 interpretation of any inpatient or outpatient diagnostic procedure or test.

When a patient has more than one procedure or diagnostic test performed or interpreted by the same practitioner during a single hospital stay, the multiple tests for that patient shall count as one patient contact.

Members of the active Medical Staff must meet the basic qualifications set forth in Article 3, Section 3.2, Qualifications for Membership.

4.2.2 PREROGATIVES: The Prerogatives of an active Medical Staff member are to:

4.2.2.1 Admit patients without limitation; unless otherwise provided in the Medical Staff bylaws, Rules and Regulations or as modified by the Practitioners Clinical Privileges;

4.2.2.2 Exercise such Clinical Privileges as are granted pursuant to the Medical Staff Credentialing Policy;

4.2.2.3 Vote on all matters presented at general and special meetings of the Medical Staff and committees of which he is a member: if has attended 26% of all combined Medical Staff committee meetings that he/ she is responsible to attend during preceding year or portion of year since appointment to the Medical Staff. Voting requirements would be implemented at the October 2013 elections: (Revision approved by the BOT on December 5, 2012)

Examples:

- Active staff members, who have been active staff members greater than one year and not on any committees and attended 2 of 4 quarterly Medical Staff meetings, with 50% attendance would have voting privileges;
- Active staff members, who have been active for 6 months and not on any committees and attended 1 Medical Staff meeting to meet the 26% attendance requirement for voting privileges;
- Active staff members, who are on 1 committee that meets monthly, the active staff member would need to attend 4 meetings, a combination of the monthly committee meetings and quarterly Medical Staff meetings to meet the 26% attendance requirements for voting privileges.

An annual Medical Staff meeting calendar will be sent to the Medical Staff in January or as soon as the dates have been determined by the committees. Once the committee dates have been scheduled for the year, any meetings rescheduled will not be counted as an absence for any physician who is unable to attend due to a prior engagement. (Revision approved by the BOT on July 31, 2013)

4.2.2.4 Attend continuing education activities sponsored by the Medical Staff;

4.2.2.5 Hold office in the Staff organization and in committees of which he is a member, except as noted in Article 8; and

4.2.2.6 With the concurrence of the MEC, call in any non-Staff consultant provided that a written report of the consultation is made a part of the patient's permanent record.

4.2.3 RESPONSIBILITIES: Each member of the active Staff shall:

4.2.3.1 Meet the basic responsibilities set forth in Article 3, Section 3.3;

4.2.3.2 Retain responsibility within his area of professional competence for the continuous care and supervision of each patient in the Hospital for whom he is providing services, or arrange a suitable alternative for such care and supervision;

4.2.3.3 Actively participate in the performance improvement activities and other quality evaluation and monitoring activities required of the Staff, in supervising provisional appointees where appropriate, in the emergency services program, and in discharging such other Staff functions as may be required from time-to-time; and

4.2.3.4 Satisfy the requirements set for the in Article 10 for attendance at meetings and committees of which he is a member (REVISION APPROVED BY BOT ON MAY 1, 2002).

4.3 THE COURTESY STAFF (NEW STAFF CATEGORY APPROVED BY BOT DECEMBER 5, 2012)

4.3.1 QUALIFICATIONS: The Courtesy Staff shall consist of practitioners, each of whom:

4.3.1.1 Meets the basic qualifications set forth in Article 3, Section 3.2, Qualifications for Membership; and

4.3.1.2 Arrange to have continuous coverage of these patients by another member of the staff with privileges appropriate to the treatment provided;

4.3.1.3 Do not have a permanent residence or primary practice within 50 miles of the Hospital;

4.3.1.4 Fills a hospital or community need with the number of allowable patient contacts per month as defined by the Medical Executive Committee or Board of Trustees; and

4.3.1.5 Are members of the Medical Staff of another hospital where he/ she actively participates in the performance improvement program including the peer review process.

4.3.2 PREROGATIVES: The Prerogatives of an Courtesy Staff member shall be to:

4.3.2.1 Exercise such Clinical Privileges as are granted to him pursuant to these bylaws;

4.3.2.2 Attend continuing education activities sponsored by the Medical Staff; and

4.3.2.3 Attend meetings of the General Medical Staff.

4.3.2.4 Serve as a member of a Medical Staff committee with voting privileges. Courtesy Staff are not eligible to hold office in the Medical Staff organization.

4.3.3 RESPONSIBILITIES: Each member of the Courtesy Staff shall:

4.3.3.1 Discharge the basic responsibilities specified in Section 3.3;

4.3.3.2 Retain responsibility within his area of professional competence for the care and supervision of each patient in the Hospital for who he/ she is providing service.

4.3.3.2 Meet Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) guidelines as set forth during the application process.

4.4 THE CONSULTING STAFF (NEW STAFF CATEGORY APPROVED BY BOT ON DECEMBER 5, 2012)

4.4.1 QUALIFICATIONS: The Consulting Staff shall consist of Practitioners, each of whom:

4.4.1.1 Meets the basic qualifications set forth in Article 3, Section 3.2, Qualifications for Membership; and

4.4.1.2 Either refers patients to the Hospital for testing or inpatient care, serves as a consultant for inpatients, or uses the Hospital facilities for specialty clinics.

4.4.2 PREROGATIVES: The Prerogatives of the Consulting Staff member shall be to:

4.4.2.1 Exercise such Clinical Privileges as are granted pursuant to the Credentials Policy (Appendix B);

4.4.2.2 Attend continuing education activities sponsored by the Medical Staff; and

4.4.2.3 Attend meetings of the general Medical Staff.

Serve as a member of a Medical Staff committee with voting privileges. Consulting Staff are not eligible tor hold office in the Medical Staff organization, and may not admit patients to the Hospital.

In the event an Active Staff member changes to Consulting Staff, he/ she will accept the Limitations of Consulting Staff privileges as delineated in Section 3.2 as a voluntary reduction and will not be afforded the rights of the Fair Hearing Plan. (Appendix A).

4.4.3 **RESPONSIBILITIES:** Each member of the Consulting Staff shall be required to discharge the basic responsibilities specified in Article 3, Section 3.3 and, further, shall retain responsibility within his area of professional competence for the care and supervision of their patients.

4.4.3.1 If the consulting physician has a primary residence or practice within 30 minutes of the Hospital, he/ she would be responsible for entering into a call group if that call group already exists per the Medical Staff bylaws.

4.5 THE PROVISIONAL MEDICAL STAFF

4.5.1 Shall be provisional for a minimum of twelve (12) months.

4.5.2 Meets the qualifications specified in Article 3, Section 3.2, Qualifications for Membership.

4.5.3 Provisional members of the Medical Staff are ineligible to hold office in the Medical Staff organization, or to serve on the Executive and Credentials committees.

4.6 THE HONORARY MEDICAL STAFF

4.6.1 **QUALIFICATIONS:** The honorary Medical Staff shall consist of Practitioners who are not active in the Hospital but who are honored by emeritus positions as recommended by the Credentials Committee, approved by the MEC, and granted by the Board of Trustees.

4.6.2 **PREROGATIVES:** Honorary Staff members shall not be eligible to admit patients, to exercise Clinical Privileges, to vote, to hold office, or to serve on standing Medical Staff committees. They may attend Staff meetings or Hospital educational meetings.

4.6.3 **RESPONSIBILITIES:** Each member of the honorary Staff shall be required to discharge the basic responsibilities specified in Article 3, Section 3.3.2 and 3.3.3.

4.7 LIMITATION OF PREROGATIVES

The Prerogatives set forth under such Staff categories are general in nature and may be subject to limitation by special conditions attached to a Practitioner's Staff appointment, any other sections of these Bylaws and by other Policies or agreements of the Hospital.

4.8 DENTAL AND PODIATRIC PRACTITIONERS

The Dental/Podiatric practitioner member must have a Physician member of the active Staff co-admit and co-discharge their patients. A Physician member of the Medical Staff must be responsible for the care of any medical problem or condition of the dental/podiatric patient that may exist at the time of admission or

that may arise during hospitalization and requires attention during the hospitalization that is beyond the scope of the dentist/podiatrist license or privileges as granted by the Trustees.
A Physician member of the active Staff must determine the risk and effect of any proposed dental/podiatric surgical procedure, done as an outpatient or inpatient, on the total health status of the patient.

4.9 PRECEPTEES OR PHYSICIANS-IN-TRAINING

It is recognized that there are preceptees or Physicians-in-training working in the Hospital who, while not members of the Medical Staff, are closely involved in the delivery of health care at Hendrick Medical Center Brownwood. Preceptees or Physicians-in-training are required to abide by the Bylaws and Rules and Regulations of the Medical Staff. They have none of the privileges of the Medical Staff members and their work is done under the supervision of an active member of the Medical Staff who is responsible for their work. This active Medical Staff member must submit a letter to the Credentials Committee as specified in the Allied Health Professional Policy. The scope of their work for preceptees or Physicians-in-training in the Hospital shall be authorized individually by the MEC based upon their documented training and experience.

5 CORRECTIVE ACTION

5.1 PROCEDURE

5.1.1 Corrective action against a Practitioner may be initiated by the appropriate Department Chief, Committee Chair, the MEC, the CEO or a member of the Board of Trustees whenever the activities of the member are considered lower than the standards of the Medical Staff, in violation of the Bylaws, Rules and Regulations, or Hospital policies, or detrimental to patient care or Hospital operations. All requests for corrective action shall be in writing, shall be made to the MEC, and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request.

5.1.2 Unless the grounds for the request for corrective action have already been reviewed by the member's Department of the referring committee (to include notice to the physician/ practitioner of the activities of conduct that are being reviewed and an opportunity for an interview with the Department of committee), the Chief of Staff shall immediately appoint an investigative committee, which may include Medical Staff members or non-Medical Staff members, to investigate the matter. The Practitioner will be notified by certified mail, return receipt that a request for corrective action has been received and an investigation commenced.

5.1.3 Within thirty (30) days after the MEC's receipt of the request for corrective action, the investigative committee shall make a written report of its investigation to the MEC. Prior to the making of such report, the Practitioner against whom corrective action has been requested shall be notified by certified mail, return receipt requested, of his opportunity for an interview with the investigative committee and the activities or conduct which are the grounds for the request. At such interview he shall be informed of the general nature of the charges against him and shall be invited to discuss, explain, or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these bylaws with respect to hearings shall apply thereto. The Practitioner will not be permitted to tape or otherwise electronically record the interview. The investigative committee will forward a written report with their recommendations to the MEC. This section shall not apply if a prior investigation has been conducted as set forth in Section 5.1.2 above.

5.1.4 Within thirty (30) days following receipt of the report from the investigative committee, the MEC shall take action upon the request. The Practitioner shall be notified by certified mail, return receipt requested, of the action recommended by the MEC. If the corrective action could involve a reduction or suspension of Clinical Privileges, or a suspension or expulsion from the Medical Staff, the affected Practitioner shall be permitted to make an appearance before the MEC prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these bylaws with respect to hearings shall apply thereto. The MEC shall make a record of such appearance.

5.1.5 The action of the MEC on a request for corrective action may include, without limitation:

5.1.5.1 to reject or modify the request for corrective action;

5.1.5.2 to issue a warning, a letter of admonition, or a letter of reprimand;

5.1.5.3 to impose terms of probation or a requirement for consultation;

5.1.5.4 to require additional education or training, evaluation and/or treatment, or any other action deemed appropriate;

5.1.5.5 to recommend reduction, suspension or revocation of Clinical Privileges;

5.1.5.6 to recommend that an already imposed summary suspension of Clinical Privileges be terminated, modified, or sustained; or

5.1.5.7 to recommend that the Practitioner's Staff membership be suspended or revoked.

5.1.6 Any recommendation or action that is adverse, as defined in Section 5.4, shall entitle the Practitioner to those procedural rights set forth in the Fair Hearing Plan (Appendix A) and all further procedures shall be in accordance with the Fair Hearing Plan (Appendix A).

5.1.7 Any other recommendation and all supporting documentation shall be transmitted to the Trustees for final decision. If the Trustees take an action that is adverse, as defined in Section 5.4, following a recommendation by the MEC that was not adverse, the Practitioner shall be entitled to those procedural rights set forth in the Fair Hearing Plan (Appendix A) and all further procedures shall be in accordance with the Fair Hearing Plan (Appendix A).

5.1.8 The Chief of Staff shall promptly notify the CEO in writing of all requests for corrective action received by the MEC and shall continue to keep the CEO fully informed of all action taken in connection therewith.

5.2 SUMMARY ACTION

5.2.1 **CRITERIA AND INITIATION:** Whenever a Practitioner's conduct may require that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee, or other person present in the Hospital, the CEO, with the concurrence of the Chief of Staff or his designee, shall have the authority to summarily suspend the Staff appointment status and all or any portion of the Clinical Privileges of such Practitioner or imposes mandatory conditions on the exercise of clinical privileges. Such summary action shall become effective immediately upon imposition, and subsequently the CEO shall promptly give Special Notice of the suspension to the Practitioner.

Immediately upon the imposition of summary suspension, the Chief of Staff shall designate a physician with appropriate clinical privileges to provide continued medical care for the suspended practitioner's patients still in the hospital. The wishes of the patient shall be considered, if feasible, in the selection of the assigned physician.

5.2.2 **MEDICAL EXECUTIVE ACTION:** As soon as possible, but no later than 72 hours, after such summary action, a meeting of the MEC shall be convened to review and consider the action taken. The MEC may recommend modification, continuation, or termination of the terms of the summary action.

5.2.3 **PROCEDURAL RIGHTS:** Unless summary action is terminated on MEC recommendation, the Practitioner shall be entitled to the procedural rights set forth in the Fair Hearing Plan (Appendix A) if the summary action is adverse as defined in Section 5.4 and all further procedures shall be in accordance with the Fair Hearing Plan (Appendix A). The terms of the summary action shall remain in effect pending a decision by the Trustees.

5.3 AUTOMATIC ACTION

The following shall be grounds for automatic action and shall not entitle the physician/ practitioner to the procedural rights provided in the Fair Hearing Plan (Appendix A)

5.3.1 Failure to complete medical records shall result in automatic suspension, of a practitioner's admitting privileges, as outlined in the Rules and Regulations, Delinquency of Medical Records, No Admit.

5.3.2 Action by the State Board of Medical Examiners, Dental Examiners, or Podiatric Medical Examiners revoking or suspending a Practitioner's license or other legal credential authorizing him to practice in this State shall result in automatic termination or suspension from the Medical Staff and clinical privileges. Probation or placement of a limitation or restriction on the license shall automatically result in probation or placement of the same limitation or restriction on clinical privileges.

5.3.3 Revocation or suspension of a practitioner's DEA registration shall result in automatic termination or suspension of his or her right to prescribe medications covered by such registration. (Revision approved by the BOT on September 28, 2016)

5.3.4 Failure of a Practitioner to maintain or provide proof of current professional liability insurance upon request and as required by the Trustees shall result in automatic suspension of all clinical privileges followed by automatic termination from the Medical Staff if the required insurance is not in place within 90 days of the suspension.

5.3.5 Any Practitioner who is excluded by Sanction from the Medicare program or any state government payer program clinical privileges will be automatically suspended. As soon as possible after such action, the MEC shall convene to review and consider the facts under which the Practitioner was sanctioned and may then recommend such further corrective action as is appropriate to the facts disclosed in the investigation.

5.3.6 It shall be the duty of the Chief of Staff to cooperate with the CEO in enforcing all suspensions.

5.4 PROCEDURAL RIGHTS

The Fair Hearing Plan (Appendix A) shall set out the specific procedures for a hearing and appeal, which shall include provisions for:

a. Written notice to the Practitioner of the adverse action, the reasons for the action, and his right to request a hearing,

b. Appointment of an appropriate hearing panel,

c. Preparation of a record of the hearing with a copy of the transcript available to the Practitioner on payment of any reasonable costs,

d. The rights of each party to present evidence, call and cross-examine witnesses, be represented at the hearing by an attorney or other individual of the party's choice, and submit a written statement at the close of the hearing,

e. The right to receive the written recommendation of the hearing panel and the reasons for the

recommendation,

f. The right to appeal to the Board of Trustees, and

g. The right to receive the written decision of the Board of Trustees and the reasons for the decision.

In the event of any conflict between the Bylaws and the Fair Hearing Plan (Appendix A), the Bylaws shall control.

5.4.1 ENTITLEMENT

A Practitioner who is subject to a recommendation or action of the Medical Executive Committee that is adverse as defined below, or a recommendation or action of the Board of Trustees that is adverse as defined below and which followed a recommendation or action by the Medical Executive Committee that was not adverse, shall be entitled to a hearing and appeal prior to a final decision by the Board of Trustees. The procedures for the hearing and appeal are set out in the Fair Hearing Plan (Appendix A).

5.4.2 ADVERSE ACTION DEFINED

Except as may be qualified in Section 5.4.3 below, only recommendations by the Medical Executive Committee or actions (or any other professional review action that is reportable to the National Practitioner Data Bank) when taken by the Board of Trustees are adverse, and only when based upon competence or professional conduct and practitioner-specific.

(a) Denial of initial staff appointment, unless based upon failure to submit a completed application or failure to meet the basic objective criteria for appointment;

(b) Denial of reappointment, unless based upon failure to submit a completed application or failure to meet the basic objective criteria for appointment;

(c) Suspension of staff membership for thirty (3) days or more;

(d) Revocation of staff membership;

(e) Denial of requested advancement of staff category, if such denial materially limits the practitioner's exercise or privileges;

(f) Reduction of staff category due to an adverse determination as to a practitioner's competence or professional conduct;

(g) Limitation of the right to admit patients;

(h) Denial of an initial request for particular clinical privileges, unless based upon failure to meet the basic objective criteria for the privileges requested;

(i) Reduction of clinical privileges for a period in excess of thirty (30) days;

(j) Permanent suspension of clinical privileges;

(k) Revocation of clinical privileges;

(l) Terms of probation, if such terms of probation materially restrict the practitioner's exercise of privileges for more than thirty (30) days; and

(m) Summary suspension of privileges or staff membership for a period in excess of thirty (30) days.

5.4.3 FAVORABLE OR NON-ADVERSE ACTIONS

The following recommendations or actions, and any others specifically set forth in the Bylaws are not adverse and do not entitle the Practitioner to procedural rights of review:

a. Failure to process an application because it is incomplete, required or requested information has not been provided, or the Practitioner cannot document compliance with minimum or threshold criteria;

b. Expiration of appointment for failure to timely reapply or submit a complete application for reappointment;

c. Failure to grant an extension of the provisional period or failure to advance from provisional status because of lack of necessary patient contacts;

d. Automatic action under Article 5 of the Bylaws;

e. Imposition of any conditions on the exercise of temporary privileges or denial or termination of temporary privileges or an extension;

f. Termination of emergency privileges;

g. Issuance of a letter of reprimand or imposition of a record review, continuing medical education, or evaluation and/or treatment requirement;

h. Probation that does not reduce or limit the exercise of Clinical Privileges;

i. Imposition of a limitation or restriction when applied equally to all appointees in that Staff category or who have been granted those Clinical Privileges;

j. Removal from elected Staff office or committee appointment or chairmanship; or

k. Termination of an exclusive professional contract, which results in the concurrent termination of staff membership and clinical privileges.

5.4.4 NOTICE OF ADVERSE RECOMMENDATION OR ACTION

A Practitioner against whom an adverse recommendation or action has been taken pursuant to Section 5.4.2 above shall promptly be given Special Notice (certified or registered mail or hand delivered of such action. Such notice shall:

a. Advise the Practitioner of the proposed action and the basis for the adverse action.

b. Advise the Practitioner of his right to a hearing pursuant to the provisions of the Medical Staff Bylaws and of this Fair Hearing Plan (Appendix A).

c. Specify the number of days following the date of receipt of notice within which a request for a hearing must be submitted.

d. State that failure to request a hearing within the specified time period shall constitute a waiver of rights to a hearing and to an appellate review on the matter.

e. State that upon receipt of his hearing request, the Practitioner will be notified of the date, time and place of the hearing, and provided with a statement of issues and events upon which the adverse action is based.

f. Include a current copy of the Medical Staff Bylaws and the Fair Hearing Plan (Appendix A).

5.5 PRACTITIONER'S RIGHT TO MEDIATION (PURSUANT TO TEXAS HEALTH & SAFETY CODE §241.101)

5.5.1 If a Practitioner is subject to an adverse recommendation as defined in Section 5.4 of these Bylaws and desires to request statutorily authorized mediation, that Practitioner may file a written request for statutory mediation within 7 days of receiving notice of the adverse recommendation pursuant to Section 5.4.4. The request for mediation must be delivered to the CEO in writing, and must specify the reason the Practitioner believes mediation is desirable.

The request for mediation may be filed in addition to a request for hearing, in which case – the mediation shall be conducted prior to the hearing. The mediation must be initiated within 14 days and completed within 30 days of initiation and prior to the date of the hearing.

If the Practitioner fails to request mediation within the timeframe described herein, or if the Practitioner cannot participate in the mediation within the required time requirements, the Practitioner will be deemed to have waived his right to mediation.

5.5.2 If mediation is requested as required above, the CEO, in consultation with the Chief of Staff, shall select the mediator subject to agreement of the physician/ practitioner. If agreement can not be reached, MEC will select the mediator. The mediator must have experience in medical staff privileging and disputes, and must have all qualifications required by applicable state law unless the CEO and Practitioner agree otherwise. The mediator's fee shall be split equally between the Hospital and the Practitioner. The Hospital and Practitioner may be required to sign a written mediation agreement in a form specified by the mediator.

5.5.3 The CEO shall appoint an individual to participate in the mediation and represent the MEC or the Trustees whichever issue the adverse recommendation. Unless otherwise provided by the Trustees, that individual must have the authority to enter into an agreement with the Practitioner on behalf of the MEC or the Trustees.

5.5.4 Both the Practitioner and the individual representative of the MEC or the Trustees may be accompanied in the mediation by counsel of their choice.

5.5.5 The mediation shall be held in accordance with the standards of the American Health Lawyers Alternative Dispute Resolution service. Under no circumstances may the mediation delay an already scheduled hearing or appeal, delay the filing of any report required by law, result in an agreement to take any action not permitted by law or require the MEC, Trustees or Hospital to violate any legal or accreditation requirement or the Medical Staff Bylaws.

5.6 REMOVAL FROM OFFICE OF MEDICO-ADMINISTRATIVE PRACTITIONERS

Removal from office of a medico-administrative Practitioner for grounds unrelated to his or her professional clinical ability and his or her exercise of Clinical Privileges may be accomplished in accordance with the usual personnel Policies of the Hospital or the terms of such Practitioner's employment agreement, if any. To the extent that the grounds for removal include matters relating to competence in performing professional clinical tasks or in exercising Clinical Privileges, resolution of the practitioner's Medical Staff privileges shall be in accordance with Article 5 and the Fair Hearing Plan unless otherwise stated in a contract between the Practitioner and the Hospital.

6 OFFICERS

6.1 OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff shall be:

6.5.1 Chief of Staff

6.5.2 Vice-Chief of Staff

6.2 QUALIFICATIONS OF OFFICERS

Officers must be Physician members of the active Medical Staff at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office affected. The Officers should be physicians who have demonstrated commitment to the improvement of the Medical Staff and the ability to work well with others and provide effective leadership. Officers shall be certified by an appropriate specialty board, or have affirmatively established comparable competence, through the credentialing process.

6.3 ELECTION OF OFFICERS

6.3.1 Officers shall be elected at the annual meeting of the Medical Staff. Only members of the active Medical Staff shall be eligible to vote.

6.3.2 Nominations will be made from the floor at the time of the annual meeting.

6.3.3 Officers and all other elected positions within the Medical Staff will require a majority vote of the members present. If there are multiple nominees for a given position but none achieves a majority, a run-off will be held between the two nominees with the greatest number of votes.

In the case of At-Large-Members (3) of MEC, run-off voting will proceed as follows:

a. If none of the nominees achieves a majority, a run-off will be held between the four nominees with the greatest number of votes;

b. If one of the nominees receives a majority, a run-off will be held between three of the remaining nominees with the greatest number of votes for the two open positions; and

c. If two of the nominees receive a majority, a run-off will be held between two of the remaining nominees with the greatest number of votes for the open position.

6.4 TERM OF OFFICE

The Vice-Chief of Staff will automatically serve as the incoming Chief of Staff, without need for re-election. The outgoing Chief of Staff will serve as an *ex officio* member of the MEC. Officers shall serve a two- (2) year term until a successor is elected, unless he shall sooner resign or be removed from office. Officers cannot succeed themselves in the same office in consecutive years. Officers shall take office on the first day of the Medical Staff year. Removal of an officer is outlined in Section 6.7 of this Article.

6.5 VACANCIES IN OFFICE

The MEC of the Medical Staff shall fill vacancies in office during the Medical Staff year, except for the Chief of Staff. If there is a vacancy in the office of the Chief of Staff, the Vice-Chief of Staff shall serve out the remaining term. A special election shall be conducted as reasonably soon after the vacancy as possible to fill the office of Vice-Chief.

6.6 DUTIES OF OFFICERS

6.6.1 CHIEF OF STAFF: The Chief of Staff shall serve as the principal elected official of the Medical Staff. He shall:

6.6.1.1 Act in coordination and cooperation with the CEO in all matters of mutual concern within the Hospital;

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

6.6.1.3 Serve on and preside at the MEC;

6.6.1.4 Serve as *ex officio* member of all other Medical Staff committees without vote;

6.6.1.5 Be responsible for the enforcement of Medical Staff bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner;

6.6.1.6 Appoint Medical Staff members to all standing, special, and multidisciplinary Medical Staff committees except the MEC and the Department Peer review committees;

6.6.1.7 Represent the views, policies, needs, and grievances of the Medical Staff, including determining if there exists sufficient space, equipment, staffing, and financial resources to support each privilege requested by applicants to the Medical Staff to the CEO and to the Trustees;

6.6.1.8 Receive and interpret the Policies of the Trustees to the Medical Staff and be responsible to the Trustees in conjunction with the MEC for the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;

6.6.1.9 Be responsible for the educational activities of the Medical Staff;

6.6.1.10 Develop and implement, in cooperation with the Credentials Committee, the MEC, and the Department chairmen, methods for credentials review, delineation of privileges, continuing education, utilization review, continual monitoring functions, and patient care evaluation studies;

6.6.1.11 Be the spokesman for the Medical Staff in its external professional and public relations;

6.6.1.12 Be responsible with the MEC and CEO, for the accreditation status of the Hospital;

6.6.1.13 Confer with the CEO, CFO, CNO and Service Chief on at least a quarterly basis as to whether there exists sufficient space, equipment, staffing, and financial resources or that the same will be available within a reasonable time to support each privilege requested by applicants to the Medical Staff; and report on the same to the MEC and to the Board; and

6.6.1.14 Assist the Service Chief as to the types and amounts of data to be collected and compared in determining and informing the Medical Staff of the professional practice of its members.

6.6.1 **VICE-CHIEF OF STAFF:** In the absence of the Chief of Staff, he shall assume all the duties and have the authority of the Chief of Staff. He shall be a member of the executive committee of the Medical Staff. He shall automatically succeed the Chief of Staff when the latter fails to serve for any reason. He shall perform such additional duties as may be assigned by the Chief of Staff, the MEC, or the Trustees.

6.6.3 **ADDITIONAL APPOINTMENTS:** The Chief of Staff or Chief Executive Officer may appoint additional Practitioners to medico-administrative positions within the Hospital (e.g., chiefs of departments, medical directors, director of medical education, academic chiefs, etc.) to perform such duties as prescribed by the MEC and the Trustees, or as defined by amendment to these Bylaws. To the extent that any such officer performs any patient care function, he must become and remain an appointee of the Staff. In all events, he must be subject to these Bylaws and to the other Policies of the Hospital.

6.7 REMOVAL FROM OFFICE

The Medical Staff may remove from office Officers of the Staff by petition of 20% of the active Staff members and subsequent two-thirds vote by ballot of the active Staff. If the Chief of Staff is to be removed the petition is presented to the Vice-Chief of Staff who shall assume responsibility for its presentation to the full Medical Staff. Removal shall be for failure to conduct those responsibilities assigned within these Bylaws or violation of other Policies and procedures of the Medical Staff.

Any member appointed to serve in any identifiable position or capacity within the Medical Staff may be removed for just cause from said position or capacity by that individual or group of individuals authorized to have appointed that member whose removal is sought. Just cause may include, but is not limited to, failure to carry out the usual and expected duties of the office, failure to be a member in good standing of the Medical Staff, failure to comply with applicable laws and regulations, failure to comply with professional ethics or failure to observe Medical Staff bylaws, policy or procedure.

6.8 CONFLICT OF INTEREST AMONG MEDICAL STAFF LEADERS

Medical Staff leaders shall abstain from voting on any issue in which the Medical Staff leader has an interest other than as a fiduciary of the Medical Staff. A breach of these provisions is deemed sufficient grounds for removal of a breaching member by the remaining members of the MEC or the Board on majority vote.

7 DEPARTMENTS

7.1 ORGANIZATION OF DEPARTMENTS

There shall be Departments of medicine and surgery. Each Department shall be headed by a Chief and shall function under the authority of the MEC. Individuals will be assigned to and vote in only one Department but they may attend both Department meetings. If appropriate, individuals may request reassignment at the time of their reappointment.

7.2 FUNCTIONS OF DEPARTMENTS

7.2.1 The primary responsibility of each Department is to implement and conduct specific monitoring review and evaluation activities that contribute to preserve and improve the quality and efficiency of patient care provided in the Hospital.

7.2.2 To carry out this responsibility, each Department shall:

7.2.2.1 Conduct ongoing monitoring to analyze, review and evaluate the quality and efficiency of care within the Department based on objective criteria reflecting current knowledge and clinical experience. Each Department shall review all clinical work performed under its jurisdiction whether or not the physician/ practitioner is a member of that Department. The Department shall also identify actions to be taken to resolve identified problems.

7.2.2.2 Help establish criteria for granting Clinical Privileges in the Department and submit to the Credentials Committee and MEC the recommendations required under these bylaws regarding the specific privileges to be granted to each Staff member or applicant and each AHP.

7.2.2.3 Recommend, conduct or participate in continuing education programs pertinent to changes in the state-of-the-art and to findings of review and evaluation activities.

7.2.2.4 Monitor, on a continuing and concurrent basis, adherence to:

7.2.2.4.1 Medical Staff Bylaws, Rules and Regulations, and Hospital Policies and procedures;

7.2.2.4.2 Requirements for alternate coverage and consultations;

7.2.2.4.3 Sound principles of clinical practice; and

7.2.2.4.4 Fire, disaster, and other regulations designed to promote patient safety.

7.2.2.5 Work with nursing, ancillary services and administrative support services to improve patient care.

7.2.2.6 Foster an atmosphere of professional decorum within the Department.

7.2.2.7 Submit written reports to the MEC on a regularly scheduled basis concerning:

7.2.2.7.1 Findings of the Department's review and evaluation activities, actions taken thereon, and the results of such actions;

7.2.2.7.2 Care provided in the Department and the Hospital;

7.2.2.7.3 Such other matters as may be requested from time to time by the MEC and

7.2.2.8 Meet at least quarterly to receive, review and consider patient care monitors, findings and the results of the Department's other monitoring, evaluation and education activities and to perform or receive reports on other Department and Staff functions.

7.2.2.9 Establish such committees or other mechanisms, as are necessary and desirable to perform properly the functions assigned to it.

7.2.2.10 Establish written Rules and Regulations for the organization, operation and function of the Department that do not conflict with the Medical Staff bylaws and Rules and Regulations. The Rules and Regulations must be reviewed annually and any additions, deletions, revisions or changes must be approved by the MEC and ratified by the Governing Body.

7.2.2.11 Make recommendations to the MEC subject to Board approval of the kinds, types, and amounts of data to be collected and evaluated to allow the Medical Staff to include an evidence-based analysis of the quality of professional practice of its members.

7.3 QUALIFICATION, SELECTION AND TENURE OF DEPARTMENT CHIEFS/VICE CHIEFS

7.3.1 Department Chief: Each chief shall be a Physician member in good standing of the active Medical Staff and the Department.

Department Vice-Chief: Each Vice-Chief shall be a Physician member in good standing of the active Medical Staff and the Department

The chief and vice-chief shall be qualified by training, experience, interest, and demonstrated current ability in a clinical area covered by the Department and shall be willing and able to discharge the administrative responsibilities and functions of the office. The chief and vice-chief of each Department shall be certified by an appropriate specialty board, or affirmatively establish comparable competence, through the credentialing process.

7.3.2 Chiefs of Departments shall be elected by the members of their Departments and reported to the Board of Trustees.

The Vice-Chief of Departments shall be elected by members of their Departments and reported to the Board of Trustees. The Vice-Chief shall automatically be nominated for the Department Chief. Elections will occur at the last Department meeting of every other year.

7.3.3 Removal of a chief or vice-chief during his term of office may be accomplished by a two-thirds majority vote of all active Department members as outlined in Article 6, Section 6.7.

7.4 RESPONSIBILITIES OF DEPARTMENT CHIEF

The Department Chief responsibilities are as follows:

7.4.1 To represent his Department as a voting member of MEC;

7.4.2 To account to the MEC for all professional and clinical activities within the Department, particularly for the quality of patient care rendered by members of the Department. This includes ensuring effective Peer review and other quality improvement functions delegated to the Department;

7.4.3 To ensure continuous surveillance of the professional performance of all Department members and health professional affiliates who have delineated clinical privileges;

7.4.4 To make recommendations to the Credentials Committee and MEC regarding criteria for Clinical Privileges for the Department based on Department recommendations;

7.4.5 To make recommendations to the Credentials Committee and MEC concerning appointment and Staff category, reappointment, delineation of Clinical Privileges or specific services, and disciplinary action with respect to Practitioners in the Department based on Department recommendations;

7.4.6 To recommend to the relevant Hospital authority appropriate off-site sources for needed patient care services not provided by the Department;

7.4.7 To supervise coordination and integration of the interdepartmental and intradepartmental services;

7.4.8 To develop, based on Department recommendations, and implement policies and procedures that guide and support the provision of services. To lead the Department to develop and implement Departmental programs to review credentials and delineate privileges, continuing medical education, utilization review, concurrent monitoring of practice, and other quality improvement functions as required by the Bylaws;

7.4.9 To assist in developing recommendations for sufficient number of qualified and competent persons to provide care/service;

7.4.10 Along with the Credentials Committee, to ensure the determination of the qualifications and competence of non-Hospital Department personnel who are not licensed independent Practitioners and who provide patient care services within the Department;

7.4.11 To ensure orientation and continuing education of all persons in the Department;

7.4.12 To make recommendations for space and other resources needed by the Department; and

7.4.13 To supervise all administrative activities of the Department, unless otherwise provided by the Hospital.

7.5 RESPONSIBILITIES OF THE DEPARTMENT VICE-CHIEF

In the absence of the Department Chief, he shall assume all the duties and have the authority of the Department Chief. He shall automatically succeed the Department Chief when the latter fails to serve for any reason. He shall perform such additional duties as may be assigned by the Department Chief, the MEC or the Trustees.

7.6 DEPARTMENT CHIEF/VICE-CHIEF UNAVAILABLE

In the event that both the Department Chief and Vice-Chief are unavailable for an extended period of time, the Chief of Staff or his designee will act on their behalf.

7.7 SECTIONS

7.7.1 Any group of Practitioners may organize themselves into a Section upon approval by the Board and MEC. Any Section, if organized, will not be required to hold any number of regularly scheduled meetings, nor will attendance be required.

7.7.2 Sections may perform any of the following functions:

7.7.2.1 Continuing education;

7.7.2.2 Discussion of policy;

7.7.2.3 Discussion of equipment needs;

7.7.2.4 Development of recommendations for Department Chief or the MEC;

7.7.2.5 Participation in the development of criteria for Clinical Privileges (when requested by the Department Chief);

7.7.2.6 Discuss a specific issue at the special request of a Department Chief or the MEC; and

7.7.2.7 Peer review as per the Peer Review policy.

7.7.3 Except in extraordinary circumstances or peer review, no minutes or reports will be required reflecting the activities of Sections. Only when Sections are making formal recommendations to a Department will a report be required from the Department Chair documenting the Section-specific position.

8 COMMITTEES

8.1 DESIGNATION AND SUBSTITUTION

The standing committees of the Medical Staff will be the Medical Executive Committee, the Credentials/Bylaws Committee, and the Medical and Surgical Peer Review Committees.

The MEC may, by resolution, and upon approval by the Trustees, establish such other standing and special committees to perform one or more of the required Staff Functions. Those functions requiring participation of, rather than direct oversight by the Staff, may be discharged by Staff representation on such Hospital management committees as are established to perform such functions.

8.2 MEDICAL PEER REVIEW COMMITTEE STATUS

Each committee (whether Medical Staff, department, section, special, ad hoc, subcommittee, or joint), department, and section, as well as the Medical Staff 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 is authorized by the Board of Trustees to engage in medical peer review as such term is defined in Article 11.

The Chief of Staff, department chair, section chief, or chair of a committee may appoint Practitioners or other individual to serve as agents of a committee, department, section, or the Medical Staff and assist in carrying out the functions and responsibilities of the committee, department, section, or Medical Staff. The CEO or his designee, the Hospital's legal counsel, and Hospital employees shall be considered agents of the committee, department, section, or Medical Staff when performing these functions and responsibilities. An authorized action by an agent or member of a committee, department, section, or the Medical Staff in performing these functions and responsibilities shall be considered an action taken on behalf of the appropriate committee, department, section, or Medical Staff, not an action taken in the agent or member's individual capacity.

8.3 MEDICAL EXECUTIVE COMMITTEE

8.3.1 COMPOSITION: The MEC shall consist of the officers of the Medical Staff, three-elected Physician members-at-large, the Department Chiefs, the immediate past Chief of Staff (*ex officio*) and the Hospital CEO (*ex officio*). At least one MEC member shall have served on the previous year's MEC for continuity. No member of the active Medical Staff is ineligible for membership on the MEC solely because of their professional discipline or specialty.

8.3.2 DUTIES: The authority of the MEC is outlined in this Section 8.3.2 and additional functions may be delegated or removed through amendment of this Section 8.3.2. The duties of the MEC shall be:

8.3.2.1 to receive and act upon committee reports;

8.3.2.2 to provide liaison between Medical Staff and the CEO and the Trustees;

8.3.2.3 to coordinate the activities and general Policies of the various Departments and oversee the Medical Staff structure;

8.3.2.4 to participate in identifying community health needs, and to provide the preparation of all meeting programs designed to address these needs either directly or through delegation to a program committee or other suitable agent;

8.3.2.5 to fulfill the Medical Staff's accountability to the Trustees for the medical care rendered to patients in the Hospital;

8.3.2.6 to take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted in accordance with Article 5 and the Fair Hearing Plan (Appendix A), if applicable;

8.3.2.7 to recommend action to the CEO on matters of a medico-administrative nature including but not limited to approving contracts pertaining to medical care of patients, i.e. dialysis care, etc;

8.3.2.8 to ensure, with the Chief of Staff and CEO, that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital;

8.3.2.9 to review the credentials of all applicants and to recommend to the Trustees all matters relating to Medical Staff membership, assignments to Departments and delineation of Clinical Privileges;

8.3.2.10 to represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these bylaws;

8.3.2.11 to report at each general Medical Staff meeting;

8.3.2.12 to ensure the participation of the Medical Staff in organization performance improvement activities;

8.3.2.13 to maintain and execute the mechanism by which Medical Staff membership may be terminated, and the mechanism for fair-hearing procedures;

8.3.2.14 to develop and monitor compliance with these Bylaws, the Rules and Regulations, policies and other Hospital standards; and

8.3.2.15 Provide education about practitioner health, address prevention of physical, psychiatric, or emotional illness, and facilitate confidential diagnosis, treatment, and rehabilitation of practitioners who suffer from a potentially impairing condition.

8.3.3 **MEETINGS:** The MEC shall meet at least 10 times per year and maintain a permanent record of its proceedings and actions.

8.4 CREDENTIALS/BYLAWS COMMITTEE

8.4.1 **COMPOSITION:** The credentials/bylaws committee shall consist of at least five (5) Physician members of the active Medical Staff appointed by the Chief of Staff with one of the members designated as the Chairman.

8.4.2 **DUTIES:** The duties of the Credentials Committee shall be to develop and maintain an unbiased system to:

8.4.2.1 Review and evaluate the qualifications, competence, and performance of each applicant for initial appointment, reappointment or modification of appointment and for Clinical Privileges and make appropriate recommendations to the MEC and the Trustees in accordance with the Credentials Policy (Appendix B).

8.4.2.2 Investigate, review and report on matters, including the clinical or ethical conduct of any Practitioner assigned or referred to it by the MEC.

8.4.2.3 BYLAWS REVIEW AND REVISION: The Committee will review, as needed but at least annually, the Medical Staff bylaws and Rules and Regulations, and submit recommendations to the MEC for changes in these documents. The Committee will review, as needed, but at least every three (3) years, the Medical Staff Policies, and submit recommendations to the MEC for changes in these documents. **(Revision approved by the BOT on 8/16/2017)**

8.4.3 **MEETINGS:** The committee shall meet at least bimonthly and maintain a permanent record of its proceedings and actions.

8.5 ETHICS COMMITTEE

8.5.1 **COMPOSITION:** The ethics committee shall be composed of members appointed jointly by the Chief of Staff and the CEO and shall include appropriate non-Physician members.

8.5.2 **DUTIES:** The duties of the Ethics Committee shall be to provide guidance, evaluation, or consultation regarding ethical issues surrounding patient care such as end-of-life issues, pain management, etc.

8.5.3 **MEETINGS:** The committee shall meet at least annually and maintain a permanent record of its proceedings and actions.

8.6 MEDICAL STAFF FUNCTIONS

8.6.1 The MEC shall designate appropriate Medical Staff committees to perform the functions of the Medical Staff.

8.6.2 Medical Staff functions, as delineated here, will always be limited by, and dependent upon, the available resources as determined by the hospital owner, Administration, and the Board of Trustees.

8.6.2.1 Monitor, evaluate and improve care provided in and develop clinical policy for all clinical areas;

8.6.2.2 Conduct or coordinate appropriate performance improvement reviews, including review of invasive procedures, blood and blood component usage, drug usage, medical record and other appropriate reviews;

8.6.2.3 Conduct or coordinate utilization review activities;

8.6.2.4 Assist the Hospital in providing continuing education opportunities responsive to performance improvement activities, new state-of-the-art developments, services provided within the Hospital and other perceived needs and supervise Hospital's professional library services;

8.6.2.5 Develop and maintain surveillance over drug utilization policies and practices;

8.6.2.6 Investigate and control nosocomial infections and monitor the Hospital's infection control program;

8.6.2.7 Plan for responses to disasters, and for the provision of services required to meet the needs of the community;

8.6.2.8 Direct staff organizational activities, including staff bylaws, review and revision, staff officer and committee nominations, liaison with the Board and Hospital administration, and review and maintenance of Hospital accreditation;

8.6.2.9 Provide leadership in activities related to patient safety;

8.6.2.10 Encourage that the Medical Staff provides leadership for process measurement, assessment and improvement for processes which are dependent on the activities o individuals with clinical privileges;

8.6.2.11 Encourage that the Medical Staff participates in the measurement, assessment and improvement of other patient care processes;

8.6.2.12 Encourage that when the findings of assessment processes are relevant to an individual's performance, the Medical Staff determines their use in peer review or the ongoing evaluation of a practitioner's competence;

8.6.2.13 Recommend to the Board policies and procedures that define the trends, indications, deviated expectations of outcomes, or concerns that trigger a focused review of a practitioner's performance and evaluation of a practitioner's performance by peers. The information relied upon to investigate a practitioner's professional conduct and practice may include (among other items or information), internal or external chart reviews, prospective, concurrent and/or retrospective monitoring of actual practice, monitoring of clinical practice patterns, proctoring, and consultations with other physician, assistants, nursing or Administrative personnel involved in the care of patients;

8.6.2.14 Make recommendations to the Board regarding the Medical Staff Bylaws, Rules & Regulations, and review same on a regular basis;

8.6.2.15 Review and evaluate the qualifications, competence and performance of each applicant and make recommendations for membership and delineation of clinical privileges;

8.6.2.16 Review, on a periodic basis, applications for reappointment including information regarding the competence of staff members; and as a result of such reviews make recommendations for the granting of privileges and reappointments;

8.6.2.17 Investigate any breach of ethics that is reported to it.

8.7 REPRESENTATION ON INTERDISCIPLINARY COMMITTEES

Staff functions and responsibilities relating to liaison with the Trustees and/or the CEO may be discharged by appointment of one or more Staff appointees to the appropriate Hospital committees. These appointments shall be made by the Chief of Staff when appropriate.

8.8 SPECIAL COMMITTEES

8.8.1 **COMPOSITION AND APPOINTMENT:** If a special Staff committee is established by the MEC to perform one or more of the Staff functions required by these bylaws, it shall be composed of appointees of the active Medical Staff and may include, where appropriate, representation from Hospital Administration, nursing service, medical records service, pharmaceutical service, social service and such other Hospital Departments as are appropriate to the function(s) to be discharged. Unless otherwise specifically provided, the Staff appointees shall be appointed by the Chief of Staff, and the CEO shall appoint the administrative Staff appointees.

8.8.2 **TERM AND PRIOR REMOVAL:** Unless otherwise provided, a special committee appointee shall continue as such until the end of his or her normal period of Staff appointment and until his or her successor is elected or appointed. A Staff special committee appointee, other than one serving *ex officio*, may be removed by a majority vote of the MEC. An administrative Staff committee appointee may be removed by action of the CEO.

8.8.3 **VACANCIES:** Unless otherwise specifically provided, vacancies on any Staff committee shall be filled in the same manner in which original appointment to such committee is made.

8.8.4 **MEETINGS:** A special committee established to perform one or more of the Staff functions required by these bylaws shall meet as often as is necessary to discharge its assigned duties.

9 MEDICAL STAFF MEETINGS

9.1 REGULAR MEETINGS

9.1.1 Staff meetings shall be held at least annually to review and evaluate the medical performance of the Staff and to consider and act upon administrative and committee reports. Debate will be conducted under the rules of "informal consideration".

9.1.2 The last Staff meeting of every two years shall be the meeting at which any elections of officers for the ensuing period shall be conducted.

9.1.3 The MEC shall, by standing resolution, designate the time and place for all regular Staff meetings. Notice of the original resolution and any changes thereto shall be given to each member of the Staff in the same manner as provided in Section 2 of this Article for notice of a special meeting.

9.2 SPECIAL MEETINGS

9.2.1 The Trustees, the Chief of Staff, the MEC, or not less than twenty percent (20%) of the active Medical Staff may at any time file a written request with the Chief of Staff that a special meeting of the Medical Staff be called. The MEC shall designate the time and place of any such special meeting.

9.2.2 Written or printed notice stating the place, day and hour of any special meeting of the Medical Staff shall be made to each member of the active Staff not less than seven (7) days, nor more than fourteen (14) days before the date of such meeting, by or at the direction of the Chief of Staff. Notice may also be sent to members of other Medical Staff groups who have so requested. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

9.2.3 In the event that it is necessary for the Staff to act on a question without being able to meet, the voting Staff may be presented with the question by certified mail, return receipt or hand-delivered and their votes returned to the Chief of Staff by certified mail, return receipt or hand-delivered. Such a vote shall be binding so long as the question is voted on by a majority of the Staff eligible to vote.

9.3 MINUTES

9.3.1 Minutes of all meetings shall be prepared by the Medical Staff Coordinator or their designee and shall include a record of such attendance and the vote taken on each matter. The presiding officer shall sign copies of the minutes. A permanent file of the minutes of each meeting shall be maintained. Copies of the minutes of all meetings shall be distributed at the beginning of the meeting and retrieved at the close of the meeting.

9.3.2 Notwithstanding the foregoing, minutes of committees reviewing reapplication for Medical Staff appointment, reviewing applications or reapplications for Clinical Privileges, investigating the activities of specific appointees to the Medical Staff, or otherwise dealing with confidential credentialing information shall be confidential and shall not be divulged to the subject Practitioner except as otherwise expressed required by these Bylaws.

9.3.3 **EXECUTIVE SESSION:** Any quality issues to be addressed for Peer review action will be done in Executive Session with only Members, Administration, Risk Manager/Patient Advocate, and the

Medical Staff Coordinator present. The minutes of Executive Session will be stamped "Medical Peer Review Privileged and Confidential Document Pursuant to Tex. Occ. Code § 160.007 and Tex. Health & Safety Code § 161.032".

9.3.4 **CONFIDENTIALITY:** Medical Staff members involved in department, section, and committee proceedings that involved medical peer review shall maintain the confidentiality of the proceedings.

9.4 AGENDA

9.4.1 The agenda at any regular Medical Staff meeting shall be arranged so that the following items will be covered. Any new business brought up during Staff meeting without being placed on the Medical Staff agenda ahead of time will require 2/3 vote by Staff members before it will be discussed.

9.4.1.1 Call to order
9.4.1.2 Approval of Minutes
9.4.1.3 Old Business
9.4.1.4 New Business
9.4.1.5 Report from the Chief Executive Officer
9.4.1.6 Report from the Chief Nursing Officer — as needed
9.4.1.7 Performance Improvement Reports
9.4.1.8 Committee Reports
9.4.1.9 Adjournment

9.4.2 The agenda at special meetings shall be:

9.4.2.1 Reading of the notice calling the meeting.

9.4.2.2 Transaction of business for which the meeting was called.

9.4.2.3 Adjournment

10 ATTENDANCE AND QUORUM REQUIREMENTS

10.1 ATTENDANCE

Members of the MEC, Credentials Committee and Peer Review Committees are expected to attend at least 50% of the meetings held. Members of the Medical Staff are encouraged to attend meetings of the Medical Staff. Meeting attendance will not be used in evaluating members of the Medical Staff at the time of reappointment.

10.2 QUORUM

Medical Staff meetings:	those present and voting
Committee/Department meetings:	those present and voting

10.3 RIGHTS OF EX-OFFICIO MEMBERS

Except as otherwise provided in these Bylaws, persons serving as *ex-officio* members of a committee shall have all rights and privileges of regular members thereof, except they shall not vote or be counted in determining the existence of a quorum.

11 CONFIDENTIALITY AND IMMUNITY

11.1 MEDICAL PEER REVIEW DEFINED

Medical peer review is as defined in Chapter 151 of the Texas Occupations Code and includes, without limitation, the evaluation of medical and health care services, including evaluation of the qualifications and professional conduct of professional health care practitioners (which shall include, without limitation, Members of the Medical Staff, Practitioners holding clinical privileges, and employees of the Hospital) and of patient care provided by those practitioners.

The term includes:

a. evaluation of the merits of a complaint relating to a health care practitioner and a determination or recommendation regarding the complaint;

b. evaluation of the accuracy of a diagnosis;

c. evaluation of the quality of the care provided by a health care practitioner;

d. reports made to a medical peer review committee/medical committee/professional review body concerning activities under the committee's review authority;

e. reports made by a medical peer review committee to another committee or to the Texas Medical Board as permitted or required by law; and

f. implementation of the duties of a medical peer review committee/medical committee/ professional review body by a member or agent of the committee. The term also includes "professional review activities" as defined in the federal Health Care Quality Improvement Act.

11.2. CONFIDENTIALITY

11.2.1. All records and proceedings of the Medical Staff, departments and sections, and all Medical Staff committees, including, without limitation, any minutes of meetings, disclosures, discussion, information received or generated by the department, section, or committee, statements, actions, or recommendations in the course of medical peer review, shall be privileged and confidential, subject to disclosure only in accordance with policies of the Medical Staff and the policies of the Hospital unless otherwise required by state or federal law, and shall be privileged to the fullest extent permitted by state and federal law.

11.2.2. All practitioners and other individuals participating in, providing information to, or attending meetings of the Medical Staff, departments, sections, or committees, or serving as agents or members thereof, are required to maintain all of the records and proceedings related to any medical peer review confidential, subject to disclosure only in accordance with policies of the Medical Staff and the Hospital, unless otherwise required by state or federal law.

11.2.3. The minutes of all meetings of Medical Staff committees, departments, sections, and the Medical Staff shall be confidential, kept in an orderly fashion in a minute book maintained by the Hospital and available for inspection by the Medical Executive Committee, the Board of Trustees, and any employees and agents of the Hospital whose authorized functions necessitate access. A member of the Medical Staff may review minutes of meetings of the Medical Staff during the member's term of appointment and of Medical Staff committees, departments, or sections to which the member was assigned and that occurred while the member was so assigned. Access is also permitted as required

by state or federal law, accreditation requirements, or third party contract of the Hospital. These provisions are in addition to those in Section 9.3.

11.3 IMMUNITY FROM LIABILITY

11.3.1 The Hospital, the Medical Staff and its members, the Board of Trustees, and any committees, representatives, agents, employees, or members thereof, and third parties as defined below, will have absolute immunity from civil liability for any act, communication, report, recommendation, or disclosure in good faith in the course of performing functions authorized by these Medical Staff Bylaws, including, without limitation, for the purpose of medical peer review, to the fullest extent permitted by state and federal law.

11.3.2 For the purpose of this Section 11, the term "third parties" means individuals and organizations from which information has been requested and/or received by the Hospital or the Medical Staff for purposes of medical peer review, and any committees, representatives, agents, employees, or members thereof, and an authorized representative of a hospital or other health care entity, its governing board, the medical staff and its members, and any committee or component thereof.

11.3.3 All applicants for Medical Staff membership and/or clinical privileges and members shall execute a release of liability and authorization to disclose confidential information as necessary for medical peer review, provided that the effectiveness of the immunity provisions of these Medical Staff Bylaws is not contingent on execution of those authorizations and releases. These immunity provisions and any releases of liability shall be in addition to and not in limitation of any immunity afforded by state and federal law.

CONSULTATIONS

1. Consultations shall show evidence of:
   a. Review of the patient's medical record;
   b. Pertinent findings on examination of the patient; and
   c. The opinion and recommendation of the consultant.

2. Consultations shall be held, except in extreme emergencies, under the following conditions:
   a. Psychiatric consultation and treatment should be recommended to all patients who have attempted suicide or who have taken a chemical overdose. This recommendation should be documented in the medical record.

   b. When a physician does not have privileges for managing the patient's needs.

   c. Obstetrical
      1. Consultations shall be required for any procedures where a pregnancy with a live fetus may be interrupted.
      2. A negative pregnancy test is considered a consultation.
      3. Consultations for Termination of Pregnancy: Refer to Termination of Pregnancy portion of the Rules and Regulations.
      4. An OB/GYN consultations with an OB/GYN physician is to be obtained for obstetrical patients admitted to: Con as soon as possible as appropriate depending on the patient's condition but not to exceed 12-hours of admission to ICU.

   d. Pediatric
      1. A pediatric consultation with a pediatrician is to be obtained for pediatric patients admitted to ICU as soon as possible as appropriate depending on the patient's condition but not to exceed 12-hours of admission to ICU; 16 through 18 year old patients will be considered on a case-by-case basis.

   e. Surgery
      1. Major surgical cases in which the patient is not a good risk or in which the diagnosis or indications for surgery are in doubt.
      2. If time permits, a consultation may be desirable, in emergencies involving a minor or unconscious patient in which consent for surgery can not be immediately obtained from patents, guardian or next-of-kin. These circumstances should be fully documented in the medical record.
      3. Except in emergency situations, the consultation report must be documented in the medical record prior to the surgical procedure.

   f. ICU
      1. All Active Staff members may admit to the ICU.
      2. Upon arrival to ICU, the Apache II scale will be utilized to determine the severity of the patient. **(Revision approved by the BOT on 8/16/2017)**
      3. If a patient scores 10 or above on the Apache II scale, or is not under the care of a surgeon, an Internal Medicine consult will be requested by the attending physician. **(Revision approved by the BOT on 8/16/2017)**

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g. The Department Chief or the Chief of Staff has the authority to request a consultation on any patient when there is reason to doubt or question the care provided.

DISCHARGE SUMMARY

1. A discharge summary shall be written or dictated for all patients hospitalized except:
   a. Newborns with uncomplicated deliveries;
   b. Emergency Services

2. The discharge summery contains the following information:
   a. Final diagnosis
   b. The reason for hospitalization
   c. Significant findings
   d. Complications, if any
   e. Procedures performed and treatment rendered
   f. The patient's condition at discharge; and
   g. Instructions to the patient and family, if any.

3. There must be a discharge summary or a discharge summary progress note for:
   a. Day Surgery (Short Stay/Procedural Sedation Discharge Summary – Appendix D and the Medication Reconciliation Form – Appendix C)
   b. Observation (Short Stay/Procedural Sedation Discharge Summary – Appendix D and the Medication Reconciliation Form – Appendix C)
   C. GI Lab (Short Stay/Procedural Sedation Discharge Summary – Appendix D and the Medication Reconciliation Form – Appendix C)
   d. Newborns with uncomplicated deliveries – the Newborn Discharge Form is acceptable
   e. Patients hospitalized <48 hours with only minor problems

4. The discharge summary progress note, which may be handwritten, documents:
   a. Final diagnosis
   b. Condition at discharge
   c. Discharge instructions; and
   d. Required follow-up care

5. The Emergency Services final disposition note includes:
   a. Discharge diagnosis
   b. Instructions given to the patient or family
   c. Follow-up care; and
   d. Condition of patient on discharge

6. The attending physician is responsible for completing the discharge summary or discharge summary progress note unless the physicians covering for each other have a letter on file with the HIM Department outlining who will be responsible for completing the discharge summary or discharge summary progress note of patients discharged while providing coverage. In the event of a disagreement it is the physician of record's responsibility to ensure the discharge summary is completed.

HISTORY AND PHYSICAL

1. A history and physical examination must be completed on each patient admitted for care.

2. The history and physical may be completed by one of the following:
   a. A physician member of the Medical Staff

b. A Nurse Practitioner or a Physician Assistant on the Allied Health Professional Staff who has been granted those privileges and the history and physical is countersigned by the supervising physician

c. History and physicals for podiatric and dental patients are completed as follows
   1. A podiatric member of the Medical Staff is responsible for the detailed podiatric history justifying hospital admission that includes a detailed description of the examination of the feet and a pre-operative diagnosis.
   2. A dental member of the Medical staff is responsible for the detailed dental history justifying hospital admission that includes a detailed description of the examination of the oral cavity and a pre-operative diagnosis.
   3. A physician member of the Medical Staff is responsible for completing a medical history pertinent to the patient's general health and a physical examination to determine the patient's condition prior to anesthesia and surgery.

3. The history and physical contains the following elements:
   a. Identification data
   b. Chief complaint
   c. History of present illness
   d. Past medical history including allergies and medications
   e. Family history
   f. Review of systems/social history
   g. Physical examination
   h. Diagnosis; and
   i. Plan of care

4. Unit specific alternative history and physicals:
   a. Obstetrical: A legible copy of the attending physician's current pre-natal record that includes:
      1. A review of systems, and
      2. Findings from the last office visit; or
      3. Completion of the Admitting Obstetrical History & Physical form (Appendix E)

   b. Cesarean Section or Post-Partum Tubal Ligation: An updated history and physical examination must be completed. A progress note on important or new physical finding since their last physical examination on the pregnancy record will suffice.

   c. Newborn: The completed Physician's Record of Newborn Infant form (Appendix F). For the purposes of History & Physical documentation, a newborn is defined as birth to 30-days per the American Academy of Pediatrics.

   d. Skilled Nursing Facility: A copy of the acute care history and physical and
      1. A copy of the discharge summary, or
      2. A progress note describing any changes that have occurred since the completion of the acute history and physical, or
      3. Completion of the Skilled Nursing Unit Admission Interval Note (Appendix G).

      This must be completed within 24 hours of admission to the Skilled Nursing Facility.

   e. Observation: If the patient is in observation $\leq$23 hours the History and Physical form (Appendix H) may be used as the H&P.

f. Non-inpatient services: The following non-inpatient services require completion of a history and physical, which could be completed on the approved Procedure Record for GI Lab, Heart Center, and Radiology (Appendix J).
   1. Cardiac Catheter procedures
   2. All radiological invasive procedures with the exception of Arthrograms and Breast Biopsies; and **(Revision approved by the BOT on 5/28/2014)**
   3. Procedures performed in the GI Lab excluding nursing procedures such as esophageal manometry and phlebotomy.

g. Day Surgery: Prior to taking the patient to surgery the following items must be completed and the form signed, dated and timed:
   1. History and Physical form (Appendix H), if the H&P is not dictated; and
   2. Procedure Record
      a. History and Physical update if H&P was completed >24 hours prior t the procedure
      b. Pre-procedure diagnosis and plan
      c. Pre-procedure informed consent; and
      d. Patient with DNR status prior to procedure

h. Hospice
   1. A copy of the discharge summary, or
   2. A progress note describing any changes that have occurred since the completion of the acute history and physical, or
   3. Completion of the Hospice Admission Interval Note (Appendix K). This must be completed within 24 hours of admission to Hospice.

i. Emergency Department Electronic Medical Record (EMR): The EMR history and physical may be used as an admission H&P with inclusion of: **(Approved by BOT 8/26/2015)**
   1. A brief note of agreement of the contents of the history and physical along with signature, date and time; or
   2. A progress note with any important or new physical findings.

j. Behavioral Medicine: Elements of the H&P with inclusion of:
   1. Documentation of assessment of all 12 cranial nerves. **(Approved by BOT 2/25/2015)**

5. Alternative history and physical reports that are accepted:
   a. A durable, legible copy of a history and physical examination performed ≤30 days prior to admission may be used in the patient's medical record. An updated examination must be completed and documented in the patient's medical record within 24 hours after admission.
   b. The History and Physical Form (Appendix H) will be accepted as a handwritten H&P for inpatients.

6. Prior to surgery, except in a documented emergency, the following information must be in the patient's medical record:
   a. History and physical, dictated or handwritten;
   b. Results of any indicated diagnostic tests that were performed

7. In an emergency surgical situation, the admitting physician may elect to postpone completion of the history and physical until after the surgery. If the physician elects to postpone completion of the history and physical, he must:

a. Document in the admission note a brief history, appropriate physical findings and a pre-operative diagnosis.
b. The post-surgery completion of the history and physical must include documentation as to the emergent nature of the procedure that precluded completion of the history and physical prior to surgery.

OPERATIVE REPORTS

1. A post-operative progress note is entered in the medical record by the surgeon before the patient is transferred to the next level of care (mandatory completion of the post-operative progress note approved by the BOT 11/28/01 – Pre/Post Procedure Record – Appendix I). This is to ensure that pertinent information is available to the next caregiver.

2. Operative reports are dictated or written by the surgeon within 72 hours after surgery and includes:
   a. Primary surgeon
   b. Assistants
   c. Pre- and Post-operative diagnoses
   d. Description of the procedure used
   e. Specific operative findings
   f. Unique elements or unusual events during the course of the procedures performed on the patient
   g. Specimens removed; and
   h. Condition of the patient post-operatively

3. The completed operative report is authenticated by the surgeon and filed in the medical record as soon as possible.

PROGRESS NOTES

1. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability.

2. Whenever possible each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.

3. Progress notes shall be written at least daily on all patients, excluding Skilled Nursing and Senior Behavioral Health patients, especially critically ill patients and those where there is difficulty in diagnosis or management of the clinical problem.
   a. Skilled Nursing Unit progress notes shall be written at least once a week.
   b. Senior Behavioral Health Unit progress notes shall be written at least 5 of every 7 days. **(Approved by BOT 8/26/2015)**

4. Specific Progress Notes:
   a. Transfer of Responsibility of Patient Care: Please refer to the Responsibility of Patient Care portion of the Rules and Regulations.
   b. Dental and Podiatric progress notes are the responsibilities of the Dentist and the Podiatrist and are pertinent to the oral and podiatric condition respectively.
   c. Obstetrical: The reason for induction should be stated in the progress note.
   d. Post-Operative Progress Notes: Please refer to the Operative Report section.

13 RULES, REGULATIONS AND POLICIES

The Medical Staff and its Departments shall adopt such rules, regulations and policies as may be necessary to implement more specifically the general principles found within these bylaws, subject to the approval of the Trustees. These shall relate to the proper conduct of Medical Staff organizational activities, as well as embody the level of practice that is to be required of each Practitioner in the Hospital. The Rules and Regulations shall be considered a part of these Medical Staff Bylaws.

14 AMENDMENTS

These bylaws may be amended after submission of the proposed amendment at any regular or special meeting of the Medical Staff. A proposed amendment shall be referred to the appropriate standing committee or a special committee appointed by the Chief of Staff, which shall report on it at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. To be adopted, an amendment shall require a majority vote of the active Medical Staff. Amendments so made shall be effective when approved by the Trustees.

Changes of punctuation, grammar, and syntax, provided they do not result in a substantive change in meaning or content, as well as changes required to maintain compliance with applicable regulatory and legal standards may be made by MEC subject to approval by the Trustees. Such changes will be reported at the next regularly scheduled Medical Staff meeting.

Neither the Medical Staff nor the Board of Trustees may unilaterally amend the Medical Staff Bylaws, Rules, Regulations or Policies.

15 ADOPTION

These bylaws, together with the appended Rules and Regulations, and Policies shall be adopted by a majority vote at any regular or special meeting of the active Medical Staff. They shall replace any previous Bylaws, Rules and Regulations, and Policies and become effective when approved by the Trustees of the Hospital.