Medical Staff Bylaws

Of

Scott & White Hospital - Round Rock

Revised the Twenty Fourth of October 2008, Round Rock, Texas
Revised the Twenty Fourth of July 2009, Round Rock, Texas
Revised the Twenty Third of October 2009, Round Rock, Texas
Revised the Twenty First of January 2010, Round Rock, Texas
Revised the Twenty Third of April 2010, Round Rock, Texas
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Revised the Twenty Seventh of April 2012, Round Rock, Texas
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Revised the Eighteenth of October 2013, Round Rock, Texas
### Part I: Governance

<table>
<thead>
<tr>
<th>Article</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ARTICLE I – MEDICAL STAFF PURPOSE &amp; AUTHORITY</strong></td>
<td>8</td>
</tr>
<tr>
<td>Section 1 – Purpose</td>
<td>8</td>
</tr>
<tr>
<td>Section 2 – Authority</td>
<td>8</td>
</tr>
<tr>
<td><strong>ARTICLE II – MEDICAL STAFF MEMBERSHIP</strong></td>
<td>8</td>
</tr>
<tr>
<td>Section 1 – Nature of Medical Staff Membership</td>
<td>8</td>
</tr>
<tr>
<td>Section 2 – Qualifications of Membership</td>
<td>8</td>
</tr>
<tr>
<td>Section 3 – Nondiscrimination</td>
<td>9</td>
</tr>
<tr>
<td>Section 4 – Conditions and Duration of Appointment</td>
<td>9</td>
</tr>
<tr>
<td>Section 5 – Medical Staff Membership and Clinical Privileges</td>
<td>9</td>
</tr>
<tr>
<td>Section 6 – Responsibilities of Each Medical Staff Member</td>
<td>9</td>
</tr>
<tr>
<td><strong>ARTICLE III – CATEGORIES OF THE MEDICAL STAFF</strong></td>
<td>11</td>
</tr>
<tr>
<td>Section 1 – The Medical Staff</td>
<td>11</td>
</tr>
<tr>
<td>Section 2 – The Honorary/Emeritus Medical Staff</td>
<td>11</td>
</tr>
<tr>
<td>Section 3 – The Active Medical Staff</td>
<td>11</td>
</tr>
<tr>
<td>Section 4 – The Courtesy Medical Staff</td>
<td>11</td>
</tr>
<tr>
<td>Section 5 – The Consulting Medical Staff</td>
<td>12</td>
</tr>
<tr>
<td>Section 6 – The Consulting without Clinical Privileges Staff</td>
<td>12</td>
</tr>
<tr>
<td>Section 7 – Provisional Appointment</td>
<td>12</td>
</tr>
<tr>
<td><strong>ARTICLE IV – OFFICERS OF THE MEDICAL STAFF</strong></td>
<td>13</td>
</tr>
<tr>
<td>Section 1 – Officer of the Medical Staff</td>
<td>13</td>
</tr>
<tr>
<td>Section 2 – Qualifications of Officers</td>
<td>13</td>
</tr>
<tr>
<td>Section 3 – Election of Officers</td>
<td>13</td>
</tr>
<tr>
<td>Section 4 – Term of Office</td>
<td>14</td>
</tr>
<tr>
<td>Section 5 – Vacancies of Office</td>
<td>14</td>
</tr>
<tr>
<td>Section 6 – Duties of Officers</td>
<td>14</td>
</tr>
<tr>
<td>Section 7 – Removal and Resignation from Office</td>
<td>14</td>
</tr>
<tr>
<td><strong>ARTICLE V – MEDICAL STAFF ORGANIZATION</strong></td>
<td>15</td>
</tr>
<tr>
<td>Section 1 – Organization of the Medical Staff</td>
<td>15</td>
</tr>
<tr>
<td>Section 2 – Functions of the Clinical Section Chiefs</td>
<td>15</td>
</tr>
<tr>
<td>Section 3 – Assignment to Clinical Section</td>
<td>15</td>
</tr>
<tr>
<td><strong>ARTICLE VI – COMMITTEES</strong></td>
<td>16</td>
</tr>
<tr>
<td>Section 1 – Designation and Substitution</td>
<td>16</td>
</tr>
<tr>
<td>Section 2 – Medical Executive Committee</td>
<td>16</td>
</tr>
</tbody>
</table>
ARTICLE VII – MEDICAL STAFF MEETINGS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1 – Meetings of the Entire Medical Staff</td>
<td>17</td>
</tr>
<tr>
<td>Section 2 – Regular Meetings of Medical Staff Committees and Sections</td>
<td>18</td>
</tr>
<tr>
<td>Section 3 – Special Meetings of Committees and Sections</td>
<td>18</td>
</tr>
<tr>
<td>Section 4 – Quorum</td>
<td>18</td>
</tr>
<tr>
<td>Section 5 – Attendance Requirements</td>
<td>18</td>
</tr>
<tr>
<td>Section 6 – Participation by Chief Executive Officer (CEO)</td>
<td>19</td>
</tr>
<tr>
<td>Section 7 – Robert’s Rules of Order</td>
<td>19</td>
</tr>
<tr>
<td>Section 8 – Waiver of Notice of Meetings</td>
<td>19</td>
</tr>
<tr>
<td>Section 9 – Action of Committee or Section</td>
<td>19</td>
</tr>
<tr>
<td>Section 10 – Rights of Ex-Officio Members</td>
<td>19</td>
</tr>
<tr>
<td>Section 11 – Minutes</td>
<td>19</td>
</tr>
</tbody>
</table>

ARTICLE VIII – CONFLICT MANAGEMENT

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1 – Conflict Management Generally</td>
<td>20</td>
</tr>
<tr>
<td>Section 2 – Process for Conflict Management</td>
<td>20</td>
</tr>
<tr>
<td>Section 3 – Confidentiality</td>
<td>21</td>
</tr>
</tbody>
</table>

ARTICLE IX – REVIEW, REVISION, ADOPTION AND AMENDMENT

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1 – Medical Staff Responsibility</td>
<td>22</td>
</tr>
<tr>
<td>Section 2 – Methods of Adoption and Amendment to Part I and Part II (Investigations, Corrective Action, Hearing and Appeal Plan) of these Medical Staff Bylaws</td>
<td>22</td>
</tr>
<tr>
<td>Section 3 – Methods of Adoption and Amendment to Part III (Credentialing Procedures Manual) and Part IV (Organization and Functions Manual), as well as any Medical Staff Rules, Regulations and Policies</td>
<td>22</td>
</tr>
</tbody>
</table>

Part II: Investigations, Corrective Action, Hearing and Appeal Plan

SECTION 1 – INVESTIGATION AND CORRECTIVE ACTION

<table>
<thead>
<tr>
<th>Subsection</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Criteria for Initiation</td>
<td>23</td>
</tr>
<tr>
<td>1.2 Initiation</td>
<td>23</td>
</tr>
<tr>
<td>1.3 Investigation</td>
<td>24</td>
</tr>
<tr>
<td>1.4 Medical Executive Committee Action</td>
<td>24</td>
</tr>
<tr>
<td>1.5 Subsequent Action</td>
<td>25</td>
</tr>
<tr>
<td>1.6 Automatic Relinquishment/ Voluntary Resignation</td>
<td>25</td>
</tr>
<tr>
<td>1.7 Precautionary Restriction or Suspension</td>
<td>27</td>
</tr>
<tr>
<td>1.8 Disciplinary Time Out</td>
<td>28</td>
</tr>
</tbody>
</table>

SECTION 2 – INITIATION AND NOTICE OF HEARING

<table>
<thead>
<tr>
<th>Subsection</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Criteria for Initiation</td>
<td>29</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
</tr>
<tr>
<td>---------</td>
<td>-------</td>
</tr>
<tr>
<td>2.1</td>
<td>Initiation of Hearing</td>
</tr>
<tr>
<td>2.2</td>
<td>Actions or Events That Shall Not Constitute Grounds for Hearing</td>
</tr>
<tr>
<td>2.3</td>
<td>Notice of Recommendation</td>
</tr>
<tr>
<td>2.4</td>
<td>Request for Hearing</td>
</tr>
<tr>
<td>2.5</td>
<td>Notice of Hearing and Statement of Reasons</td>
</tr>
<tr>
<td>SECTION 3 – HEARING PANEL AND PRESIDING OFFICER OR HEARING OFFICER</td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td>Hearing Panel</td>
</tr>
<tr>
<td>3.2</td>
<td>Hearing Panel Chairperson or Presiding Officer</td>
</tr>
<tr>
<td>3.3</td>
<td>Hearing Officer</td>
</tr>
<tr>
<td>SECTION 4 – PRE-HEARING AND HEARING PROCEDURE</td>
<td></td>
</tr>
<tr>
<td>4.1</td>
<td>Provision of Relevant Information</td>
</tr>
<tr>
<td>4.2</td>
<td>Pre-Hearing Conference</td>
</tr>
<tr>
<td>4.3</td>
<td>Failure to Appear</td>
</tr>
<tr>
<td>4.4</td>
<td>Record of Hearing</td>
</tr>
<tr>
<td>4.5</td>
<td>Rights of Both Sides</td>
</tr>
<tr>
<td>4.6</td>
<td>Admissibility of Evidence</td>
</tr>
<tr>
<td>4.7</td>
<td>Burden of Proof</td>
</tr>
<tr>
<td>4.8</td>
<td>Post-Hearing Memoranda</td>
</tr>
<tr>
<td>4.9</td>
<td>Official Notice</td>
</tr>
<tr>
<td>4.10</td>
<td>Postponements and Extensions</td>
</tr>
<tr>
<td>4.11</td>
<td>Persons to be Present</td>
</tr>
<tr>
<td>4.12</td>
<td>Order of Presentation</td>
</tr>
<tr>
<td>4.13</td>
<td>Adjournment and Conclusion</td>
</tr>
<tr>
<td>4.14</td>
<td>Deliberations and Recommendation of the Hearing Panel</td>
</tr>
<tr>
<td>4.15</td>
<td>Disposition of Hearing Panel Report</td>
</tr>
<tr>
<td>SECTION 5 – APPEAL TO THE GOVERNING BOARD</td>
<td></td>
</tr>
<tr>
<td>5.1</td>
<td>Time for Appeal</td>
</tr>
<tr>
<td>5.2</td>
<td>Grounds for Appeal</td>
</tr>
<tr>
<td>5.3</td>
<td>Time, Place and Notice</td>
</tr>
<tr>
<td>5.4</td>
<td>Nature of Appellate Review</td>
</tr>
<tr>
<td>5.5</td>
<td>Final Decision of the Governing Board</td>
</tr>
<tr>
<td>5.6</td>
<td>Right to One Appeal Only</td>
</tr>
</tbody>
</table>
## PART III: Credentialing Procedures Manual

<table>
<thead>
<tr>
<th>Section 1 – Medical Staff Credentials Committee</th>
<th>38</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Composition</td>
<td>38</td>
</tr>
<tr>
<td>1.2 Meetings</td>
<td>38</td>
</tr>
<tr>
<td>1.3 Responsibilities</td>
<td>38</td>
</tr>
<tr>
<td><strong>Section 2 – Qualifications for Membership and Privileges</strong></td>
<td>38</td>
</tr>
<tr>
<td>2.1 Membership</td>
<td>38</td>
</tr>
<tr>
<td>2.2 Qualifications</td>
<td>39</td>
</tr>
<tr>
<td>2.3 Exceptions</td>
<td>40</td>
</tr>
<tr>
<td><strong>Section 3 – Application Request Procedure</strong></td>
<td>41</td>
</tr>
<tr>
<td>3.1 Application Request</td>
<td>41</td>
</tr>
<tr>
<td><strong>Section 4 – Initial Appointment Procedure</strong></td>
<td>41</td>
</tr>
<tr>
<td>4.1 Applicant’s Attestation, Authorization and Acknowledgement</td>
<td>41</td>
</tr>
<tr>
<td>4.2 Completion of Application</td>
<td>42</td>
</tr>
<tr>
<td>4.3 Application Evaluation</td>
<td>43</td>
</tr>
<tr>
<td><strong>Section 5 – Focused Professional Practice Evaluation</strong></td>
<td>47</td>
</tr>
<tr>
<td><strong>Section 6 – Reappointment</strong></td>
<td>47</td>
</tr>
<tr>
<td>6.1 Criteria for Reappointment</td>
<td>47</td>
</tr>
<tr>
<td>6.2 Information Collection and Verification</td>
<td>47</td>
</tr>
<tr>
<td>6.3 Evaluation of Application for Reappointment of Membership and/or Privileges</td>
<td>48</td>
</tr>
<tr>
<td><strong>Section 7 – Clinical Privileges</strong></td>
<td>49</td>
</tr>
<tr>
<td>7.1 Exercise of Privileges</td>
<td>49</td>
</tr>
<tr>
<td>7.2 Requests</td>
<td>49</td>
</tr>
<tr>
<td>7.3 Basis for Privileges Determination</td>
<td>49</td>
</tr>
<tr>
<td>7.4 Special Conditions for Oral Maxillofacial Privileges</td>
<td>50</td>
</tr>
<tr>
<td>7.5 Special Conditions for Licensed Independent Practitioners</td>
<td>50</td>
</tr>
<tr>
<td>7.6 Special Conditions for Podiatric Privileges</td>
<td>51</td>
</tr>
<tr>
<td>7.7 Special Conditions for Residents or Fellows in Training</td>
<td>51</td>
</tr>
<tr>
<td>7.8 Telemedicine Privileges</td>
<td>51</td>
</tr>
<tr>
<td>7.9 Temporary Privileges</td>
<td>52</td>
</tr>
<tr>
<td><strong>Section 8 – Preceptorship</strong></td>
<td>55</td>
</tr>
<tr>
<td>8.1 Requirement</td>
<td>55</td>
</tr>
<tr>
<td>8.2 Preceptorship Program Description</td>
<td>55</td>
</tr>
<tr>
<td><strong>Section 9 – Reapplication After Modifications of Membership Status or Privileges and Exhaustion of Remedies</strong></td>
<td>55</td>
</tr>
<tr>
<td>Section</td>
<td>Topic</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------------------------------------</td>
</tr>
<tr>
<td>9.1</td>
<td>Reapplication after Adverse Credentials Decision</td>
</tr>
<tr>
<td>9.2</td>
<td>Reapplication after Administrative Revocation</td>
</tr>
<tr>
<td>9.3</td>
<td>Request for Modification of Appointment Status or Privileges</td>
</tr>
<tr>
<td>9.4</td>
<td>Resignation of Staff Appointment</td>
</tr>
<tr>
<td>9.5</td>
<td>Exhaustion of Administrative Remedies</td>
</tr>
<tr>
<td>9.6</td>
<td>Reporting Requirements</td>
</tr>
<tr>
<td>Section 10 – Leave of Absence</td>
<td>56</td>
</tr>
<tr>
<td>10.1</td>
<td>Leave Request</td>
</tr>
<tr>
<td>10.2</td>
<td>Termination of Leave</td>
</tr>
<tr>
<td>Section 11 – Practitioners Providing Contracted Services</td>
<td>57</td>
</tr>
<tr>
<td>11.1</td>
<td>Practitioners Providing Services Under Control of TJC-Accredited Organization</td>
</tr>
<tr>
<td>11.2</td>
<td>Practitioners Providing Services Who Are Not Under Control of TJC-Accredited Organization</td>
</tr>
<tr>
<td>11.3</td>
<td>Exclusivity Policy</td>
</tr>
<tr>
<td>11.4</td>
<td>Qualifications</td>
</tr>
<tr>
<td>11.5</td>
<td>Effect of Disciplinary or Corrective Action Recommended by MEC</td>
</tr>
<tr>
<td>11.6</td>
<td>Effect of Contract Expiration or Termination</td>
</tr>
<tr>
<td>Section 12 – Supervision of Physicians in Training and Other Students</td>
<td>58</td>
</tr>
<tr>
<td>12.1</td>
<td>Activities</td>
</tr>
<tr>
<td>Section 13 – Medical Administrative Officers</td>
<td>58</td>
</tr>
<tr>
<td>13.1</td>
<td>Activities</td>
</tr>
<tr>
<td>13.2</td>
<td>Qualifications</td>
</tr>
<tr>
<td>13.3</td>
<td>Duties of CMO</td>
</tr>
<tr>
<td>13.4</td>
<td>Effect of Removal from Office or Adverse Change in Appointment Status or Clinical Privileges</td>
</tr>
<tr>
<td>Section 14 – Review, Revision, Adoption, and Amendment</td>
<td>59</td>
</tr>
</tbody>
</table>

**Part IV: Organization and Functions Manual**

<table>
<thead>
<tr>
<th>SECTION 1. ORGANIZATION AND FUNCTIONS OF THE STAFF</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Organization of the Medical Staff</td>
<td>60</td>
</tr>
<tr>
<td>1.2 Responsibilities for Medical Staff Functions</td>
<td>60</td>
</tr>
<tr>
<td>1.3 Description of Medical Staff Functions</td>
<td>60</td>
</tr>
<tr>
<td>1.4 Responsibilities of Medical Staff President</td>
<td>65</td>
</tr>
<tr>
<td>1.5 Responsibilities of Clinical Section Chiefs</td>
<td>65</td>
</tr>
<tr>
<td>SECTION 2. MEDICAL STAFF COMMITTEES</td>
<td>Page</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>2.1 Medical Staff Committees</td>
<td>66</td>
</tr>
<tr>
<td>2.2 Medical Executive Committee (Standing committee)</td>
<td>67</td>
</tr>
<tr>
<td>2.3 Credentials Committee (Standing committee)</td>
<td>67</td>
</tr>
<tr>
<td>2.4 Peer Review Committee (Standing committee)</td>
<td>67</td>
</tr>
<tr>
<td>2.5 Pharmacy and Therapeutics Committee (Joint committee)</td>
<td>68</td>
</tr>
<tr>
<td>2.6 Infection Control Committee (Joint committee)</td>
<td>69</td>
</tr>
<tr>
<td>2.7 Quality and Patient Safety Council (Joint committee)</td>
<td>69</td>
</tr>
<tr>
<td>2.8 Peer Review Oversight Committee (Joint committee)</td>
<td>70</td>
</tr>
<tr>
<td>2.9 Bioethics Committee (Joint committee)</td>
<td>71</td>
</tr>
<tr>
<td>2.10 Physician Advocacy and Wellness Committee</td>
<td>71</td>
</tr>
<tr>
<td>2.11 Trauma Committee (Joint committee)</td>
<td>72</td>
</tr>
<tr>
<td>2.12 Intensive Care Committee (Joint committee)</td>
<td>73</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION 3. CONFIDENTIALITY, IMMUNITY, AND RELEASES</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Confidentiality of Information</td>
<td>74</td>
</tr>
<tr>
<td>3.2 Immunity From Liability</td>
<td>74</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION 4. REVIEW, REVISION, ADOPTION, AND AMENDMENT</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>75</td>
</tr>
</tbody>
</table>
ARTICLE I. MEDICAL STAFF PURPOSE & AUTHORITY

Section 1. Purpose

1.1 The purpose of this Medical Staff is to bring together qualified physicians and other licensed independent practitioners (collectively, “Practitioners”) who practice at Scott & White Hospital - Round Rock (the “Hospital”) to promote good care and to offer advice, recommendations, and input to Hospital Administration and the Governing Board.

Section 2. Authority

2.1 Subject to the authority and approval of the Governing Board, the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these Bylaws and under the corporate bylaws of the Hospital.

ARTICLE II. MEDICAL STAFF MEMBERSHIP

Section 1. Nature of Medical Staff Membership

1.1 Membership on the Medical Staff of Scott & White Hospital - Round Rock shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated policies of the Medical Staff and Scott & White Hospital - Round Rock. Medical Staff membership is a privilege, and not a right of any Practitioner.

Section 2. Qualifications for Membership

2.1 Specific qualifications for Medical Staff membership are delineated in Part III of these Bylaws (the Credentialing Procedure Manual).

2.2 General qualifications include evidence of the following:

a. current Texas licensure;

b. adequate education, training, experience and evidence of current competence and sound clinical judgment to warrant all privileges requested;

c. the ability to safely and competently meet the obligations of the Medical Staff category requested;

d. demonstration to the satisfaction of the Medical Staff and Governing Board that patients the applicant may treat can reasonably expect quality medical care;

e. willingness to properly discharge the responsibilities established by the Hospital;

f. satisfaction of any applicable office or residence location requirements established by the Medical Staff and/or Governing Board;
g. Request of privileges in a specialty which is not subject to an exclusive contract granted by the Governing Board or which is closed in accordance with any Medical Staff development plan adopted by the Governing Board;

h. compliance with professional liability insurance requirements as set out in these Bylaws or in Medical Staff policies;

i. demonstration of an ability and willingness to work cooperatively with other Practitioners and Hospital staff in a professional manner and in compliance with established Medical Staff and Hospital policies; and

j. compliance with any other criteria for eligibility that may be established by the Governing Board.

2.3 No Practitioner shall be entitled to Medical Staff membership or to specific privileges merely because he is licensed, or a member of any professional organization, or board certified, or because he previously had or presently has privileges at this Hospital or any other Scott & White facility.

Section 3. Nondiscrimination

3.1 The Hospital will not discriminate in granting Medical Staff appointment and/or clinical privileges on the basis of national origin, race, gender, religion, disability unrelated to the provision of patient care, or on any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified. Credentialing or recredentialing decisions will not be based solely on an applicant’s sexual orientation, the type(s) of procedure in which the Practitioner specializes, or on the patient population typically served by the Practitioner.

Section 4. Conditions and Duration of Appointment

4.1 The Governing Board shall make initial appointment and reappointment to the Medical Staff. The Governing Board shall act on appointment and reappointment only after the Medical Staff has had an opportunity to submit a recommendation from the Medical Executive Committee (MEC). Appointment and reappointment to the Medical Staff shall be for no more than twenty-four (24) calendar months.

Section 5. Medical Staff Membership and Clinical Privileges

5.1 Requests for Medical Staff membership and clinical privileges will be processed only when the potential applicant meets the current minimum qualifying criteria approved by the Governing Board. Requested clinical privileges will be considered only when the request demonstrates compliance with any threshold criteria recommended by the MEC and approved by the Governing Board. In the event there is a request for a clinical privilege for which there are no approved criteria, the Governing Board, with input from the MEC and Hospital administration, will first determine if it will allow the privilege to be practiced at the Hospital and if so, direct the MEC to promptly develop privileging criteria by considering required licensure, relevant training or experience, etc. Once specific criteria for the clinical privilege have been recommended by the MEC and approved by the Governing Board, the request for the clinical privilege will be evaluated as described in Part III of these Bylaws (the Credentialing Procedure Manual).

Section 6. Responsibilities of Each Medical Staff Member

By signing an application for Medical Staff membership or clinical privileges, the Practitioner agrees to the following:

6.1 Each Medical Staff member must provide appropriate, timely, and continuous care of his/her patients.
6.2 Each Medical Staff member must participate, as assigned, in quality/performance improvement/peer review activities and in the discharge of other Medical Staff functions as may be required.

6.3 Each Medical Staff member must participate in the on-call coverage of the emergency department by accepting emergency call within his/her clinical specialty and granted privileges and other coverage programs as determined by the MEC and Governing Board to see that patient care needs of the community are met.

6.4 Each Medical Staff member agrees to comply with EMTALA regulations.

6.5 Each Medical Staff member must submit to any type of health or screening evaluation when requested by the MEC or Credentials Committee as part of an investigation of the member’s ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any Hospital or Medical Staff policies addressing physician health or impairment.

6.6 Each Medical Staff member must abide by the Bylaws, rules and regulations, and other policies, procedures, and plans of the Hospital and the Medical Staff, including but not limited to the Medical Staff and Hospital policies on professional conduct and behavior.

6.7 Each Medical Staff member must provide evidence of professional liability coverage of a type and in an amount established by the Governing Board. In addition, Medical Staff members shall comply with any financial responsibility requirements that apply under any applicable laws.

6.8 Each Medical Staff member must immediately notify the Chief Medical Officer and the President of the Medical Staff of any change in required health status; loss or reduction of professional liability insurance coverage; conviction of any felony criminal charges; any disciplinary proceeding against him by any licensing authority, the Texas Medical Board, or its counterpart in any other state; the loss or restriction of privileges at any other hospital or health care institution; and any pending change in the Medical Staff member’s eligibility to participate in a federal program (i.e. Medicare, Medicaid, Champus).

6.9 Patient Care/History and Physical within 24 Hours
Provide appropriate, timely, and continuous care of his/her patients. Each Practitioner with Clinical Privileges to admit patients must ensure that a medical history and physical examination (H&P) has been completed and is documented for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration but prior to surgery or any procedure requiring anesthesia services. The H&P shall be performed by a Physician or qualified licensed individual and in accordance with state law and applicable Governing Policies. When an H&P has been completed within thirty (30) days before admission or registration, an updated medical record entry must be completed and documented within twenty-four (24) hours after admission, but prior to surgery or a procedure requiring anesthesia services. The pertinent elements of the H&P may vary by setting or level of care, treatment, and service and shall be provided in accordance with any applicable Governing Policies. The Physician or qualified licensed individual performing an H&P need not be credentialed and privileged by the Hospital or the SWHC System.
ARTICLE III. CATEGORIES OF THE MEDICAL STAFF

Section 1. The Medical Staff

The Medical Staff shall be divided into Honorary/Emeritus, Active, Courtesy, Consulting, and Consulting without Clinical Privileges categories.

Section 2. The Honorary/Emeritus Medical Staff

The category of Honorary/Emeritus Medical Staff may consist of Practitioners who are not active in the Hospital. These may be Medical Staff members who have retired from active hospital practice or who are of outstanding reputation and not necessarily residing in the community. Honorary/Emeritus Medical Staff members shall not be eligible to admit patients, vote or hold office. They may, however, at the recommendation of the Chief Medical Officer, serve on Hospital committees as voting members.

Section 3. The Active Medical Staff

The category of Active Medical Staff may consist of Practitioners who can and will respond to emergency call by being physically present within thirty (30) minutes, if requested or necessary; who assume all the functions and responsibilities of membership on the Active Medical Staff, including where appropriate emergency, indigent patient, consultative, educational and teaching responsibilities; and who admit more than twenty-four (24) patients, or perform more than twenty-four (24) procedures, during the two year period of appointment. Members of the Active Medical Staff shall be eligible to vote, hold office, and serve on Medical Staff committees and should attend Medical Staff meetings. Active Medical Staff will be board certified or board eligible. Those Active Medical Staff members without sufficient volumes of patient care involvement per appointment period, therefore hindering ongoing professional practice evaluations, are required to provide case documentation from their office or primary operating hospital, whichever appropriate, as approved by the Medical Staff [e.g. Family Medicine practitioners without hospital activity will provide documentation of their office-based practices]. The option of changing categories to “Consulting without Clinical Privileges” will be presented to such low/no volume Active category providers. Consideration will be made for those Active Medical Staff members, without clinical volumes, who participate in the governance of the hospital by virtue of their administrative/fiduciary responsibilities for reviewing and determining policies/guidelines related to the delivery of patient care, and therefore require Committee leadership and voting rights.

Section 4. The Courtesy Medical Staff

The category of Courtesy Medical Staff may consist of Practitioners qualified for Medical Staff membership who are involved in the care and treatment of at least five (5) patients per appointment period, and fewer than twenty-five (25) patients per appointment period (not including use of the hospital’s diagnostic facilities, access to which is unlimited). To be eligible for Courtesy Medical Staff a practitioner must be board certified or board eligible, as defined in Part I Governance, Article II, Section 2.

A member of the Courtesy Medical Staff who admits more than 24 patients, or performs more than 24 procedures at the Hospital in less than 24 months, shall be required to assume the responsibilities of Active Medical Staff membership, including emergency call responsibilities, if the Hospital in its discretion requests the practitioner to assume emergency call responsibilities. If a Practitioner is unable or unwilling to fulfill the responsibilities of Active Medical Staff membership, he will notify the Chief Medical Officer in writing and will be considered to have voluntarily withdrawn from the Medical Staff.
Section 5. The Consulting Medical Staff

The category of Consulting Medical Staff may consist of Practitioners who have been requested and are willing to serve in such capacity. Consulting Medical Staff may include PRN, Locum Tenens or Temporary Staff. They shall consist of Practitioners who are not actively involved in Medical Staff affairs and are not major contributors to fulfillment of Medical Staff functions, due to practicing primarily at another hospital or in an office-based specialty, or other reasons, but who wish to remain affiliated with the Hospital for consultation, referral of patients, or other patient care purposes. They shall not qualify for Admitting privileges. Their duties shall be to provide consultative services in the care of their patients or at the request of a member of the Medical Staff. Resident physicians who have an individual Texas license who are in good standing in their Scott and White Memorial Hospital post-graduate training program may be appointed to the Consulting Medical Staff upon recommendation of their program director and concurrence of the Section Chief. Consulting Medical Staff shall not be eligible to hold office, vote, or serve on standing Medical Staff committees. Consulting Medical Staff (except for Residents) will be board certified or board eligible, pursuant to Bylaws requirements.

Section 6. The Consulting without Clinical Privileges Staff

The category of Consulting without Clinical Privileges Medical Staff may refer patients to the hospital and visit with them, but are not eligible to write orders or manage the patient’s clinical care. They may read the chart and communicate with attending physician and consultants, but can not document in the chart. They may participate in Medical Staff meetings without vote.

Section 7. Provisional Appointment

All initial appointments to the Medical Staff shall be provisional. The appointment and clinical privileges for Active and Courtesy Staff will be provisionally granted for a period of six (6) months, during which time the Practitioner’s performance will be monitored as outlined in these Bylaws. The provisional period may be extended for up to twelve months, if necessary, to permit the collection and analysis of data necessary to evaluate performance.
ARTICLE IV. OFFICERS OF THE MEDICAL STAFF

Section 1. Officers of the Medical Staff

1.1 President
1.2 Vice-President
1.3 Immediate Past President

The initial Medical Staff Officers shall be appointed by the Governing Board to serve two (2) years. Thereafter, the Medical Staff Officers shall be elected as set forth below.

Section 2. Qualifications of Officers

2.1 Officers must be members in good standing of the Active Medical Staff category for at least two years, and must have previously served in a leadership position on the Medical Staff, (e.g., Section Chair, Committee Chair or Committee member) for at least two years. In addition, Officers must satisfy the following criteria:

- Possess a willingness and ability to serve as an Officer;
- No pending adverse recommendations concerning Medical Staff appointment or clinical privileges;
- Training in medical administrative and medical staff leadership or demonstrate willingness to attend training at least two calendar days per year during the term of office;
- Demonstrate an ability to work well with co-workers and comply with the professional conduct policies of the Hospital; and
- Possess excellent administrative and communication skills.

The Medical Staff Nominating Committee will have discretion to determine if a Medical Staff member wishing to run for office meets the qualifying criteria. Officers may not simultaneously hold medical staff or board leadership positions at another hospital or at a facility that is directly competing with the Hospital. Noncompliance with this requirement will result in automatic removal from office unless the Governing Board determines that continuation in office will serve the interests of the Hospital. The Governing Board shall have discretion to determine what constitutes a “leadership position” at another hospital and whether continued service is in the “interest of the hospital.”

Section 3. Election of Officers

3.1 Every other year, the MEC shall appoint a Nominating Committee chaired by the Immediate Past President of the Medical Staff and comprised of at least three members. The committee shall offer at least one nominee for each office. Nominations must be announced, and the names of the nominees distributed to all members of the Active Medical Staff at least thirty (30) calendar days prior to the election.

3.2 A nomination may be made via a petition signed by at least 10% of the Active Medical Staff. Such petition must be submitted to the President of the Medical Staff at least fourteen (14) calendar days prior to the election for placement on the ballot. The candidate nominated by petition must be confirmed by the Nominating Committee to meet the qualifications in Article IV, Section 2, above before he/she can be placed on the ballot.

3.3 Officers shall be elected every other year. Voting will be done via a printed or electronic ballot or in a manner determined by the MEC. The nominee receiving the highest vote total will be elected. Only members of the Active Medical Staff category shall be eligible to vote.
Section 4. Term of Office

4.1 All Officers serve a term of two (2) years. Officers shall take office in the month of January. An Officer may consecutively serve in different Officer positions, as elected by the Medical Staff, so long as he serves no more than two (2) full consecutive terms in any one office.

Section 5. Vacancies of Office

5.1 The MEC shall have the sole discretion to fill vacancies of office during the Medical Staff year, except the office of the Medical Staff President and the office of Immediate Past President. If there is a vacancy in the office of the Medical Staff President, the Vice-President shall serve the remainder of the term. If there is a vacancy in the position of Immediate Past President, such position shall remain vacant until the term of the current President of the Medical Staff expires.

Section 6. Duties of Officers

6.1 President of the Medical Staff – The President will fulfill the duties specified in Part IV of these Bylaws (Organization and Functions Manual).

6.2 Vice President – In the absence of the President, the Vice President shall assume all the duties and have the authority of the President of the Medical Staff. He or she shall coordinate communication within the Medical Staff and perform such further duties to assist the President as the President may from time to time request.

6.3 Immediate Past President – The Immediate Past President will serve as a consultant to the President and Vice President of the Medical Staff and provide feedback regarding their performance of assigned duties on an annual basis. He or she shall perform such further duties to assist the President as the President may from time to time request.

Section 7. Removal and Resignation from Office

7.1 The Medical Staff may remove from office any Officer by petition of 20% of the Active Medical Staff and a subsequent two-thirds (2/3) affirmative vote by ballot of the Active Medical Staff.

An Officer shall be subject to automatic removal in the event:

- He/she fails to conduct those responsibilities assigned within these Bylaws;
- He/she fails to comply with policies and procedures of the Hospital or Medical Staff;
- He/she engages in conduct or makes statements damaging to the Hospital, its goals, or programs; or
- He/she becomes subject to an automatic or summary suspension of clinical privileges which lasts for more than fourteen (14) calendar days.

The Governing Board will determine the existence of such failures and may obtain input from the Joint Conference Committee.

7.2 Any elected Officer of the Medical Staff may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date of receipt, when a successor is elected, or any later time specified therein.
ARTICLE V. MEDICAL STAFF ORGANIZATION

Section 1. Organization of the Medical Staff

1.1 The Medical Staff shall be organized as a non-departmentalized staff consisting of Clinical Sections, as recognized in these Bylaws or by the MEC. The Clinical Sections to which Medical Staff members may be appointed are: (1) surgery, (2) medicine, and (3) primary care medicine. The MEC may recognize additional Clinical Sections if any group of Practitioners who wish to organize themselves into a Clinical Section submit a request to the MEC. Any Clinical Section, may, but shall not be required to, hold regularly scheduled meetings, keep routine minutes, or require attendance. A written report is required only when the Clinical Section is making a formal recommendation. Clinical Section Chiefs will be appointed by the Chief Medical Officer in consultation with the President of the Medical Staff. Functions of Clinical Sections may include:

1.1.1 Continuing education/discussion of patient care;
1.1.2 Grand rounds;
1.1.3 Discussion of policies and procedures;
1.1.4 Discussion of equipment needs;
1.1.5 Development of recommendations for Clinical Section Chiefs or MEC;
1.1.6 Participation in the development of criteria for clinical privileges when requested by the Credentials Committee or MEC; and
1.1.7 Discussion of a specific issue at the request of a Medical Staff committee or the MEC.
1.1.8 Evaluation of the quality of medical and healthcare services provided by or under the direction of Practitioners in the Section, including evaluation of the competence of physicians as requested by the MEC.

1.2 The current Clinical Sections that are organized by the Medical Staff and formally recognized by the MEC shall be listed in Part IV of the Bylaws (Organization and Functions Manual).

Section 2. Functions of Clinical Section Chiefs

2.1 Clinical Section Chiefs shall carry out the responsibilities assigned in Part IV of the Bylaws (Organization and Functions Manual).

Section 3. Assignment to Clinical Section

3.1 The MEC will, after consideration of the recommendations of the Section Chief of the appropriate Clinical Section, recommend Clinical Section assignments for all Medical Staff members in accordance with their qualifications. Each Medical Staff member will be assigned to one primary Clinical Section. Clinical privileges are independent of Clinical Section assignment.
ARTICLE VI. COMMITTEES

Section 1. Designation and Substitution

1.1 There shall be a MEC and such other standing, joint and special committees as established by the MEC and enumerated in Part IV of the Bylaws (Organization and Functions Manual.) Those functions requiring participation of, rather than direct oversight by, the Medical Staff may be discharged by Medical Staff representation on such Hospital committees as are established to perform such functions. The MEC may appoint ad hoc committees as necessary to address time-limited or specialized tasks as a subsection of MEC.

Section 2. Medical Executive Committee

2.1 Committee Membership:

2.1.1 Composition: The MEC shall be a standing committee consisting of the Medical Staff Officers, the chairs of the Credentials and Peer Review Committees, the Chair of the Quality Patient Safety Council, the Chief Medical Officer, and two at-large members appointed by the Chief Medical Officer in consultation with the President of the Medical Staff. At least one of the at-large members will be an Active medical staff member who practices primarily in an outpatient clinic that is physically located off the main hospital campus. The President of the Medical Staff will chair the committee. The Chief Executive Officer, Chief Nursing Officer, Finance Director, and Director of Quality will attend as ex-officio members without vote. Other guests may attend MEC meetings upon invitation of the MEC chair.

2.1.2 An Officer who is removed from his/her position in accordance with Article IV, Section 7 above will automatically lose his/her membership on the MEC. If the chair of either the Credentials or Peer Review Committee resigns or is removed from this position, his/her replacement will serve on the MEC. Other members of the MEC may be removed by a two-thirds (2/3) affirmative vote of the MEC members.

2.2 Duties: This authority may be removed by amending these Bylaws and related policies. The duties of the MEC shall be to:

2.2.1 Serve as the final decision-making body of the Medical Staff in accordance with the Medical Staff Bylaws and provide oversight for all Medical Staff functions;

2.2.2 Coordinate the implementation of policies adopted by the Board;

2.2.3 Submit recommendations to the Governing Board concerning all matters relating to appointment, reappointment, Medical Staff category, Clinical Section assignments, clinical privileges, and corrective action;

2.2.4 Account to the Governing Board and to the Medical Staff for the overall quality and efficiency of professional patient care services provided in the Hospital by individuals with clinical privileges and coordinate the participation of the Medical Staff in organizational performance improvement activities;

2.2.5 Encourage professionally ethical conduct and competent clinical performance on the part of Medical Staff appointees including collegial and educational efforts and investigations, when warranted;

2.2.6 Make recommendations to the Governing Board on medical, administrative and Hospital management matters;
2.2.7 Keep the Medical Staff up-to-date concerning the licensure and accreditation status of the Hospital;

2.2.8 Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;

2.2.9 Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;

2.2.10 Formulate and recommend to the Governing Board Medical Staff rules, policies, and procedures;

2.2.11 Request evaluations of Practitioners privileged through the Medical Staff process in instances in which there is question about an applicant’s or member’s ability to perform privileges requested or currently granted;

2.2.12 Make recommendations concerning the structure of the Medical Staff, the mechanism by which Medical Staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures;

2.2.13 Consult with Hospital administration on the quality, timeliness, and appropriateness of aspects of contracts for patient care services provided to the Hospital by entities outside the Hospital;

2.2.14 Oversee that portion of the corporate compliance plan that pertains to the Medical Staff;

2.2.15 Hold Medical Staff leaders, committees, and Sections accountable for fulfillment of their duties and responsibilities;

2.2.16 Make recommendations to the Medical Staff for changes or amendments to the Medical Staff Bylaws; and

2.2.17 Evaluate the quality of medical and healthcare services provided by or under the direction of Practitioners in the Section, including evaluation of the competence of physicians.

2.3 The MEC shall meet at least four (4) times per year and more often as needed to perform its assigned functions. Permanent records of its proceedings and actions shall be maintained. All such records shall be privileged and confidential.

ARTICLE VII. MEDICAL STAFF MEETINGS

Section 1. Meetings of the Entire Medical Staff

1.1 An annual meeting of the Medical Staff shall be held at a time determined by the MEC. Notice of the meeting shall be given to all Medical Staff members via appropriate media and posted conspicuously at least fourteen (14) calendar days in advance of the meeting.

1.2 Except for Bylaws amendments or as otherwise specified in these Bylaws, the actions of a majority of the Active Medical Staff members present and voting at a meeting of the Medical Staff is the action of the group. Action may be taken without a meeting by the Medical Staff by presentation of the question to each member eligible to vote (in person, via telephone, fax,
and/or by mail or internet) and each member’s vote shall be recorded in accordance with procedures approved by the MEC. Such vote shall be binding so long as the question that is voted on receives a majority of the votes cast.

1.3 Special Meetings of the Medical Staff

1.3.1 The President of the Medical Staff, in consultation with the Chief Medical Officer, may call a special meeting of the Medical Staff at any time. Such request or resolution shall state the purpose of the meeting. The President shall designate the time and place of any special meeting.

1.3.2 Written or printed notice stating the time, place, and purposes of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each member of the Medical Staff at least seven (7) calendar days before the date of such meeting. No business shall be transacted at any special meeting except that stated in the notice of such meeting.

Section 2. Regular Meetings of Medical Staff Committees and Sections

2.1 Committees and Sections may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

Section 3. Special Meetings of Committees and Sections

3.1 A special meeting of any Committee or Section may be called by or at the request of the chairperson or Section Chief thereof or by the President of the Medical Staff.

Section 4. Quorum

4.1 Medical Staff meetings: A quorum shall consist of those Active Medical Staff members present or those eligible Active Medical Staff members voting on an issue.

4.2 Medical Executive Committee, Credentials Committee and Peer Review Committee: A quorum will exist when 50% of the voting Medical Staff committee members are present. For the purposes of expedited credentialing, a quorum will consist of two (2) members of the MEC.

4.3 Clinical Section meetings or Medical Staff committees other than those listed in Section 4.2 above: A quorum shall consist of those present or those eligible Medical Staff members voting on an issue.

Section 5. Attendance Requirements

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

5.1.1 MEC, Credentials Committee and Peer Review Committee meetings: Members of these committees are expected to attend at least fifty percent (50%) of the meetings held.

5.1.2 Special meeting attendance requirements: Whenever suspected deviation from standard clinical or professional practice is identified, the President of the Medical Staff or the applicable Section or committee chair may require the Practitioner to confer with him/her or with a standing, joint or ad hoc committee that is considering the matter. The Practitioner will be given notice of the special meeting at least five (5) calendar days prior to the conference. Such notice shall include the date, time, and place of the meeting, as well as a statement of the issue involved and that the Practitioner’s appearance is mandatory. Failure of the Practitioner to appear at any such special
meeting after two notices, unless excused by the MEC upon showing good cause, will be considered a voluntary resignation of Medical Staff membership. Such termination will not give rise to a fair hearing.

5.1.3 Nothing in the foregoing paragraph shall preclude the initiation of precautionary restriction or suspension of Clinical Privileges as outlined in Part II of these Bylaws (Investigations, Corrective Action, Hearing and Appeal Plan).

Section 6. Participation by Chief Executive Officer (CEO)

6.1 The CEO or any representative assigned by the CEO may attend any committee or Clinical Section meetings of the Medical Staff. The CEO shall be informed in writing and may attend all regular meetings and any special called meetings of any committee, section or the Medical Staff.

Section 7. Robert’s Rules of Order

7.1 Medical Staff and committee meetings shall be run in a manner determined by the individual who is the chair of the meeting. When parliamentary procedure is needed, as determined by the chair or evidenced by a majority vote of those attending the meeting, the latest edition of Robert’s Rules of Order shall determine procedure.

Section 8. Waiver of Notice of Meetings

8.1 The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

Section 9. Action of Committee or Section

9.1 The recommendation of a majority of its members present at a meeting at which a quorum is present shall be the action of a committee or Clinical Section. Such recommendation will then be forwarded to the MEC for information or action.

Section 10. Rights of Ex-Officio Members

10.1 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 that they shall not vote or be counted in determining the existence of a quorum.

Section 11. Minutes

11.1 Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The presiding chair shall sign the minutes and copies thereof shall be submitted to the MEC or other designated committee. A permanent file of the minutes of each meeting shall be maintained. All minutes will be maintained as confidential.
Section 1. Conflict Management Generally

1.1 The Medical Staff shall have a process to manage conflict between leadership groups, including the Medical Staff, MS Committees, Clinical Services, Local Committees, Hospital Committees, and the Governing Body, as a means of protecting patient safety and quality of care at the Hospital ("Conflict Management Process.")

1.2 The Conflict Management Process is intended to address conflicts regarding the review of, development of, recommendations for, and amendments to these Bylaws or the Medical Staff rules, regulations, or policies (each a "Qualifying Conflict.") The Conflict Management Process is also intended to address significant conflicts that, if not managed, could adversely affect patient safety or quality of care at the Hospital (also each a "Qualifying Conflict.") The Conflict Management Process is not intended to address individual Members’ grievances or matters related to credentialing, privileging, performance evaluation or monitoring activities, peer review, investigation, or corrective action of individual Members.

1.3 Qualifying Conflicts subject to the Conflict Management Process include the following as limited by subsection (b) above:

   a. Non-approval by the MEC or Governing Body of proposals to adopt or amend these Bylaws or any rule, regulation, policy, or procedure of the Medical Staff;

   b. Disputes among the various MS Committees, Clinical Services, Local Committees, Hospital committees, and the Governing Body; and

   c. Other issues of significant importance to the clinical safety of patients or quality of care at the Hospital, as evidenced by a petition signed by at least ten percent (10%) of the Members eligible to vote.

Section 2. Process for Conflict Management

2.1 The affected group or concerned Member(s) may initiate the Conflict Management Process only by a written (specifically excluding electronic mail) Memorandum of Conflict which includes the following information in reasonable detail:

   a. The substance of the conflict;

   b. If applicable, the particular rule, regulation, policy, or procedure of concern;

   c. The solution recommended by the affected group or concerned Member(s); and

   d. A description of how the conflict, if not managed, could adversely affect patient safety or quality of care.

2.2 The Memorandum of Conflict shall be submitted to the Medical Staff President (with a copy to the Director of Risk Management for the Scott & White Healthcare system).

2.3 The Qualifying Conflict will be resolved as follows:

   a. The involved parties shall meet to identify the conflict.

   b. Relevant information shall be gathered and considered as a part of the Conflict Management Process.
c. The Governing Body or its designee shall work with the involved parties to manage and, when possible, resolve the conflict.

d. The Governing Body shall have ultimate authority to resolve the conflict in the manner it deems appropriate. The conflict will be considered resolved upon the decision of the Governing Body.

Section 3. Confidentiality

The Conflict Management Process shall be considered privileged and confidential under Texas Occupations Code §§ 160.005-007, Texas Health and Safety Code § 161.032, and Texas Civil Practice and Remedies Code § 154.073. The participants in the Conflict Management Process, including any affected group or concerned Member that submits a Memorandum of Conflict, shall be considered to have acted in good faith and shall be entitled to the protections and immunities afforded under 42 USC §§ 11101 et seq. (Health Care Quality Improvement Act of 1986 or HCQIA), Texas Occupations Code § 160.010, and Texas Health and Safety Code § 161.033.
Article IX. REVIEW, REVISION, ADOPTION, AND AMENDMENT

Section 1. Medical Staff Responsibility

1.1 The Medical Staff shall have the responsibility to formulate, review at least biennially, and recommend to the Governing Board Medical Staff Bylaws, procedures, plans, policies, rules and regulations, and amendments as needed, which shall be effective when approved by the Governing Board. The Medical Staff can exercise this responsibility through its elected and appointed leaders. Such responsibility shall be exercised in good faith and in a reasonable, responsible and timely manner.

Section 2. Methods of Adoption and Amendment to Part I (Governance) and Part II (Investigations, Corrective Action, Hearing and Appeal Plan) of these Medical Staff Bylaws

2.1 Amendments to Part I (Governance) of the Medical Staff Bylaws, and to Part II (Investigations, Corrective Action, Hearing and Appeal Plan) may be recommended by the MEC, another standing committee, via a petition signed by 10% of the membership of the Active Medical Staff, or by the Governing Board. All such recommended amendments shall be reviewed, discussed and voted on by the MEC.

2.2 The MEC shall vote on proposed amendments at a regular meeting, or at a special meeting called for such purpose. If the MEC votes to approve such amendment, it will be submitted for a vote to the Active Medical Staff. Each member of the Active Medical Staff will be eligible to vote on the proposed amendment to these Bylaws via printed ballot or in a manner determined by the MEC. All members of the Active Medical Staff shall receive at least thirty (30) calendar days advance notice of the proposed changes. To be adopted, such changes must receive a majority of the votes cast by the eligible members of the Active Medical Staff. A “yes” vote may be cast by returning the ballot and marking “yes” or by not returning the ballot. Amendments so adopted shall be effective when approved by the Governing Board.

Section 3. Methods of Adoption and Amendment to Part III (Credentialing Procedures Manual) and Part IV (Organization and Functions Manual), as well as any Medical Staff rules, regulations and policies

3.1 Amendments to the Credentialing Procedures Manual and the Organization and Functions Manual, or to any Rules, Regulations and Policy Manual recommended by the MEC and adopted by the Governing Board, may be recommended by the MEC, another standing committee, or via a petition signed by 10% of the membership of the Active Medical Staff. All such recommended amendments shall be reviewed, discussed and voted on by the MEC.

3.2 The MEC shall vote on the proposed amendments at a regular meeting, or at a special meeting called for such purpose. Language in the Credentialing Procedures Manual, the Organization and Functions Manual, and any Rules, Regulations and Policy Manual shall be adopted, amended or repealed, in whole or part, when recommended by the MEC and approved by the Governing Board.

3.3 The MEC will review the Credentialing Procedures Manual, the Organization and Functions Manual, and the Rules, Regulations, and Policy Manual every two (2) years.

3.4 The MEC may correct typographical, spellings, or other obvious errors in these Manuals via written resolution, approved by the Governing Board.
Part II: Investigations, Corrective Action, Hearing and Appeal Plan

These Bylaws encourage the use of progressive steps by Medical Staff leaders and Hospital management, beginning with collegial and education efforts, to address questions relating to a Practitioner’s clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the Practitioner to resolve questions that have been raised. All collegial intervention efforts by Medical Staff leaders and Hospital management are part of the Hospital’s performance improvement and professional and peer review activities. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and Hospital management. Failure to use collegial intervention shall not give rise to any right to initiate the Hearing process.

SECTION 1. INVESTIGATION AND CORRECTIVE ACTION

1.1 Criteria for Initiation

Any person may provide information to any member of the MEC about the conduct, performance, or competence of Medical Staff members. When reliable information indicates a Medical Staff member may have exhibited acts, demeanor, or conduct reasonably likely to be:

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

b. unethical;

c. contrary to the Medical Staff Bylaws, associated manuals, rules and regulations, or Medical Staff or Hospital policies; or

d. below applicable professional standards of behavior or clinical management,

a request for an investigation or action against such member may be initiated. The purpose of such investigation shall be to evaluate the quality of medical and health care services and/or the professionalism, ethics or competence of a Practitioner.

1.2 Initiation

A request for an investigation may be submitted to the MEC by the President of the Medical Staff, the Chief Medical Officer, the Hospital Chief Executive Officer (CEO), the Hospital Chief Nursing Officer (CNO), any member of the MEC, or member of the Governing Board. The Governing Board may direct the MEC to investigate any Medical Staff member.
1.3 Investigation

At the direction of the Governing Board, or upon resolution of the MEC, the MEC shall commence an investigation of the Practitioner of concern. The MEC may conduct the investigation itself or may assign the task to an appropriate standing or ad hoc committee of the Medical Staff. If the investigation is delegated to a committee other than the MEC, such committee shall proceed with the investigation in a prompt manner and shall forward a written report of its findings, conclusions, and recommendations to the MEC as soon as practicable. The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an internal or external consultant if it deems them necessary and such use is approved by the MEC and Hospital CEO.

The investigating body also may require the Practitioner of concern to undergo a physical and/or mental examination and may access the results of such exams to inform its deliberation. The Practitioner of concern shall be notified that the investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate.

Any meeting or interview conducted as a part of the investigation process shall not constitute a “hearing” as that term is used in the hearing and appeals sections of these Bylaws, nor shall the procedural rules with respect to hearings or appeals apply.

The individual being investigated shall not have the right to be represented by legal counsel before the investigating body nor to compel the Medical Staff to engage external consultation. Despite the status of any investigation, at all times the MEC shall retain authority and discretion to take whatever action may be warranted by the circumstances, including suspension, termination of the investigative process, or other action.

1.3.1 An external peer review consultant may be considered when:

   a. Litigation seems likely;

   b. The Hospital is faced with ambiguous or conflicting recommendations from the Medical Staff committees, or where there does not appear to be a strong consensus for a particular recommendation;

   c. There is no one on the Medical Staff with expertise in the subject under review, or when the only Practitioners on the Medical Staff with that expertise are direct competitors, partners, or associates of the Practitioner under review.

1.4 Medical Executive Committee Action

As soon as practicable after the conclusion of the investigation, the MEC shall take action that may include, without limitation:

1.4.1 Determining no corrective action is necessary, and if the MEC determines there was not credible evidence for the complaint in the first instance, removing any adverse information from the member’s file.

1.4.2 Deferring action for a reasonable time where circumstances warrant.

1.4.3 Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude Section chairs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response, which shall be placed in the member’s file.
1.4.4 Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, which may include, without limitation, requirements for co-admissions, mandatory consultation, monitoring and chart reviews, or requiring outside or independent assessment and verification of Practitioner’s clinical skills and judgment.

1.4.5 Recommending denial, restriction, modification, reduction, suspension or revocation of clinical privileges.

1.4.6 Recommending reductions of membership status or limitation of any privileges directly related to the member’s delivery of patient care.

1.4.7 Recommending suspension or revocation of Medical Staff membership.

1.4.8 Taking other actions deemed appropriate under the circumstances.

1.5 Subsequent Action

If the MEC recommends corrective action, that recommendation shall be transmitted to the Governing Board. The recommendation of the MEC shall become final unless the member requests a hearing, in which case the final decision shall be determined as set forth in the Hearing and Appeal plan.

1.6 Automatic Relinquishment/ Voluntary Resignation

In the following instances, the member’s privileges or membership will be considered relinquished, or limited as described, which action shall be final without a right to hearing. Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment or limitation will stand until the MEC determines it is not applicable. The MEC will make such a determination as soon as practicable.

1.6.1 Licensure:

a. Revocation and suspension: Whenever a member’s license or other legal credential authorizing practice in this or other state is revoked or suspended, Medical Staff membership and clinical privileges shall be automatically relinquished by the member as of the date such action becomes effective.

b. Restriction: Whenever a member’s license or other legal credential authorizing practice in this or another state is limited or restricted by an applicable licensing or certifying authority, any clinical privileges that the member has been granted at this Hospital that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

c. Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.
d. Medicare, Medicaid, Tricare: (a managed-care program that replaced the former Civilian Health and Medical Program of the Uniformed Services), or other federal programs: Whenever a member is sanctioned or barred from Medicare, Medicaid, Tricare, or other federal programs, Medical Staff membership and clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any Practitioner listed on the United States Department of Health and Human Services Office of the Inspector General’s List of Excluded Individuals/Entities will be considered to have automatically relinquished his or her privileges.

1.6.2 Controlled Substances:

a. Whenever a member’s United States Drug Enforcement Agency (DEA) certificate or Department of Public Safety (DPS) registration is revoked, limited, non-renewed or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

b. Probation: Whenever a member’s DEA certificate is subject to probation, the member’s right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

1.6.3 Medical record completion requirements: A member of the Medical Staff will be considered to have voluntarily relinquished the privilege to admit new patients or schedule new procedures when he or she fails to complete medical records within time frames established by the MEC. This relinquishment of privileges shall not apply to patients admitted or already scheduled at the time of relinquishment, to emergency patients, or to imminent deliveries. The relinquished privileges will be automatically restored upon completion of the record(s) and compliance with medical records policies. Repeated problems shall constitute a reasonable basis for corrective action including revocation of privileges.

1.6.4 Professional liability insurance: Failure of a Practitioner to maintain professional liability insurance in the amount required by state regulations and/or Medical Staff and Governing Board policies shall result in immediate automatic relinquishment of a member’s clinical privileges. If within 60 calendar days of the relinquishment the Practitioner does not provide evidence of required professional liability insurance (including coverage for any period during which insurance was not maintained), the member shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the Medical Staff. The member must notify the Medical Staff office immediately of any change in professional liability insurance carrier or coverage.

1.6.5 Felony conviction: A Medical Staff member who has been convicted of, or pled “guilty” or “no contest” or its equivalent to a felony or to a misdemeanor involving a charge of moral turpitude in any jurisdiction shall automatically relinquish his or her clinical privileges. Such relinquishment shall become effective immediately upon such conviction or plea, regardless of whether an appeal is filed. Such relinquishment shall remain in effect until the matter is resolved by subsequent action of the Governing Board or through corrective action, if necessary.

1.6.6 Failure to satisfy the special appearance requirement: A Practitioner who fails without good cause to appear at a meeting where his or her special appearance is required in accordance with these Bylaws shall be considered to have automatically relinquished all clinical privileges with the exception of emergencies and imminent deliveries. These privileges will be restored upon compliance with the special appearance requirement. Failure to comply within 30 calendar days will be considered a voluntary resignation from the Medical Staff.
1.6.7 Failure to participate in an evaluation: A Practitioner who fails without good cause to participate in an evaluation of his or her qualifications for Medical Staff membership or privileges as required under these Bylaws (whether an evaluation of physical or mental health or of clinical management skills) shall be considered to have automatically relinquished all privileges. These privileges will be restored upon compliance with the requirement for an evaluation. Failure to comply within 30 calendar days will be considered a voluntary resignation from the Medical Staff.

1.6.8 Failure to become board certified or failure to maintain board certification: A Practitioner who fails to become board certified or maintain board certification in compliance with these Bylaws or Medical Staff credentialing policies will be deemed to have immediately and voluntarily relinquished his or her Medical Staff appointment and clinical privileges. A grace period of one (1) year may be given when the member is in the re-certification process.

1.6.9 Medical Executive Committee Deliberation: As soon as practicable after action is taken or warranted as described in Section 1.6.1. through Section 1.6.8, the MEC shall convene to review and consider the facts, and may recommend such further action as it may deem appropriate following the procedure generally set forth in Section 1.3.

1.6.10 Reinstatement: Reinstatement may be considered only upon resolution of the issue and upon the written request of the Practitioner.

1.7 Precautionary Restriction or Suspension

1.7.1 Criteria for Initiation

The CEO, President of the Medical Staff, the Chief Medical Officer, or the MEC may impose a precautionary restriction or suspension of a Practitioner’s Medical Staff membership or clinical privileges in the following circumstances:

a. to protect the life or well-being of patient(s);

b. to reduce a substantial and imminent likelihood of significant impairment of the life, health, or safety of any person; or

c. there is a need to carefully consider any event, concern, or issue that, if confirmed, has the potential to affect patient or employee safety or the effective operation of the Hospital, or to impair the reputation of the Medical Staff or Hospital.

Unless otherwise stated, such precautionary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the member, the Chief Medical Officer, the MEC, the CEO, and the Governing Board. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. The precautionary restriction or suspension is not a complete professional review action in and of itself, and it shall not imply any final finding regarding the circumstances that caused the suspension. Unless otherwise indicated by the terms of the precautionary restriction or suspension, the Practitioner’s patients shall be promptly assigned to another member by the Section chair or by the President of the Medical Staff, considering, where feasible, the wishes of the affected Practitioner and the patient in the choice of a substitute member.
1.7.2 MEC Action:

As soon as practicable and within 14 calendar days after such precautionary restriction or suspension has been imposed, a meeting of the MEC shall be convened to review and consider the action and if necessary begin the investigation process as noted in Section 1.3 above. Upon request and at the discretion of the MEC, the member will be given the opportunity to address the MEC concerning the issues giving rise to the precautionary restriction or suspension, on such terms and conditions as the MEC may impose. In no event shall any meeting of the MEC, with or without the member, constitute a “hearing” within the meaning defined in the Hearing and Appeal plan, nor shall any procedural rules with respect to Hearing and Appeal apply. The MEC may modify, continue, or terminate the precautionary restriction or suspension, but in any event it shall furnish the member with notice of its decision.

1.7.3 Procedural rights:

Unless the MEC promptly terminates the precautionary restriction or suspension prior to or immediately after reviewing the results of any investigation described in Section 1.3, the member shall be entitled to the procedural rights afforded by the hearing and appeal plan once the restrictions or suspension last more than fourteen (14) calendar days.

1.8 Disciplinary Time Out

1.8.1 Criteria for Initiation

Upon the recommendation of the Hospital CEO or Chief Medical Officer, the MEC may institute one or more Disciplinary Time-Outs upon a Practitioner in the following circumstances:

a. Failure to comply with Hospital policies concerning timely completion of medical records;
b. Failure to meet requirements for emergency call coverage;
c. Inappropriate Practitioner behavior;
d. Receipt of two (2) or more written warnings within twelve (12) months related to (a) – (c) above;
e. Failure of the Practitioner to appear before the MEC in response to a request from the MEC to address concerns related to (a) – (c) above.

1.8.2 Scope and Effect of Disciplinary Time-Out

a. A Disciplinary Time-Out results in temporary suspension of admitting or delineated clinical privileges.
b. A Disciplinary Time-Out may be imposed for a cumulative period not to exceed fourteen (14) calendar days in a calendar year.
c. Imposition of a Disciplinary Time-Out three times in any twelve (12) month period may constitute the basis for an investigation and revocation of a Practitioner’s Medical Staff membership and/or clinical privileges.
d. A Disciplinary Time-Out will take effect after the Practitioner has been given an opportunity to either arrange for his/her patients currently at the Hospital to be cared for by another qualified Practitioner or until he/she has had an opportunity to provide needed care prior to such patients’ discharge. During this period, the Practitioner will not be permitted to schedule any elective admissions, surgeries, or procedures. In no event shall any Practitioner subject to a Disciplinary Time-Out be entitled to more than 14 days to arrange for another Practitioner to care for his/her patients or provide care to existing inpatients.

e. The Chief Medical Officer or designee will determine details of the extent to which the Practitioner may continue to be involved with hospitalized patients prior to the effective date of the Disciplinary Time-Out.

SECTION 2. INITIATION AND NOTICE OF HEARING

2.1 Initiation of Hearing

An applicant or an individual holding a Medical Staff appointment shall be entitled to request a hearing under the following circumstances:

2.1.1 Denial of Medical Staff appointment or reappointment;
2.1.2 Revocation of Medical Staff appointment;
2.1.3 Denial or restriction of requested clinical privileges;
2.1.4 Reduction in clinical privileges;
2.1.5 Involuntary reduction/revocation of clinical privileges;
2.1.6 Application of a mandatory concurring consultation requirement, or an increase in the stringency of a pre-existing mandatory concurring consultation requirement, when such requirement only applies to an individual Medical Staff member;
2.1.7 Suspension of staff appointment or clinical privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the member’s failure to complete medical records, failure to maintain required malpractice insurance coverage or any other reason unrelated to clinical competence or professional conduct; or
2.1.8 Imposition of a precautionary suspension or revocation that lasts for more than fourteen (14) days.

2.2 Actions or Events That Shall Not Constitute Grounds for a Hearing

1) Issuance of a letter of guidance, warning, or reprimand;
2) Imposition of a requirement for proctoring (i.e., observation of the Practitioner’s performance by a peer in order to provide information to a Medical Staff peer review committee) with no restriction on privileges;
3) Failure to process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege;
4) Conducting an investigation into any matter or the appointment of an ad hoc investigation committee;
5) Requirement to appear for a special meeting under the provisions of these Bylaws;

6) Automatic relinquishment or voluntary resignation of appointment or privileges;

7) Imposition of a precautionary suspension or disciplinary time out that does not exceed 14 calendar days;

8) Denial of a request for leave of absence, or for an extension of a leave;

9) Determination that an application is incomplete or untimely;

10) Determination that an application will not be processed due to misstatement or omission;

11) Decision not to expedite an application;

12) Termination or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct;

13) Determination that an applicant for membership does not meet the requisite qualifications/criteria for membership as an Active Member of the Medical Staff under Part I, Article III, Section 1 of these Bylaws;

14) Ineligibility to request membership or privileges or continue privileges because a relevant specialty is closed under a Medical Staff development plan or covered under an exclusive provider agreement;

15) Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted or if exhaustion of due process rights is pending;

16) Termination of any contract with or employment by Scott & White Clinic or Hospital;

17) Proctoring, monitoring, and any other performance monitoring requirements imposed during any provisional period imposed under these Bylaws or in order to fulfill TJC standards on focused professional practice evaluation;

18) Any recommendation voluntarily accepted by the member;

19) Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;

20) Change in assigned staff category;

21) Refusal of the Credentials Committee or MEC to consider a request for appointment, reappointment, or privileges within five (5) years of a final adverse decision regarding such request;

22) Removal or limitation of emergency department call obligations;

23) Any requirement to complete an educational assessment;

24) Retrospective chart review;

25) Any requirement to complete a physical or mental examination as required under these Bylaws;

26) Grant of conditional appointment or reappointment for a limited duration;
27) Appointment or reappointment for duration of less than 24 months; or

28) Any other event so designated in these Bylaws.

2.3 Notice of Recommendation

When a precautionary suspension lasts more than fourteen (14) calendar days or when a recommendation is made, which, according to this plan entitles an individual to request a hearing prior to a final decision of the Governing Board, the CEO or his designee shall promptly (within 7 calendar days) provide written notice to the affected Practitioner, either by hand delivery or by mailing via US mail, certified mail, return receipt requested. This notice shall contain:

2.3.1 A statement of the recommendation made and a concise statement of the general reasons for it;

2.3.2 Notice that the individual has the right to request a hearing on the recommendation within thirty (30) calendar days of receipt of this notice;

2.3.3 Notice that the recommendation, if finally adopted by the Governing Board, may result in a report to the state licensing authority (or other applicable state agencies) and the National Practitioner Data Bank; and

2.3.4 A copy of Part II Section 4.5 of the Bylaws outlining the rights of both sides in the hearing.

2.4 Request for Hearing

Such individual shall have thirty (30) calendar days following the date of the receipt of such notice within which to request the hearing. The request shall be made in writing to the Hospital CEO or his/her designee. In the event the affected individual does not request a hearing within the time and in the manner required by these Bylaws, the individual shall be deemed to have waived the right to such hearing and to have accepted the recommendation made, and such recommended action shall thereupon become effective immediately upon final Governing Board action with no further right of hearing or appeal.

2.5 Notice of Hearing and Statement of Reasons

If a hearing is timely requested, the CEO shall schedule the hearing and shall give written notice, certified mail return receipt requested, to the person who requested the hearing. The notice shall include:

2.5.1 The time, place and date of the hearing; and

2.5.2 A concise statement of the acts or omissions with which the Practitioner is charged (the “Statement of Reasons”), and a list of charts in question, where applicable. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing, and that individual and the individual’s counsel have sufficient time to study this additional information and rebut it.

The hearing shall begin as soon as practicable, but no sooner than thirty (30) calendar days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by the parties.
SECTION 3. HEARING PANEL AND PRESIDING OFFICER OR HEARING OFFICER

3.1 Hearing Panel

3.1.1 When a hearing is requested, the CEO, acting for the Governing Board and after considering the recommendations of the Chief Medical Officer (in consultation with the Medical Staff President) and those of the President of the Governing Board (if the hearing is occasioned by a Board determination), shall appoint a hearing panel that shall be composed of not fewer than three members. No individual appointed to the hearing panel shall have actively participated in the consideration of the matter involved at any previous level. However, mere knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel. Employment by, or a contract with, Scott & White Clinic or the Hospital or an affiliate shall not preclude any individual from serving on the hearing panel. Hearing panel members need not be members of the Hospital Medical Staff. When the issue before the panel is a question of clinical competence, all panel members shall be clinical practitioners. Panel members need not be clinicians in the same specialty as the member requesting the hearing.

3.1.2 The CEO or designee shall notify the Practitioner requesting the hearing of the names of the panel members in writing. Any objection to any member of the hearing panel or to the hearing officer or presiding officer shall be made in writing to the CEO by the Practitioner no later than seven (7) days prior to the hearing date. The CEO shall determine whether a replacement panel member should be identified. While the Practitioner who is the subject of the hearing may object to a panel member, he or she is not entitled to veto that member’s participation. Final authority to appoint panel members will rest with the CEO.

3.2 Hearing Panel Chairperson or Presiding Officer

3.2.1 In lieu of a hearing panel chairperson, the CEO and Chief Medical Officer may appoint an attorney at law or other individual experienced in due process as presiding officer. Such presiding officer will not act as a prosecuting officer, or as an advocate for either side at the hearing. The presiding officer may participate in the private deliberations of the hearing panel and may serve as a legal advisor to it, but shall not be entitled to vote on its recommendation.

3.2.2 If no presiding officer has been appointed, a chairperson of the hearing panel shall be appointed by the CEO to serve as the presiding officer and shall be entitled to one vote.

3.2.3 The presiding officer (or hearing panel chair) shall do the following:

a. Act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process.

b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no longer than fifteen (15) hours.

c. Maintain decorum throughout the hearing.

d. Determine the order of procedure throughout the hearing.

e. Have the authority and discretion, in accordance with this policy, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence.
f. Hear argument by counsel on procedural points, including arguments outside the presence of the hearing panel if desired.

g. Seek legal counsel when he or she feels it is appropriate. Legal counsel to the Hospital may advise the presiding officer or panel chair.

3.3 Hearing Officer

3.3.1 As an alternative to the hearing panel described in Section 3.1 of this manual, the CEO, after consulting with the Chief Medical Officer (and President of the Governing Board if the hearing was occasioned by a Board determination) may instead appoint a hearing officer to perform the functions that would otherwise be carried out by the hearing panel. The hearing officer may be an attorney.

3.3.2 The hearing officer shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a hearing officer is appointed instead of a hearing panel, all references in this Article to the “hearing panel” or “presiding officer” shall be deemed to refer instead to the hearing officer, unless the context would clearly require otherwise.

SECTION 4. PRE-HEARING AND HEARING PROCEDURE

4.1 Provision of Relevant Information

4.1.1 There is no right to formal “discovery” in connection with the hearing. The presiding officer, hearing panel chairperson, or hearing officer shall rule on any dispute regarding discovery and may impose any safeguards, including denial or limitation of discovery to protect the peer review process and assure a reasonable and fair hearing. In general, the individual requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties that such documents shall be maintained as confidential consistent with all applicable state and federal peer review and privacy statutes and shall not be disclosed or used for any purpose outside of the hearing:

a. Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at his or her expense;

b. Reports of experts relied upon by the Hospital or committee;

c. Copies of redacted relevant committee minutes; and

d. Copies of any other documents relied upon by the MEC or the Governing Board.

4.1.2 The Practitioner shall not be entitled to obtain information regarding other Practitioners or other patient charts;

4.1.3 At least ten (10) calendar days before the hearing or as established by the presiding officer, each party shall provide to the other a written list of the names and addresses of the individuals expected to offer testimony or evidence and a list or index of documents, charts, literature, expert reports, other materials the party intends to present at the hearing, and provide copies of such materials, unless previously provided. The witness and document lists of either party may, in the discretion of the presiding officer, be supplemented or amended at any time during the course of the hearing. The presiding officer shall have the authority to limit the number of witnesses or to allow any witness to testify.
4.1.4 There shall be no contact by the individual who is the subject of the hearing with those individuals appearing on the Hospital’s witness list concerning the subject matter of the hearing, nor shall there be contact by the Hospital with individuals appearing on the affected individual’s witness list concerning the subject matter of the hearing, unless specifically agreed upon by that individual or his or her counsel.

4.1.5 All objections to witnesses or documents shall be made in writing in advance of the hearing. The presiding officer shall not entertain additional objections unless the objecting party demonstrates good cause.

4.2 Pre-Hearing Conference

The presiding officer may require a representative for the individual and for the MEC (or the Governing Board) to participate in a pre-hearing conference. At the pre-hearing conference, the presiding officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and determine the time to be allotted to each witness’s testimony and cross-examination.

4.3 Failure to Appear

Failure, without good cause, of the individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute a waiver of all hearing and appeal rights and a voluntary acceptance of the recommendations or actions pending, which shall then be forwarded to the Governing Board for final action.

4.4 Record of Hearing

The hearing panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the Hospital, but copies of the transcript shall be provided to the individual requesting the hearing at that individual’s expense. The hearing panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in the State of Texas.

4.5 Rights of Both Sides

4.5.1 At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the presiding officer:

a. To call and examine witnesses to the extent available;

b. To introduce exhibits;

c. To cross-examine any witness on any matter relevant to the issues and to rebut any evidence;

d. Representation by counsel who may be present at the hearing, advise their client, and participate in resolving procedural matters. Attorney for the Practitioner may not introduce evidence or examine or cross-examine witnesses. Both sides shall notify the other of the name of that counsel at least ten (10) calendar days prior to the date of the hearing.

4.5.2 Any individuals requesting a hearing who do not testify in their own behalf may be called and examined as if under cross-examination.

4.5.3 The hearing panel may question the witnesses, call additional witnesses or request additional documentary evidence.
4.6 Admissibility of Evidence

The hearing shall not be conducted according to rules of evidence. Hearsay evidence shall not be excluded merely because it may constitute hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which reasonable persons customarily rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

4.7 Burden of Proof

The hearing panel shall recommend in favor of the MEC (or the Governing Board) unless it finds that the individual who requested the hearing has proved by preponderance of the evidence that the recommendation which prompted the hearing was arbitrary, capricious, or appears to be unfounded or not supported by credible evidence. It is the Practitioner’s burden to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment, and clinical privileges and fully complies with all Medical Staff and Hospital Bylaws, policies, rules and regulations.

4.8 Post-Hearing Memoranda

Each party shall have the right to submit a post-hearing memorandum, and the hearing panel may request such a memorandum to be filed, following the close of the hearing.

4.9 Official Notice

The presiding officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested by either party, to present written rebuttal of any evidence admitted on official notice.

4.10 Postponements and Extensions

Postponements and extensions of time beyond any time limit set forth in these Bylaws may be requested by anyone but shall be permitted only by the presiding officer or the CEO on a showing of good cause.

4.11 Persons to be Present

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the CEO or the Chief Medical Officer.

4.12 Order of Presentation

The Scott & White Hospital – Round Rock Board of Directors or the MEC, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

4.13 Adjournment and Conclusion

The presiding officer may adjourn the hearing and reconvene the same, as he or she deems necessary. Upon conclusion of the presentation of evidence by the parties and questions by the hearing panel, the hearing shall be closed.
4.14 Deliberations and Recommendation of the Hearing Panel

Within twenty (20) calendar days after final adjournment of the hearing, the hearing panel shall conduct its deliberations outside the presence of any other person (except the presiding officer, if one is appointed) and shall render a recommendation, accompanied by a report, which shall contain a concise statement of the reasons for the recommendation.

4.15 Disposition of Hearing Panel Report

The hearing panel shall deliver its report and recommendation to the CEO, who shall forward it, along with supporting documentation, to the Governing Board for further action. The CEO shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the Practitioner who requested the hearing, and to the MEC for information and comment.

SECTION 5. APPEAL TO THE GOVERNING BOARD

5.1 Time for Appeal

Within ten (10) calendar days after notice of the hearing panel’s recommendation, either the Practitioner or the MEC may appeal the recommendation. The request for appellate review shall be in writing, and shall be delivered to the CEO either in person or by certified mail, and shall include a brief statement of the reasons for appeal and the specific facts or circumstances which justify further review. If such appellate review is not requested within ten (10) calendar days as provided herein, both parties shall be deemed to have accepted the recommendation involved, and the hearing panel’s report and recommendation shall be forwarded to the Governing Board for final action.

5.2 Grounds for Appeal

The grounds for appeal shall be limited to the following:

5.2.1 There was substantial failure to comply with fair hearing plan and/or the Hospital Medical Staff Bylaws prior to the hearing so as to deny a fair hearing; or

5.2.2 The recommendation of the hearing panel was not supported by sufficient evidence based upon the hearing record.

5.3 Time, Place and Notice

Whenever an appeal is requested as set forth in the preceding sections, the President of the Governing Board shall schedule and arrange for an appellate review as soon as arrangements can be reasonably made, taking into account the schedules of all individuals involved. The affected Practitioner shall be given notice of the time, place and date of the appellate review. The President of the Governing Board for good cause may extend the time for appellate review.

5.4 Nature of Appellate Review

5.4.1 The President of the Governing Board shall appoint a review panel composed of not fewer than three (3) members of the Governing Board to consider the information upon which the recommendation before the Governing Board was made. Members of the review panel should not have participated in any formal investigation leading to the recommendation for corrective action that is under consideration.
5.4.2 The review panel may, but is not required to, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the hearing panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied.

5.4.3 Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the review panel may allow each party or its representative to appear personally and make a time-limited thirty-minute (30) oral argument. The review panel shall recommend final action to the Governing Board.

5.4.4 The Governing Board may affirm, modify or reverse the recommendation of the review panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Governing Board’s ultimate legal responsibility to grant appointment and clinical privileges.

5.5 Final Decision of the Governing Board

Within thirty (30) calendar days after receipt of the review panel’s recommendation, the Governing Board shall render a final decision in writing, including specific reasons for its action, and shall deliver copies thereof to the affected Practitioner and to the chairpersons of the Credentials Committee and MEC, in person or by certified mail, return receipt requested.

5.6 Right to One Appeal Only

No applicant or Medical Staff appointee shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter, which may be the subject of an appeal. In the event that the Governing Board ultimately determines to deny Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or clinical privileges of a current appointee, that individual may not apply within five (5) years for Medical Staff appointment or for those clinical privileges at this Hospital unless the Governing Board provides otherwise.
PART III. Credentialing Procedures Manual

Section 1. Medical Staff Credentials Committee

1.1 Composition

Membership of the Medical Staff Credentials Committee shall consist of the Chief Medical Officer, the President of the Medical Staff, and at least five (5) members of the Active Medical Staff who are experienced leaders. The Chief Medical Officer will appoint the Chair of the committee. The President of the Medical Staff in consultation with the Chair will appoint the members. Members will be appointed for three (3) year terms with the initial terms staggered such that approximately one third of the members will be appointed each year. The Chair will be appointed for a three (3) year term. The Chair and members may be reappointed for additional terms without limit. Any member of the Medical Staff Credentials Committee, including the Chair, may be relieved of his/her committee membership by a two-thirds (2/3) vote of the Medical Executive Committee (MEC). The Medical Staff Credentials Committee may also invite ex-officio members such as representatives from Hospital administration and the Board.

1.2 Meetings

The Medical Staff Credentials Committee shall meet on call of the Chair or President of the Medical Staff.

1.3 Responsibilities

1.3.1 To review and recommend action on all completed applications and reapplications for membership on the Hospital Medical Staff. Such recommendations include assignments of Medical Staff category.

1.3.2 To review and recommend action on all requests regarding privileges from eligible Practitioners.

1.3.3 To recommend eligibility criteria for the granting of Medical Staff membership and privileges at the Hospital.

1.3.4 To develop, recommend, and implement policy and procedures for all credentialing activities at the Hospital.

1.3.5 To review, and where appropriate take action on, reports that are referred to it from other Medical Staff committees, the Medical Staff or Hospital leaders.

1.3.6 To evaluate the qualifications of Practitioners.

1.3.7 To perform such other functions as requested by the MEC.

Section 2. Qualifications for Membership and Privileges

2.1 Membership

No Practitioner shall be entitled to membership on the Medical Staff or to privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization.
2.2 Qualifications

The following qualifications must be met by all applicants for Medical Staff appointment, reappointment or for privileges:

2.2.1 The applicant must demonstrate that he/she has successfully graduated from an approved school of medicine, osteopathy, dentistry, psychology, or podiatry.

2.2.2 The applicant must have a current state license as a Practitioner, applicable to his or her profession, and providing permission to practice within the state of Texas.

2.2.3 The applicant must have a record that is free from current Medicare/Medicaid sanctions and not be on the OIG List of Excluded Individuals/Entities.

2.2.4 The applicant must have a record that is free of felony convictions or occurrences that would raise questions of undesirable conduct which could injure the reputation of the Medical Staff or Hospital.

2.2.5 A physician applicant, MD or DO, must have successfully completed a postgraduate residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME), Royal College of Physicians and Surgeons of Canada, or American Osteopathic Association, and be currently board certified or demonstrate active pursuit of board certification as defined by the appropriate specialty board of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists. Board certification must be achieved within five years of completion of formal training and continuous maintenance of Board certification must be maintained thereafter.

2.2.6 An oral and maxillofacial surgeon applicant must have graduated from an American Dental Association approved school of dentistry accredited by the Commission on Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified or board admissible by the American Board of Oral and Maxillofacial Surgery. Board certification must be achieved within five years of completion of formal training and continuous maintenance of Board certification must be maintained thereafter.

2.2.7 A podiatric physician applicant (DPM) must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified or board admissible by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine. Board certification must be achieved within five years of completion of formal training and continuous maintenance of Board certification must be maintained thereafter.

2.2.8 A dentist applicant must have graduated from an American Dental Association approved school of dentistry accredited by the Commission on Dental Accreditation, and must have successfully completed a post graduate program in hospital dentistry approved by the American Dental Association.

2.2.9 A psychologist applicant must have an earned doctorate degree (Ph.D. or Psy.D) in psychology from an accredited educational institution recognized by the Texas State Board of Psychologists, and have a current active license to practice as a licensed psychologist issued by the Texas State Board of Psychologists.

2.2.10 The applicant must demonstrate his/her background, experience and training, current competence, knowledge, judgment, and ability to perform all privileges requested.
2.2.11 The applicant must, upon request, provide evidence of both physical and mental health that would not impair the fulfillment of his/her responsibilities of Medical Staff membership and the specific privileges requested.

2.2.12 The applicant must have appropriate personal qualifications, including consistent observance of ethical and professional standards. These standards include, at a minimum:

a. Abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities; and

b. A history of consistently acting in a professional, appropriate and collegial manner with others in previous clinical and professional settings.

2.2.13 The applicant must demonstrate appropriate written and verbal communication skills.

2.2.14 Any Practitioner granted privileges who may have occasion to admit an inpatient must demonstrate the capability to provide continuous and timely care to the satisfaction of the MEC and Governing Board.

2.2.15 The applicant must possess a current, valid drug enforcement administration (DEA) number, if applicable.

2.2.16 The applicant must demonstrate recent clinical performance within the last twelve (12) months with an active clinical practice in the area in which clinical privileges are sought that are adequate to meet current clinical competence criteria.

2.2.17 The applicant must request privileges for a service the Governing Board has determined appropriate for performance at the Hospital. There must also be a need for this service under any Board approved Medical Staff development plan.

2.2.18 The applicant must provide evidence of professional liability insurance in an amount established by the Governing Board after consultation with the MEC.

2.2.19 The applicant must submit to a criminal background check and demonstrate no substantial concerns regarding his/her character.

2.2.20 The applicant must submit a representative, legible writing sample exemplifying written medical chart entries.

2.3 Exceptions

2.3.1 The MEC may recommend appropriate exceptions to the requirements under Section 2.2. Exceptions shall be at the sole discretion of the Governing Board, and the granting of exceptions in one instance shall not give rise to a right or expectation of the same exception for any other applicant or at any future time for the applicant.
Section 3. Application Request Procedure

3.1 Application Request

All requests for applications for appointment to the Medical Staff and requests for privileges will be forwarded to the Medical Staff Office. Upon receipt of a request for an application, the Medical Staff Office will provide the potential applicant with an application package. An overview of the Medical Staff Bylaws or a complete set of Medical Staff Bylaws and rules and regulations will be provided or made available to the applicant.

Section 4. Initial Appointment Procedure

4.1 Applicants Attestation, Authorization and Acknowledgement

The applicant must complete and sign the application forms. By signing the application, the applicant:

4.1.1 Attest to the accuracy and completeness of all information on the application or accompanying documents and agrees that any inaccuracy, omission, or misrepresentation, whether intentional or not, will be grounds for termination of the application process. If the inaccuracy, omission or misstatement is discovered after an individual has been granted appointment and/or clinical privileges, the individual’s appointment and privileges may be deemed to be automatically relinquished. In either situation, there shall be no entitlement to a hearing or appeal.

4.1.2 Consents to appear for any requested interviews in regard to his/her application.

4.1.3 Authorizes the Hospital and Medical Staff representatives to consult with prior and current associates and others who may have information bearing on his/her professional competence, character, ability to perform the privileges requested, ethical qualifications, ability to work cooperatively with others, and other qualifications for membership and the clinical privileges requested.

4.1.4 Consents to Hospital and Medical Staff representatives’ inspection of all records and documents that may be material to an evaluation of:

- Professional qualifications and competence to carry out the clinical privileges requested;
- Physical and mental/emotional health status to the extent relevant to safely perform requested privileges;
- Professional and ethical qualifications;
- Professional liability actions involving the applicant; and
- Any other issue relevant to establishing the applicant’s suitability for membership and privileges.

4.1.5 Releases from liability, promises not to sue and grants immunity to the Hospital, its Medical Staff, the Credentials Committee, MEC and the Board and their representatives for acts performed and statements made in connection with evaluation of the application and his/her credentials and qualifications to the fullest extent permitted by the law.
4.1.6 Releases from liability and promises not to sue, all individuals and organizations who provide
information to the Hospital or the Medical Staff, including otherwise privileged or confidential
information concerning his/her background; experience; competence; professional ethics;
character; physical and mental health to the extent relevant to the capacity to fulfill requested
privileges; emotional stability; utilization practice patterns; and other qualifications for staff
appointment and clinical privileges.

4.1.7 Authorizes the Hospital and the Medical Staff and administrative representatives to release
credentialing and peer review information to other hospitals, medical associations, licensing
boards, appropriate government bodies and other health care entities concerned with the
Practitioner’s performance, and releases the Hospital, Medical Staff and administrative
representatives from liability for so doing.

4.1.8 Acknowledges that the applicant has had access to the Medical Staff bylaws, including all
rules, regulations, policies and procedures of the Medical Staff and agrees to abide by their
provisions.

4.2 Completion of Application

4.2.1 The burden is on the applicant to provide all required information. It is the applicant’s
responsibility to ensure that the Medical Staff Office receives all required supporting
documents verifying information on the application and to provide sufficient evidence, as
required in the sole discretion of the Hospital, that the applicant meets the requirements for
Medical Staff membership and/or the privileges requested. If information is missing from the
application, or new, additional, or clarifying information is required, a letter requesting such
information will be sent to the applicant. If the requested information is not returned to the
Medical Staff Office within forty-five (45) calendar days of the receipt of the request letter, the
application will be deemed to have been voluntarily withdrawn.

4.2.2 Upon receipt of a completed application, the Chief Medical Officer or Chair of the Medical
Staff Credentials Committee, or their designees, in collaboration with the Medical Staff
Office, will determine if the requirements of Section 2.2 are met. In the event the
requirements of Section 2.2 are not met, the potential applicant will be notified that he/she is
ineligible to apply for membership or privileges on the Scott & White Hospital - Round Rock
Medical Staff, the application will not be processed and the applicant will not be entitled to a
hearing on this decision. If the requirements of Section 2.2 are met, the application will be
accepted for further processing.

4.2.3 Upon receipt of a completed application, the Medical Staff Office will verify current licensure,
education and relevant training from acceptable sources. When it is not possible to obtain
information from the primary source, reliable secondary sources (e.g., another hospital that
has documented the primary source) may be used if there has been a documented attempt
to contact the primary source. In addition, the Medical Staff Office may collect relevant
additional information which may include:

a. Information from all prior and current liability insurance carriers concerning claims, suits,
settlements and judgments (if any) during the past ten (10) years;

b. Documentation of the applicant’s past clinical work experience;

c. Licensure status in all current or past states of licensure. In addition, the Medical Staff Office
will primary source verify licensure at the time of renewal or revision of clinical privileges,
whenever a new privilege is requested, and at the time of license expiration;
d. Information from the AMA or AOA Physician Profile, Federation of State Medical Board, OIG list of Excluded Individuals/Entities, and FACIS (Fraud and Abuse Control Information System);

e. Information regarding the applicant’s completion of postgraduate professional training programs, including residency and fellowship programs;

f. Information from the National Practitioner Data Bank (NPDB). In addition the NPDB will be queried at the time of renewal of privileges and whenever a new privilege(s) is requested;

g. Other information about adverse credentialing and privileging decisions;

h. One or more peer recommendations, as selected by the Credentials Committee, chosen from practitioner(s) who have observed the applicant’s clinical and professional performance and can evaluate the applicant’s current and past patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, system-based practice, and physical, mental and emotional ability to perform requested privileges;

i. The results of any drug testing and/or other health testing required by a health care institution or licensing board;

j. Information from a criminal background check;

k. Information from any other sources relevant to the qualifications of the applicant to serve on the Medical Staff and/or hold privileges; and

l. Morbidity and mortality data and relevant Practitioner-specific data as compared to aggregate data, when available.

Note: In the event there is undue delay in obtaining required information, the Medical Staff Office will request assistance from the applicant. During this time period, the “time periods for processing” the application will be appropriately modified. Failure of an applicant to adequately respond to a request for assistance after forty-five calendar days will be deemed a voluntary withdrawal of the application.

4.2.4 When the items identified in Section 4.2.3 above have been obtained, the file will be considered verified and complete and eligible for evaluation.

4.3 Application Evaluation

4.3.1 Expedited Credentialing An expedited review and approval process may be used for initial appointment. All initial applications for membership and privileges will be designated Category 1 or Category 2 as follows;

Category 1: A completed application that does not raise concerns as identified in the criteria for Category 2. Applicants in Category 1 will be granted Medical Staff membership and/or privileges after review and approval by the Chair of the Medical Staff Credentials Committee or designee acting on behalf of the Medical Staff Credentials Committee, the MEC and a Board Committee consisting of at least two individuals.
Category 2: If one or more of the following criteria are identified in the course of reviewing a completed and verified application, the application will be treated as Category 2. The Medical Staff Credentials Committee, the MEC, and the Governing Board review and act on applications in Category 2. The Medical Staff Credentials Committee may request that an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is upon the applicant to provide evidence that he/she meets the criteria for membership on the Medical Staff and for the granting of application requested privileges. Criteria for Category 2 applications include but are not necessarily limited to the following:

a. The application is deemed to be incomplete;

b. The final recommendation of the MEC is adverse or with limitation;

c. The applicant is found to have experienced an involuntary termination of medical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization;

d. The applicant is, or has been, under investigation by a state medical board or has prior disciplinary actions or legal sanctions;

e. The applicant changed medical schools or residency programs or has gaps in training or practice;

f. The applicant has one or more reference responses that raise concerns or questions;

g. Discrepancy is found between information received from the applicant and references or verified information;

h. The applicant has an adverse National Practitioner Data Bank report;

i. The request for privileges is not reasonable based upon applicant’s experience, training, and demonstrated current competence, and/or the applicant is not in compliance with applicable criteria;

j. The applicant has been removed from a managed care panel for reasons of professional conduct or quality;

k. The applicant has potentially relevant physical, mental and/or emotional health problems; or

l. Other reasons exist as determined by the Chief Medical Officer, Chair of the Medical Staff Credentials Committee or his designee, Chair of the MEC, the MEC or any representative of the Governing Board, which raise questions about the qualifications, competency, professionalism or appropriateness of the applicant for membership or privileges.
4.3.2 Applicant Interview

4.3.2.1 Applicants will be required to participate in an interview as part of the application for appointment to the Medical Staff at the discretion of the Medical Staff Credentials Committee, Chief Medical Officer, MEC or Governing Board. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., clinical knowledge and judgment, professional behavior, malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant’s ability to render care at the generally recognized level for the community. The interview may also be used to communicate Medical Staff performance expectations.

4.3.2.2 The applicant will be notified as to the date, time, and place of the interview. Failure of the applicant to appear for a scheduled interview will be deemed a voluntary withdrawal of the application.

4.3.3 Medical Staff Credentials Committee Action

4.3.3.1 If the application is designated Category 1, it is presented to the Credentials Chair or designee for review and recommendation. The Credentials Chair or designee reviews the application to ensure that it fulfills the established standards for membership and clinical privileges. The Credentials Chair or designee has the opportunity to determine whether the application is forwarded as a Category 1 or may change the designation to a Category 2.

If forwarded as a Category 1, the Credentials Chair or designee acts on behalf of the Medical Staff Credentials Committee and the application is presented to the MEC for review and recommendation.

4.3.3.2 If the application is designated Category 2, the Medical Staff Credentials Committee reviews the application and forwards the following to the MEC:

a. A recommendation as to whether the application should be acted on as Category 1 or Category 2.

b. A recommendation to approve the applicant’s request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges.

4.3.4 Medical Executive Committee Action

4.3.4.1 If the application is designated Category 1, it is presented to the MEC. The MEC or its designee has the opportunity to determine whether the application is forwarded to the Board as a Category 1, or may change the designation to a Category 2. The application is reviewed to ensure that it fulfills the established standards for membership and clinical privileges. The MEC forwards the following to the Board:

a. A recommendation as to whether the application should be acted on as Category 1 or Category 2.

b. A recommendation to approve the applicant’s request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges.
The MEC may refer a recommendation back to the Credentials Committee for further consideration and setting a time limit within which a subsequent recommendation must be made.

4.3.5 Board Action

4.3.5.1 If the application is designated by the MEC as Category 1, it is forwarded to the Board where the application is reviewed to ensure that it fulfills the established standards for membership and clinical privileges. If it is impractical for the entire Board to review the application, the application may be reviewed by two (2) members of the Board to ensure that it fulfills the established standards for membership and clinical privileges. If the Board (or two (2) Board members) agrees with the recommendations of the MEC, the application is approved and the requested membership and/or privileges are granted for a period not to exceed twenty-four (24) months. If two (2) Board members take the action, it is reported to the entire Board at its next scheduled meeting.

4.3.5.2 If the application is designated as a Category 2, the Board (or two (2) Board members, as set forth in Section 4.3.5.1) reviews the application and votes for one of the following actions:

a. The Board (or two (2) Board members) may adopt or reject in whole or in part a recommendation of the MEC or refer the recommendation back to the MEC for further consideration, setting a time limit within which a subsequent recommendation must be made. If the Board (or two (2) Board members) concurs with the applicant’s request for membership and/or privileges, the application is approved and the requested membership and/or privileges are granted for a period not to exceed twenty-four (24) months.

b. If the Board’s action (or action of the two (2) Board members) is adverse to the applicant, a notice will be sent to the applicant who shall then be entitled to the procedural rights provided in the Part II of these Bylaws (the Investigation, Corrective Action, Hearing and Appeal Plan).

c. In the case of an adverse MEC recommendation, the Board (or two (2) Board Members) shall take final action in the matter as provided in the Investigation, Corrective Action, Hearing and Appeal Plan.

4.3.6 Notice of Final Decision

Notice of the Board’s final decision shall be given to the MEC. The applicant shall receive written notice of appointment and of any adverse final decisions. A decision and notice of appointment includes the staff category to which the applicant is appointed, the section to which he/she is assigned, the clinical privileges he/she may exercise, and any conditions attached to the appointment.

4.3.7 Time Periods for Processing

The Credentials Committee will act expeditiously and without unnecessary delay when a licensed applicant submits a completed application for Medical Staff membership or privileges. The Credentials Committee shall take action on the completed application not later than the 120th day after receipt of said application. The Board shall take final action on the application not later than 60 days after the date on which the recommendation of the Credentials Committee is received.
4.3.7.1 If the provisions of the Investigation, Corrective Action, Hearing and Appeal Plan are activated, the time requirements provided therein govern the continued processing of the application.

Section 5. Focused Professional Practice Evaluation

The Credentials Committee, with the approval of the MEC, may define circumstances that require monitoring and evaluation of the clinical performance of a Practitioner following his or her initial grant of clinical privileges at the Hospital. Such monitoring may utilize a range of techniques, including but not limited to: chart review, the tracking of performance monitors/indicators, proctoring, external peer review, simulations, morbidity and mortality reviews, and clinical-pathologic conferences (CPCs). The Committee may also establish duration for such focused professional practice evaluation and triggers that indicate the need for performance monitoring.

Section 6. Reappointment

6.1 Criteria for Reappointment

It is the Hospital's policy to approve for reappointment and/or renewal of privileges only those Practitioners who meet the criteria for initial appointment as identified in Section 2. The Practitioner must also be determined by the MEC to be a provider of effective care that is consistent with Hospital standards of ongoing quality and the Hospital performance improvement program. The Practitioner must provide the information enumerated in Section 6.2 below. All reappointments and renewals of clinical privileges are for a period not to exceed twenty-four (24) months. The granting of new clinical privileges to existing Medical Staff members will follow the steps described in Section 4 above concerning the initial granting of new clinical privileges and Section 5 above concerning focused professional practice evaluation.

6.2 Information Collection and Verification

6.2.1 On or before four (4) months prior to the date of expiration of a Medical Staff appointment or grant of privileges, a representative from the Medical Staff Office will notify the Practitioner of the date of expiration and supply him/her with an application for reappointment to membership and/or privileges. At least sixty (60) calendar days prior to the expiration date, the Practitioner must return the following to the Medical Staff Office.

- A completed reapplication form, which includes complete information to update his/her file on items listed in his/her original application, any required new, additional, or clarifying information, and any required fees or dues;
- Information concerning continuing training and education internal and external to the Hospital during the preceding period; and
- Specific requests for clinical privileges sought on reappointment, with any basis for changes. Any new privileges that may be requested at any time during the appointment cycle, or at reappointment, shall require: license to be verified, one or more peer reference(s) to evaluate competency, and a query to the National Practitioner Data Bank.

6.2.2 By signing the reapplication form, the Practitioner agrees to the same terms as identified in Section 4.4 above.
6.2.3 The Medical Staff Office will collect from internal and external sources information regarding the Practitioner’s professional and collegial activities, to include those items listed in Section 4.3.3, items a-l.

6.2.4 The following information is also collected:

a. A summary of the Practitioner’s clinical activity at this Hospital;
b. Information regarding the Practitioner’s performance and conduct in this Hospital and other healthcare organizations in which the Practitioner has provided substantial clinical care since the last reappointment, including information pertaining to patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice;
c. Documentation of any required hours of continuing medical education activity;
d. Information regarding the Practitioner’s service on Medical Staff and Hospital committees;
e. Information regarding the Practitioner’s timeliness, legibility and accuracy in completion of medical records;
f. Information regarding the Practitioner’s compliance with the Bylaws, policies, rules, regulations, and procedures of the Hospital and Medical Staff;
g. Information regarding any gaps in employment or practice since the previous appointment or reappointment;
h. Information derived from the National Practitioner Data Bank;
i. One or more peer recommendation(s) to the extent sufficient peer review data is not available to evaluate competency. The peer recommendation will evaluate the applicant’s patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice; and
j. Malpractice history for the past two (2) years, which is primary source verified by the Medical Staff Office with the Practitioner’s malpractice carrier(s).

6.2.5 Failure, without good cause, to provide any requested information, at least thirty (30) calendar days prior to the expiration of appointment will result in a cessation of processing of the application and automatic expiration of appointment when the appointment period is concluded. Once the information is received, the Medical Staff Office verifies this additional information and notifies the Practitioner of any additional information that may be needed to resolve any doubts about performance or material in the credentials file.

6.3 Evaluation of Application for Reappointment of Membership and/or Privileges

6.3.1 Reappointment applications will be categorized as described in Section 4.4.1 above (i.e., Category 1 or Category 2).

6.3.2 The reappointment application will be reviewed and acted upon as described in Sections 4.3.3 through 4.3.5 above. For the purpose of reappointment an “adverse recommendation” by the Board as used in Section 4 means a recommendation or action to deny reappointment, or to deny or restrict requested clinical privileges, or any action which would entitle the Practitioner to a hearing under Part II of the Medical Staff Bylaws.
Section 7. Clinical Privileges

7.1 Exercise of Privileges

A Practitioner providing clinical services at the Hospital may exercise only those privileges granted to him/her by the Governing Board or emergency and disaster privileges as described herein. The Governing Board, upon recommendation of the MEC, may grant privileges to practitioners who are NOT members of the Medical Staff. Such individuals may be advanced practice registered nurses, physician assistants, physicians serving short locum tenens positions, telemedicine physicians or others deemed appropriate by the MEC and Governing Board.

7.2 Requests

Each application for appointment or reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. Specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappointments of privileges.

7.3 Basis for Privileges Determination

7.3.1 Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence as specified by the Hospital in its criteria for clinical privileges.

7.3.2 Privileges for which no criteria have been established:

a. In the event a request for a privilege is submitted for a new technology/drug, a procedure new to the Hospital, an existing procedure used in a significantly different manner, or a cross-specialty privilege for which no criteria has been established, the request will be tabled for a reasonable period of time, usually not to exceed sixty (60) calendar days. During this time, the MEC will:
   a. Review the community, patient and Hospital need for the privilege and reach agreement with management and the Governing Board that the privilege is approved to be exercised at the Hospital;
   b. Review with members of the Credentials Committee the efficacy and clinical viability of the requested privilege and confirm that this privilege is approved for use in the setting specific area of the Hospital by appropriate regulatory agencies (FDA, OSHA, etc.) for use;
   c. Meet with management to ensure that the new privilege is consistent with the Hospital’s mission, values, strategic, operating, capital, information and staffing plans;
   d. Work with management to ensure that any/all exclusive contract issues, if applicable, are resolved in such a way to allow the new or cross-specialty privileges in question to be provided without violating the existing contract.

b. Upon recommendation from the Medical Staff Credentials Committee and appropriate Scott and White Memorial Hospital department chairs and other appropriate clinical service/specialty or subject matter experts (as determined by the Credentials Committee), the MEC will formulate the necessary criteria and recommend these to the Governing Board. Once objective criteria have been established, the original request will be processed as described herein.
c. For the development of criteria, the Medical Staff Credentials Committee (or designee) will compile information relevant to the privileges requested which may include, but need not be limited to, position and opinion papers from specialty organizations, position and opinion statements from interested individuals or groups, and documentation from other hospitals in the region as appropriate.

d. Criteria to be established for the privilege(s) in question include education, training, board status or certification (if applicable), experience, and evidence of current competence. Proctoring requirements, if any, will be addressed, including who may serve as proctor and how many proctored cases will be required. Hospital-related issues such as exclusive contracts, equipment, clinical support staff and management will be referred to the appropriate Hospital administrator and/or department director.

e. If the privileges requested overlap two or more specialty disciplines, an ad hoc committee will be appointed by the Chair of the Medical Staff Credentials Committee to recommend criteria for the privilege(s) in question. This ad hoc committee will consist of at least one, but not more than two, members from each involved discipline. The chair of the ad hoc committee will be a member of the Medical Staff Credentials Committee who has no vested interest in the issue.

7.3.3 Valid requests for clinical privileges will be evaluated on the basis of prior and continuing education, training, experience, utilization practice patterns, current ability to perform the privileges requested, and demonstrated current competence, ability, and judgment. Additional factors that may be used in determining privileges are patient care needs, the Hospital’s capability to support the type of privileges being requested, and the availability of qualified coverage in the applicant’s absence. The basis for privileges determinations to be made in connection with periodic reappointment or a requested change in privileges must include documented clinical performance and results of the applicant’s performance improvement program activities. Privileges determinations will also be based on pertinent information from other sources, especially other institutions and health care settings where a professional exercises the clinical privileges being requested.

7.3.4 The procedure by which requests for clinical privileges are processed are as outlined in Part III, Section 4 above of these Bylaws.

7.4 Special Conditions for Oral Maxillofacial Privileges

Requests for clinical privileges for oral/maxillofacial surgeons are processed in the same manner as all other privilege requests. Privileges for surgical procedures performed by oral maxillofacial surgeons will require that all patients receive a basic medical evaluation (history and physical) by a physician member of the Medical Staff with privileges to perform such an evaluation, which will be recorded in the medical record. The oral maxillofacial surgeon will be responsible to insure that the history and physical is done. Oral surgeons may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in oral/maxillofacial surgery and demonstrated current competence.

7.5 Special Conditions for Licensed Independent Practitioners

Requests for privileges from licensed independent practitioners (LIPs) who are not qualified for Medical Staff appointment but who are eligible for privileges are processed in the same manner as requests for clinical privileges by providers eligible for Medical Staff membership, with the exception that such individuals are not eligible for membership on the Hospital Medical Staff and do not have the rights and privileges of such membership.
Only those categories of LIPs approved by the Board for providing services at the Hospital are eligible to apply for privileges. Allied health practitioners in this category may, subject to any licensure requirements or other limitations, exercise independent judgment only within the areas of their professional competence and participate directly in the medical management of patients under the supervision of a Practitioner who has been accorded privileges to provide such care.

Midlevel providers who do not function as LIPs will be credentialed and privileged in accordance with the Scott & White Hospital – Round Rock Midlevel Provider policy.

7.6 Special Conditions for Podiatric or Dental Privileges

Requests for clinical privileges for podiatrists or dentists are processed in the same manner as all other privilege requests. All podiatric and dental patients will receive a basic medical evaluation (history and physical) by a physician member of the Medical Staff that will be recorded in the medical record. The podiatrist or dentist will be responsible to insure that the history and physical is done.

7.7 Special Conditions for Residents or Fellows in Training (Except Those on Consulting Staff)

Residents or fellows in training in the Hospital shall not normally hold membership on the Medical Staff (except those on the Consulting Staff) and shall not normally be granted specific clinical privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the Chief Medical Officer or a professional graduate education committee in conjunction with the Residency Training Program. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident’s progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate Medical Staff and Hospital leaders.

The post-graduate education program director or committee must communicate periodically with the MEC and the Governing Board about the performance of its residents, patient safety issues, and quality of patient care and must work with the MEC to assure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

7.8 Telemedicine Privileges

Practitioners providing telemedicine services will not be appointed to the Medical Staff but must be granted privileges at this Hospital if, and only if, these services include prescribing care or otherwise treating patients. Practitioners providing telemedicine services limited to interpretation and second opinions do not require privileges at this Hospital. Practitioners providing official readings of images, tracings or specimens through a telemedicine mechanism must do so under one of the following two arrangements:

- The Practitioner is granted clinical privileges at both the originating and distant sites* that include these services; or

- The Hospital contracts for the provision of these services by the provider. If the Hospital contracts for the provision of these services, they must be provided consistent with the terms described in Section 11 of these procedures addressing contracted services.

(*The originating site is the site at which the patient is receiving care and the distant site is the site from which the prescribing or treating services are provided.)
7.8.1 In order for a Practitioner to be eligible to request telemedicine privileges, the following requirements must be met:

- The medical staffs at both the originating and distant sites recommend the clinical services to be provided by LIPs through a telemedicine link at their respective sites.

- The Practitioner must concurrently maintain privileges, at a minimum, for the same scope of services at the distant site as he or she is requesting at the originating site Hospital.

7.8.2 Requests for telemedicine privileges at the originating site hospital will be processed through the established procedure for reviewing and granting privileges at the originating site hospital. Information included in the completed Practitioner application for telemedicine privileges at the originating site hospital may be collected in the usual manner or may be collected from the distant site hospital or organization.

7.8.3 In order for the originating site to utilize the credentialing and privileging decision from the distant site to make a final privileging decision, the following three conditions must be fulfilled:

- the distant site is a TJC accredited hospital or ambulatory care organization;

- the Practitioner is privileged at the distant site for those services to be provided at the originating site; and

- the originating site hospital has evidence of an internal review of the Practitioner’s performance of these privileges and sends to the distant site information that is useful to assess the Practitioner’s quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information will include all adverse outcomes related to sentinel events considered reviewable by the TJC that result from the telemedicine services provided and complaints about the distant site LIP from patients, other LIP’s, or staff at the originating site.

7.9 Temporary Privileges

Temporary privileges may be granted by the CEO or his/her designee, acting on behalf of the Governing Board, and based on the recommendation of the CMO or President of the Medical Staff or their applicable designee, provided there is verification of current licensure and current competence. Temporary privileges may be granted only in two (2) circumstances: 1) to fulfill an important patient care need, or 2) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the MEC and the Board.

7.9.1 Important Patient Care Need

Temporary privileges may be granted on a case by case basis when an important patient care need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed one hundred twenty (120) calendar days. For the purposes of granting temporary privileges, an important patient care need may include but is not limited to:

a. A circumstance in which one or more individual patients will experience care that does not adequately meet their clinical needs if the temporary privileges under consideration are not granted (i.e., a patient scheduled for urgent surgery who would not be able to undergo the surgery in a timely manner);
b. A circumstance in which the Hospital will be placed at risk of not adequately meeting the needs of patients who seek care from the Hospital if the temporary privileges under consideration are not granted (i.e., the Hospital will not be able to provide adequate emergency room coverage in the applicable specialty, or the Governing Board has granted privileges involving new technology to a Practitioner provided the Practitioner is precepted for a specific number of initial cases and the precepting physician, who is not seeking Medical Staff membership, requires temporary privileges to serve as a preceptor.

7.9.2 **Clean Application Awaiting Approval**
Temporary privileges may be granted for up to one hundred and twenty (120) calendar days when the new applicant for Medical Staff membership or privileges is waiting for review and recommendation by the MEC and approval by the Governing Board. Criteria for granting temporary privileges in these circumstances include the applicant providing evidence of the following which has been verified by the Hospital: current licensure*; education*; training and experience*; current competence*; current DEA registration (if applicable); current professional liability insurance in the amount required; acceptable malpractice history; one positive reference specific to the applicant’s competence from an appropriate medical peer*; ability to perform the privileges requested; and acceptable results from a query to the National Practitioner Data Bank* (* denotes TJC required criteria). Additionally, the application must meet the criteria for Category 1, expedited credentialing consideration as noted in Section 4 of this manual.

7.9.3 Temporary privileges are not to be used at reappointment for other administrative purposes such as the following situations:

a. The Practitioner fails to provide all information necessary to the processing of his/her reappointment in a timely manner; or

b. Failure of the staff to verify performance data and information in a timely manner.

7.9.4 Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the Practitioner has agreed in writing to abide by the Bylaws, rules, and regulations and policies of the Medical Staff and the Hospital in all matters relating to his/her temporary privileges. Whether or not such written agreement is obtained, these Bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.

7.9.5 **Termination of Temporary Privileges**
The CEO, acting on behalf of the Governing Board and after consultation with the CMO or President of the Medical Staff or their applicable designee, may terminate any or all of the Practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a Practitioner’s privileges. Where the life or well being of a patient is determined to be endangered, any person entitled to impose precautionary suspension under the Medical Staff bylaws may effect the termination. In the event of any such termination, the CEO or his/her designee then will assign the Practitioner’s patients to another Practitioner. The wishes of the patient shall be considered, when feasible, in choosing a substitute Practitioner.

7.9.6 **Rights of the Practitioner with Temporary Privileges**
A Practitioner is not entitled to the procedural rights afforded by the Investigation, Corrective Action, Hearing and Appeal Plan procedures outlined in the Medical Staff Bylaws because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended, unless such refusal, termination or suspension is based on a determination of clinical incompetence or unprofessional conduct.
7.9.7 Emergency Privileges
In the case of a medical emergency, any Medical Staff appointee is authorized to do everything possible to save the patient’s life or to save the patient from serious harm, to the degree permitted by the appointee’s license, but regardless of section affiliation, staff category, or level of privileges. A Practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

7.9.8 Disaster Privileges

a. If the Hospital’s Disaster Plan has been activated and the Hospital is unable to meet immediate patient needs, the CEO and such other individuals as identified in the Hospital’s Disaster Plan with such authority, may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to provide patient care to selected Practitioners who must at a minimum present a valid government-issued photo identification issued by a state or federal agency (e.g., driver’s license or passport) and at least one of the following:

1. A current picture identification card that clearly identifies professional designation;

2. A current license to practice;

3. Primary source verification of the license;

4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organization or group;

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

6. Identification by a current Hospital or Medical Staff member (s) who possesses personal knowledge regarding the individual’s ability to act as a licensed independent practitioner during a disaster.

b. The Medical Staff oversees the professional performance of Practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The Hospital must make a decision (based on information obtained regarding the professional practice of the Practitioner) within 72 hours related to the continuation of the disaster privileges initially granted.

c. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the Practitioner presents to the Hospital.

d. Once the immediate situation has passed and such determination has been made consistent with the Hospital’s Disaster Plan, the Practitioner’s disaster privileges will terminate immediately.

e. Any individual identified in the Hospital’s Disaster Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the Hospital and will not give rise to a right to a hearing or an appeal.
Section 8. Preceptorship

8.1 Requirement

A Practitioner who has not provided acute inpatient care within the past one (1) year who requests clinical privileges at the Hospital must arrange for a preceptorship either with a current Medical Staff member in good standing who practices in the same specialty, or with another equivalently competent physician practicing outside of the Hospital. The Practitioner must assume responsibility for any financial costs required to fulfill the requirements of Sections 8.1 and 8.2.

8.2 Preceptorship Program Description

A description of the preceptorship program, including details of monitoring and consultation, must be written and submitted for approval to the Medical Staff Credentials Committee and MEC. At a minimum, the preceptorship program description must include the following:

8.2.1 The scope and intensity of required preceptorship activities; and

8.2.2 The requirement for submission of a written report from the preceptor prior to termination of the preceptorship period assessing, at a minimum, the applicant’s demonstrated clinical competence related to the privileges requested, ability to get along with others, the quality and timeliness of medical records documentation, ability to perform the privileges requested, and professional ethics and conduct.

Section 9. Reapplication After Modifications of Membership Status or Privileges and Exhaustion of Remedies

9.1 Reapplication After Adverse Credentials Decision

Except as otherwise determined by the MEC or Board in light of exceptional circumstances, a Practitioner who has received a final adverse decision or who has resigned or withdrawn an application for appointment or reappointment or clinical privileges is not eligible to reapply to the Medical Staff for a period of five (5) years from the date of the notice of the final adverse decision or the effective date of the resignation or withdrawal. Any such application is processed in accordance with the procedures then in force. As part of the reapplication, the Practitioner must submit such additional information as the Medical Staff and/or Governing Board requires, demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be processed any further.

9.2 Reapplication after Administrative Revocation

A Practitioner who has had his/her Medical Staff appointment or clinical privileges administratively revoked for failure to maintain current professional liability insurance in the specified amount or failure to maintain and complete medical records may be reinstated for appointment and appropriate privileges upon submission of documentation that he/she has resolved the reason for the revocation, including payment of any applicable fees.
9.3 Request for Modification of Appointment Status or Privileges

A Medical Staff appointee, either in connection with reappointment or at any other time, may request modification of staff category or clinical privileges by submitting a written request to the Medical Staff Services Office. A modification request must be on the prescribed form and must contain all pertinent information supportive of the request. All requests for additional clinical privileges must be accompanied by information demonstrating additional education, training, and current clinical competence in the specific privileges requested. A modification application is processed in the same manner as a reappointment, which is outlined in Section 6 of this manual. A Practitioner who determines that he/she no longer exercises, or wishes to restrict or limit the exercise of, particular privileges that he/she has been granted shall send written notice, through the Medical Staff Services Office, to the Medical Staff Credentials Committee and the MEC. A copy of this notice shall be included in the Practitioner’s credentials file.

9.4 Resignation of Staff Appointment

A Practitioner who wishes to resign his/her Medical Staff appointment and/or clinical privileges must provide written notice to the President of the Medical Staff. The resignation shall specify the reason for the resignation and the effective date. A Practitioner who resigns his/her Medical Staff appointment and/or clinical privileges is obligated to fully and accurately complete all portions of all medical records for which he/she is responsible prior to the effective date of resignation. Failure to do so shall result in an entry in the Practitioner’s credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances.

9.5 Exhaustion of Administrative Remedies

Every Practitioner agrees that he/she will exhaust all the administrative remedies afforded in the various sections of this manual, the Bylaws, the Investigation, Corrective Action, Hearing and Appeal Plan, and as required by applicable law before initiating legal action against the Hospital or its agents.

9.6 Reporting Requirements

The CEO or his/her designee shall be responsible for assuring that the Hospital satisfies its obligations under the Health Care Quality Improvement Act of 1986 and its successor statutes. Actions that must be reported include any negative professional review action against a physician related to clinical incompetence or misconduct that leads to a reduction in clinical privileges of greater than thirty (30) calendar days, resignation, surrender of privileges, or acceptance of privilege reduction either during an investigation or to avoid an investigation.

Section 10. Leave of Absence

10.1 Leave Request

A Medical Staff appointee who wishes to obtain a voluntary leave of absence must provide written notice to the CMO. The notice must state the reasons for the leave and approximate period of time of the leave, which may not exceed one year except for military service or upon express permission by the Governing Board. Requests for leave must be forwarded with a recommendation from the MEC and affirmed by the Governing Board. While on leave of absence, the Medical Staff appointee may not exercise clinical privileges or prerogatives and has no obligation to fulfill Medical Staff responsibilities.
10.2 Termination of Leave

At least thirty (30) calendar days prior to the termination of the leave, or at any earlier time, the Medical Staff appointee may request reinstatement by sending a written notice to the CMO. The Medical Staff appointee must submit a written summary of relevant activities during the leave if the MEC or Board so requests. The MEC makes a recommendation to the Board concerning reinstatement, and the applicable procedures concerning the granting of privileges are followed. If the Practitioner’s most recent grant of membership and/or privileges expired during the leave of absence, the Practitioner must complete a reappointment application and have it acted on favorably in order to resume membership and/or privileges.

Section 11. Practitioners Providing Contracted Services

11.1 Practitioners Providing Services Under Control of TJC-Accredited Organization

When the Hospital contracts for patient care services with licensed independent practitioners (LIPs) who provide official readings of images, tracings or specimens through a telemedicine mechanism, and these practitioners’ services are under the control of a TJC accredited organization, one of the following mechanisms will be implemented:

- The Hospital will specify in the contract that the entity providing these services will ensure that all services will be provided by individuals who are LIPs and that such services are within the scope of those LIPs’ privileges at the contracting entity; or

- The Hospital will verify that all individuals who are LIPs and providing services under the contract have privileges that include the services provided under the contract.

11.2 Practitioners Providing Services Who Are Not Under Control Of TJC-Accredited Organization

When the Hospital contracts for care services with LIPs who provide official readings of images, tracings or specimens through a telemedicine mechanism, and these LIPs’ services are not under the control of a TJC accredited organization, all LIPs who will be providing services under such contract will be permitted to do so only after being granted privileges at the Hospital through the mechanisms established in this manual.

11.3 Exclusivity Policy

Whenever Hospital policy specifies that certain Hospital facilities or services may be provided on an exclusive basis in accordance with contracts or letters of agreement between Scott & White Hospital - Round Rock and qualified practitioners, then other Medical Staff appointees must, except in an emergency or life threatening situation, adhere to the exclusivity policy in arranging for or providing care. Application for initial appointment or for clinical privileges related to Hospital facilities or services covered by exclusive agreements will not be accepted or processed unless submitted in accordance with the existing contract or agreement with the Hospital. Members of the Medical Staff who have been granted privileges which are covered by an exclusive contract will not be able to exercise those privileges unless they become a party to the contract.

11.4 Qualifications

A Practitioner who is or will be providing specified professional services pursuant to a contract or a letter of agreement with the Hospital must meet the same qualifications, must be processed in the same manner, and must fulfill all the same obligations of his/her appointment category as any other applicant or Medical Staff appointee.
11.5 Effect of Disciplinary or Corrective Action Recommended by the MEC

The terms of the Medical Staff Bylaws will govern disciplinary action taken or recommended by the MEC.

11.6 Effect of Contract Expiration or Termination

The effect of expiration or other termination of a contract upon a Practitioner’s Medical Staff appointment and clinical privileges will be governed solely by the terms of the Practitioner’s contract. If the contract is silent on the matter, then contract expiration or other termination alone will not affect the Practitioner’s Medical Staff appointment status or clinical privileges.

Section 12. Supervision of Physicians in Training and Other Students

12.1 Activities

a. All physicians in training will be assigned to the appropriate Clinical Section and will be under the direct supervision of the Clinical Section Chief or their designee.

b. The levels of responsibilities for physicians in training will be defined by the Training Program Director, including a description of the types of clinical activities that physicians in training may perform and those for which residents or fellows may act in a teaching capacity.

c. Oversight and credentialing of physicians in training is delegated to the Office of Graduate Medical Education and to the Clinical Section Chief.

d. Information about the quality of care, treatment and services, and educational needs of the physicians in training will be communicated to the Research Educational Council annually, which includes representation from Scott & White Hospital – Round Rock.

e. Residency review is delegated to the Graduate Medical Education Committee, including compliance with residency review committee citations.

f. Medical students, and students pursuing other health profession degrees will abide by the terms of the affiliation agreement between their facility and Scott & White.

Section 13. Medical Administrative Officers

13.1 Activities

A medical administrative officer is a Practitioner engaged by the Hospital either full or part time in an administratively responsible capacity, whose activities may also include clinical responsibilities such as direct patient care, teaching, or supervision of the patient care activities of other Practitioners under the officer’s direction.

13.2 Qualifications

Each medical administrative officer must achieve and maintain Medical Staff appointment and clinical privileges appropriate to his/her clinical responsibilities and discharge Medical Staff obligations appropriate to his/her staff category in the same manner applicable to all other Medical Staff members.

13.3 Duties of CMO

The Chief Medical Officer (CMO) will appoint the Chairs of all Medical Staff Committees. He/she will also be a member of the MEC, the Credentials Committee and will be an ex-officio member of all other Medical Staff committees without vote.
13.4 Effect of Removal from Office or Adverse Change in Appointment Status or Clinical Privileges

a. Where a contract exists between the officer and the Hospital, its terms govern the effect of removal from the medical administrative office on the officer’s Medical Staff appointment and privileges. The contract terms also govern the effect of an adverse change in the officer’s Medical Staff appointment or clinical privileges on his remaining time in office.

b. In the absence of a contract or where the contract is silent on the matter, removal from office has no effect on Medical Staff appointment status or clinical privileges. The effect of an adverse change in Medical Staff appointment status or clinical privileges on continuance in office will be as determined by the Governing Board after requesting and considering the recommendations of the Officers of the Medical Staff.

c. A medical administrative officer has the same procedural rights as all other Medical Staff members in the event of an adverse change in appointment status or clinical privileges unless the change is, by contract, a consequence of removal from office.

Section 14. Review, Revision, Adoption, and Amendment

This Medical Staff Credentialing Procedures Manual may be amended or repealed, in whole or in part in accordance with Part I of these Bylaws, Article IX, Section 3.
1.1 Organization of the Medical Staff

The Medical Staff of Scott and White Hospital shall be organized as a non-departmentalized staff. A Section Chief shall head each clinical service with overall responsibility for the supervision and satisfactory discharge of assigned functions under the MEC.

1.2 Responsibilities for Medical Staff Functions

The ultimate responsibility for Medical Staff functions as outlined in Section 1.3 lies with the MEC. The Medical Staff Officers, Section Chiefs, Hospital and Medical Staff Committee Chairs, and the CMO are responsible for working collaboratively to develop a process for communication of Medical Staff function activities by providing periodic reports as appropriate to the Section/Committee and to elevate issues of concern to the MEC as needed to ensure adherence to regulatory/accreditation compliance standards and appropriate standards of medical care.

Additionally, Medical Staff Officers may appoint designated physician leaders to help fulfill Medical Staff functions and identify other medical and administrative resources needed to adequately fulfill these functions.

1.3 Description of Medical Staff Functions

The responsible committee, joint committee, officer and/or party is listed in parentheses following each activity outlined below:

1.3.1 Governance

a. Receive, coordinate and act upon, as necessary, the reports and recommendations from Sections, Committees, other groups, and Medical Staff Officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities (MEC);

b. Account to the Governing Board and to the Medical Staff by providing written recommendations for the overall quality and efficiency of patient care at the Hospital (President, CMO and MEC);

c. Take reasonable steps to ensure professional and ethical conduct of all Medical Staff Members, initiate investigations, and pursue corrective action of Medical Staff members when warranted (President, CMO and MEC);

d. Make recommendations on medical, administrative and operational matters pertaining to the Hospital (President, CMO and MEC);

e. Inform the Medical Staff of the accreditation program and the accreditation and state licensure status of the Hospital (President, CMO and MEC);

f. Act on all matters of Medical Staff business, and fulfill any state and federal reporting requirements (MEC);

g. Oversee, develop, and prioritize Continuing Medical Education (CME) plans, programs, and activities that are designed to assist in keeping the Medical Staff informed of significant new developments and new skills in medicine (MEC);
h. Provide education on current ethical issues, recommend ethics policies and procedures, develop criteria and guidelines for the consideration of cases having ethical implications, and arrange for consultation with concerned physicians when ethical conflicts occur in order to facilitate and provide a process for conflict resolution (MEC, Bioethics Committee);

i. Provide oversight concerning the quality of care provided by residents, interns, students, and ensure that the same act within approved guidelines established by the Medical Staff and Governing Board (MEC, Graduate Medical Education Committee); and

j. Ensure effective, timely, and adequate comprehensive communication between the members of the Medical Staff and Medical Staff Officers as well as between Medical Staff Officers and Hospital administration and the Governing Board. (President, CMO, MEC)

1.3.2 Medical Care Evaluation/Performance Improvement/Patient Safety Activities (Peer Review Committee, Quality & Patient Safety Council, Transfusion Committee)

a. Set expectations, develop plans, educate members, and manage processes to measure, monitor, assess, and improve the quality of clinical activities;

b. Understand the adopted approach to and methods of performance improvement;

c. Ensure that important processes and activities are measured, assessed, and improved systematically across all disciplines throughout the hospital;

d. Communicate findings, conclusions, recommendations, and actions to appropriate Medical Staff members and the Governing Board, and define in writing responsibility for acting on recommendations for improvement;

e. Participate in ensuring that the processes are defined and implemented for identifying and managing sentinel events and events that warrant intensive analysis;

f. Ensure implementation of an integrated patient safety program throughout the Hospital;

g. Ensure that an ongoing, proactive program for identifying risks to patient safety and reducing medical/health care errors is defined and implemented;

h. Provide mechanisms to measure, analyze, and manage variation in the performance of defined processes that affect patient safety;

i. Measure and assess the effectiveness of contributions to improving performance and patient safety;

j. Evaluate the medical and healthcare services provided in the Hospital, including evaluation of qualifications and competence of Practitioners, and of patient care provided by those Practitioners; and

k. Monitor patient care activities including but not limited to the following:

1. Medical assessment and treatment of patients;

2. Use of medications;

3. Use of blood and blood components;

4. Use of operative and other procedures;
5. Education of patients and families;
6. Coordination of care with other practitioners and hospital personnel;
7. Accurate, timely, and legible completion of patients' medical records;
8. Appropriateness of clinical practice patterns;
9. Significant departures from established patterns of clinical practice;
10. Use of developed criteria for autopsies;
11. Collection and analysis of sentinel event data;
12. Collection and analysis of patient safety data;
13. Coordination of care, treatment, and services with other Practitioners and Hospital personnel, as relevant to the care, treatment, and services of an individual patient; and

1.3.3 Credentials Review (see Part III: Credentialing Procedures Manual)

1.3.4 Information Management (MEC, Quality & Patient Safety Council)

a. Review and evaluate medical records to determine that they:

1. Properly describe the condition and progress of the patient, the therapy, and the tests provided along with the results thereof, and the identification of responsibility for actions taken; and

2. Are sufficiently complete so as to facilitate continuity of care and communication between those providing patient care services in the Hospital.

b. Develop, review, enforce, and maintain surveillance at least quarterly over enforcement of Medical Staff and Hospital policies and rules relating to medical records including completion, preparation, forms, format, filing, indexing, storage, destruction, and availability; and recommend methods of enforcement thereof and changes therein;

c. Provide liaison with Hospital administration, nursing service, and medical records professionals in the utilization of the Hospital on matters relating to medical records practices and information management planning.

1.3.5 Emergency Preparedness (MEC)

Assist Hospital administration in developing, periodically reviewing, and implementing an emergency preparedness program that addresses disasters both external and internal to the Hospital.

1.3.6 Planning (President, MEC, CMO)

a. Participate in evaluating existing programs, services, and facilities of the Hospital and Medical Staff; and recommend continuation, expansion, abridgment, or termination of each;
b. Participate in evaluating the financial, personnel, and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment; and assess the relative priorities for services and needs and allocation of present and future resources; and

c. Communicate strategic, operational, capital, human resources, information management, and corporate compliance plans to Medical Staff members.

1.3.7 Bylaws Review (MEC)

a. Conduct periodic review of the Medical Staff Bylaws, Organization and Functions Manual, Credentialing Procedures Manual, and Medical Staff rules and regulations;

b. Conduct periodic review of the clinical policies and rules; and


1.3.8 Nominating (MEC)

a. Identify nominees for election to the Medical Staff officer positions and to other elected positions in the medical staff organizational structure; and

b. In identifying nominees, consult with members of the Medical Staff, the MEC, and administration concerning the qualifications and acceptability of prospective nominees.

1.3.9 Infection Control Oversight (MEC, Quality & Patient Safety Council, Peer Review Committee, Infection Control Committee)

a. Develop and approve policies describing the type and scope of surveillance activities including:

- Review of cumulative microbiology recurrence and sensitivity reports;
- Determination of definitions and criteria for nosocomial infections;
- Review of prevalence and incidence studies, as appropriate; and
- Collection of additional data as needed.

b. Approve infection prevention and control actions based on evaluation of surveillance reports and other information;

c. Evaluate and revise the type and scope of surveillance annually;

d. Develop a surveillance plan for sampling of personnel and environments;

e. Develop procedures and systems for identifying, reporting, and analyzing the incidence and causes of infections;

f. Institute surveillance, prevention, and control measures or studies when there is reason to believe patient or personnel may be at risk;

g. Report nosocomial infection findings to the attending Practitioner and appropriate clinical or administrative leader;

h. Review and make recommendations regarding policies and procedures on infection prevention, surveillance, and control at least biannually; and
i. Ensure collection of data and implementation of policies sufficient to comply with state or federal reporting requirements.

1.3.10 Pharmacy and Therapeutics Functions (MEC, Quality & Patient Safety Council, Peer Review Committee, Pharmacy and Therapeutics Committee)

a. Maintain a formulary of drugs approved for use by the Hospital;

b. Create treatment guidelines and protocols in cooperation with Medical Staff and nursing staff;

c. Monitor and evaluate the efforts to minimize drug misadventures such as adverse drug reactions, medication errors, drug/drug interactions, drug/food interactions, and pharmacist interventions;

d. Perform medication usage evaluation studies as required by the Joint Commission (TJC);

e. Approve policies and procedures related to the TJC Care of Patient Standards to include the review of nutrition policies and practices, (including guidelines/protocols on the use of special diets and total parenteral nutrition); pain management; procurement; storage; distribution; use; safety procedures; and other matters relating to medication use within the health system;

f. Develop and measure indicators for the following elements of the patient treatment functions:

- Prescribing/ordering of medications;
- Preparing and dispensing of medications;
- Administering medications; and
- Monitoring of the effects of medication.

g. Analyze and profile data regarding the measurement of the patient treatment functions by service and Practitioner, where appropriate;

h. Provide routine summaries of the above analyses and recommend process improvement when opportunities are identified;

i. Serve as an advisory group to the health system and Medical Staff pertaining to the choice of available medications; and

j. Establish standards concerning the use and control of investigational medication and of research in the use of recognized medication.

1.3.12 All functions mentioned above shall be reported through the Quality & Patient Safety Council and Peer Review Committee to the MEC. All minutes and records reviewed will be maintained and kept in compliance with the confidentiality policies of the medical staff and Scott and White Hospital - Round Rock.
1.4 Responsibilities of Medical Staff President

The Medical Staff President is the primary elected officer of the Medical Staff and is the Medical Staff’s representative in its relationships to the administration of the Hospital. The Medical Staff President, jointly with the MEC and CMO, provides direction to and oversees Medical Staff activities related to assessing and promoting improvement in the quality of clinical services and other functions of the Medical Staff as outlined in the Medical Staff Bylaws, Credentials Procedure Manual, Organization and Functions Manual, and the Medical Staff rules and regulations. Specific responsibilities and authority are to:

a. Call and preside at all general and special meetings of the Medical Staff;

1. Serve as chair and a voting member of the MEC and as ex-officio member of all other Medical Staff committees without vote, and to participate as invited by the Governing Board and the Hospital administrator on Hospital or Board committees;

2. Enforce Medical Staff Bylaws, the Credentialing Procedures Manual, the Organization and Functions Manual, Medical Staff rules and regulations, and Hospital policy;

3. Support and encourage Medical Staff leadership and participation on interdisciplinary clinical performance improvement activities;

4. Report to the Governing Board the MEC’s recommendations concerning appointment, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to practitioners or allied health professionals who are applying for appointment or privileges, or who are granted privileges or providing services in the Hospital;

5. Evaluate and periodically report to the Hospital, MEC, and the Governing Board regarding the effectiveness of the credentialing and privileging processes;

6. Review and enforce compliance with standards of ethical conduct and professional demeanor among the members of the Medical Staff in their relations with each other, the Governing Board, Hospital management, other professional and support staff, and the community the Hospital serves;

7. Communicate and represent the opinions and concerns of the Medical Staff and its individual members on organizational and individual matters affecting Hospital operations to Hospital administration, the MEC, and the Governing Board;

8. Attend Governing Board meetings and committee meetings as invited by the Governing Board;

9. Ensure that the decisions of the Governing Board are communicated and carried out within the Medical Staff; and

10. Perform such other duties, and exercise such authority commensurate with the office as are set forth in the Medical Staff Bylaws.

1.5 Responsibilities of Clinical Section Chiefs

a. Encourage continuing education and encourage discussion of patient care issues pertinent to that clinical Section;
b. Conduct Grand Rounds as desired by Practitioners in the Section;

c. Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services, and recommend same to the appropriate committee chairs;

d. Recommend space and other resource needs pertinent to that clinical Section;

e. Development of recommendations of a specific issue at the request of a committee chair or the MEC;

f. Development of criteria for clinical privileges and recommend clinical privileges for each Section member on initial application or reapplication.

g. Clinically related activities of the clinical Section;

h. Administratively related activities of the clinical Section, unless otherwise provided by the hospital;

i. Continuing surveillance of the professional performance of all individuals in the Section who have delineated clinical privileges;

j. Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the Section or the organization;

k. Integration of the Section into the primary functions of the organization;

l. Coordination and integration of interdepartmental and intradepartmental services;

m. Determination of the qualifications and competence of Section personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

n. Continuous assessment and improvement of the quality of care, treatment, and services;

o. Maintenance of quality control programs, as appropriate; and,

p. Orientation of all persons in the Section.

SECTION 2. MEDICAL STAFF COMMITTEES

2.1 Medical Staff Committees

The following committees shall be standing, independent committees of Scott & White Hospital - Round Rock and invoke all privileges and powers thereof;

   a. Medical Executive Committee
   b. Credentials Committee
   c. Peer Review Committee

The Medical Staff shall also participate in various joint committees as set forth in these Bylaws and as may be approved in the future by the MEC. The following medical committees shall be constituted as joint committees, as that term is defined and understood in Chapter 161.031, Texas Health & Safety Code, with Scott and White Memorial Hospital in Temple, Texas and any of its qualified affiliates:

   a. Pharmacy and Therapeutics Committee
b. Infection Control Committee
c. Quality and Patient Safety Council
d. Peer Review Oversight Committee
e. Bioethics Committee
f. Physician Advocacy and Wellness Committee
g. Trauma Committee
h. Intensive Care Committee

These standing and joint committees of the Hospital operate to assist in the fulfillment of the Hospital mission. This may include, but is not limited to, review of patient care, quality review, patient safety evaluation, risk management activities, oversight supervision, evaluation of the appropriateness and quality of care, and evaluation of the competence of staff. These committees may include employees, agents of the committee, the Risk Management Department, assistants, investigators, interveners, attorneys and any other person or department that assists the committee in any capacity. The functions, activities, work, proceedings, records, correspondence between members, determinations, actions taken, recommendations, evaluations, reports to other committees, internal reports, administrative files, minutes, and documents generated or received by these committees are confidential and privileged in all respects. These committees may claim all legal privileges against disclosure and subpoena provided by Texas and Federal law. Minutes of all committee meetings are deemed confidential and privileged. All Medical Staff committees and members, including chairpersons, shall be appointed by the Chief Medical Officer, with concurrence of the Medical Executive Committee and the Board. The Chief Executive Officer shall be an ex-officio member of all Medical Staff Committees. The Chief Executive Officer may designate another senior administrative member to attend any meeting in his/her place.

2.2 Medical Executive Committee (Standing committee)
(Description of the MEC is in the Medical Staff Bylaws Part I, Article VI, Section 2)

2.3 Credentials Committee (Standing committee)
(Description of the Credentials Committee is in the Medical Staff Bylaws Part III: Credentialing Procedures Manual, Section 1)

2.4 Peer Review Committee (Standing committee)
Peer review is the concurrent or retrospective review of a Practitioner’s professional qualifications, professional competence or professional conduct. Peer review is conducted to determine Medical Staff membership or clinical privileges, to determine the scope and conditions of such membership or privileges, or to change or modify such membership or privileges.

2.4.1 Composition: The Peer Review Committee shall be composed of the following members and participants, to be appointed annually:

a. A minimum of seven (7) members of the Active Medical Staff; and
b. Other Hospital staff, who shall participate in committee functions without vote, to present data or reports, as requested by the chair.

2.4.2 Duties and responsibilities:

a. Coordinate the systematic and ongoing review of the appropriateness and quality of: blood usage; drug usage; anesthesia/operative and other invasive procedures; and timeliness, completion, and accuracy of medical records.
b. Coordinate, prioritize and monitor the medical staff data gathering and analysis components of the Hospital’s quality review program, including effectiveness and cost efficiency and coordinating the Medical Staff’s activities in this area with those of the other professional and support services in the Hospital.

c. Serve as a liaison for quality review issues with the Medical Staff, the Hospital staff, and the committee(s) responsible for compliance with accreditation standards and federal and state and licensure requirements.

d. Establish systems for follow up to determine that corrective action taken results in problem resolution.

e. Implement a system for screening of clinical risk management issues, including identification and review of unexpected patient care management events and morbidity concerns; analysis and aggregation of data on significant high risk events by identifying possible patterns; and communicating same to the Section Chief and the MEC.

f. Analyze trends of hazardous and risk management events reported, and attempt to determine effective solutions and implement appropriate systems or suggest action to enhance the quality and safety of patient care.

g. Evaluate the medical and healthcare services provided in the Hospital.

h. Evaluate the quality of patient care provided by Practitioners in the Hospital.

i. Implement the Medical Staff Peer Review Process and/or policies adopted by the Governing Board.

j. Meet quarterly.

k. Maintain confidential records and minutes of committee proceedings, and forward a copy of all such records and minutes to the Medical Staff Office.

l. Report, as necessary, to the MEC and Governing Board.

2.5. Pharmacy and Therapeutics Committee (Joint committee)

2.5.1 Participation: The CMO shall appoint one physician, one nurse and a pharmacist to participate as the designated representatives from Hospital to the joint Pharmacy and Therapeutics Committee. Such appointments shall be made annually.

2.5.2 Duties and Responsibilities:

a. Responsible for the development and surveillance of Hospital pharmaceutical utilization and medication use policies to promote optimal clinical results and patient outcomes.

b. Assist in the formulation of professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and other matters relating to pharmaceuticals in the Hospital.

c. Serve as an advisory group to the Medical Staff and to the Pharmacy on matters pertaining to the choice of available pharmaceuticals in the Hospital.

d. Develop and review periodically a formulary of pharmaceuticals for facility use.

e. Evaluate clinical data concerning new pharmaceuticals requested for facility use.
Where necessary or requested, establish guidelines and algorithms for the appropriate use of medications for specific disease states and conditions of patients and specific treatment environments or conditions.

Define and review significant adverse drug reactions and medication errors, when necessary.

Conduct appropriate drug use evaluations utilizing a criteria-based, ongoing, planned and systemic CQI process.

Meet at least quarterly.

Maintain confidential records and minutes of committee proceedings, and forward a copy of all such records and minutes to the Medical Staff Office.

Report, as necessary, to the MEC and Governing Board.

### 2.6 Infection Control Committee (Joint committee)

#### 2.6.1 Participation
The CMO shall appoint one physician, one nurse and a pharmacist to participate as the designated representatives from Hospital to the Infection Control Committee. Such appointments shall be made annually.

#### 2.6.2 Duties and Responsibilities:

- Take immediate action and/or make appropriate decisions in the event there is deemed to be a danger to patients or employees related to infections or infection control.
- Initiate appropriate infection control measures or studies.
- Maintain quality improvement through an organization and system wide Infection Control Program which includes:
  - reviewing results of surveillance programs,
  - implementing programs to educate staff regarding personal responsibility in preventing spread of infection,
  - implementing appropriate actions as needed related to identified problems,
  - providing surveillance and control of environmental infectious hazards,
  - reviewing and evaluating any infection control issues related to construction, renovation or environment of care,
  - reviewing nosocomial infections and trends within the Hospital, ambulatory care, home care, hospice and other affiliated patient care areas,
  - evaluating trends and issues related to the Employee Health Program, and
  - complying with applicable Joint Commission on Accreditation of Healthcare Organizations Standards.
- Meet at least quarterly.
- Maintain confidential records and minutes of committee proceedings, and forward a copy of all such records and minutes to the Medical Staff Office.
- Report, as necessary, to the MEC and Governing Board.

### 2.7 Quality and Patient Safety Council (Joint committee)

#### 2.7.1 Participation
The CMO shall appoint one physician, the Chief Nursing Officer, and the
Director of Quality Management to participate as the designated representatives from 
Hospital to the Quality and Patient Safety Council. Such appointments shall be made 
annually.

2.7.2 Duties and Responsibilities:

a. Oversee the findings, conclusions and actions of quality management activities within 
the Hospital.

b. Identify external drivers of quality improvement activities for application at the Hospital 
including IHI, Leapfrog, etc as appropriate to the achievement of the strategic plan.

c. Define goals, design metrics, assign accountabilities and provide support for oversight 
of system-wide QM activities.

d. Review and provide adequate resources to accomplish quality and patient safety 
strategies.

e. Verify identified improvement activities are successfully addressed.

f. Support organization-wide knowledge and awareness of quality management 
including quality assurance, quality control and quality improvement activities.

g. Guide organizational policies and procedures to support quality improvement and 
patient safety efforts including human resource, administrative and clinical issues.

h. Provide periodic reports to the Board, MSEC, Departments and other committees.

i. Maintain confidential records and minutes of committee proceedings, and forward a 
copy of all such records and minutes to the Medical Staff Office.

2.8 Peer Review Oversight Committee (Joint committee)

2.8.1 Participation: The CMO shall participate in the Peer Review Oversight Committee.

2.8.2 Duties and Responsibilities:

a. Oversight, supervision and implementation of all peer review functions and quality 
assurance functions.

b. Evaluate appropriateness and quality of medical, nursing and health care services.

c. Evaluate competence and qualifications of Practitioners, nurses or other health care 
providers within the Hospital.

d. Evaluate merits of complaints regarding patient care, medical, nursing, or other 
health care.

e. Make determinations and recommendations regarding complaints and claims.

f. Evaluate accuracy of diagnosis, assessments, observations and reports made to the 
committee or its agents, members of the committee, the Risk Management 
Department, assistants, investigators, intervenors, attorneys and any other person or 
department concerning the activities within the realm of the Peer Review Oversight
Committee and patient relation functions.

g. Conduct investigations and inquiries to resolve all complaints, quality assurance concerns, patient relations issues, practice and procedure reviews and the like related to the Medical Staff, nursing staff, and any other departments or personnel that deal directly with patient care or facilities management.

h. Meet at least quarterly.

i. Maintain confidential records and minutes of committee proceedings pertaining to the Hospital, and forward a copy of all such records and minutes to the Medical Staff Office.

j. Report as necessary to the Governing Board.

2.9 Bioethics Committee (Joint committee)

2.9.1 Participation: The CMO shall appoint at least three members of the Medical Staff to participate in the Bioethics Committee. Additional members may include the Hospital chaplain, risk management representative, nursing personnel, community members, social workers, or an administrative representative. Various Hospital personnel necessary to assess and resolve ethical issues may be asked to participate in committee meetings and deliberations. Appointment to the committee shall be for a period of two years.

2.9.2 Duties and Responsibilities:

a. Educate committee members, Hospital staff, patients and the community on bioethical issues.

b. Provide consultations with concerned Practitioners, staff, patients, or family when ethical issues occur in order to facilitate and provide a process for advice and conflict resolution.

c. Recommend ethical policies and procedures.

d. Meet at least quarterly, and as necessary to conduct timely ethics consultations.

e. Maintain confidential records and minutes of committee proceedings pertaining to the Hospital, and forward a copy of all such records and minutes to the Medical Staff Office.

f. Report, as necessary, to the MEC.

2.10 Physician Advocacy and Wellness Committee

2.10.1 Participation: The CMO shall appoint one to five physicians who are members of the Medical Staff to participate in the Physician Advocacy and Wellness Committee. Such appointment shall be made annually. In addition, the Chairperson of the MEC, Chairperson of the Peer Review Committee and the Medical Staff President shall participate in the committee.

2.10.2 Duties and Responsibilities: The committee shall be responsible for addressing problems dealing with impaired professional performance among Practitioners. The CEO, any Medical Staff Officer, or any other committee can refer a Practitioner for consideration by the
committee. The committee will have the following specific duties and responsibilities:

a. Establish a program for identifying and contacting Practitioners who may have become professionally impaired in varying degrees because of drug dependence, including alcohol use, or because of mental, physical or aging problems.

b. Accept Medical Staff, other senior staff and resident/fellow physicians as referred.

c. Maintain information and work in a confidential manner.

d. Establish programs for educating Practitioners to prevent substance dependence or other behavioral problems.

e. Notify the President of the Medical Staff, the CMO and the CEO when the committee feels that the impaired Practitioner’s actions could endanger patients. The existence of the committee does not alter the primary responsibility of the Section Chief for clinical performance within that Section Chief’s section.

f. Provide a support system to referred Practitioners whose health care practice may be or is affected due to chemical dependence, physical or mental illness, or disruptive behaviors.

g. Promote Practitioner welfare while protecting patients and colleagues.

h. Create opportunities for referral (including self-referral, when feasible) while maintaining confidentiality to the greatest extent possible.

i. Report to the MEC all Practitioners under consideration by the Physician Advocacy and Wellness Committee with appropriate follow-up and recommendation.

j. As appropriate, receive and consider information related to the Practitioner, investigate, assist, collaborate, conduct intervention, make recommendations for evaluation and rehabilitative programs, assist with re-entry, monitoring and recovery; make recommendations regarding leave of absence and practice related changes; and communication with the Practitioner with the goal of preventing further incident.

k. As appropriate, report internally and externally to any other committee, board, and/or licensing authority, maintaining confidentiality to the extent possible.

l. Meet as necessary to fulfill the functions of the committee.

m. Maintain confidential records and minutes of committee proceedings pertaining to the Hospital, and forward a copy of all such records and minutes to the Medical Staff Office.

2.11 Trauma Committee (Joint committee)

2.11.1 Participation: The CMO shall appoint one physician who is a member of the Active Medical Staff to participate in the Trauma Committee. Such appointment shall be made annually.
2.11.2 Duties and Responsibilities:

a. Approve guidelines, procedures and policies regarding trauma care.

b. Receive and review recommendations, reports and minutes from any trauma sub-committees.

c. Provide for coordination and interdisciplinary oversight of all issues related to trauma to include:
   - Trauma research,
   - Continuing trauma medical education,
   - Trauma credentialing,
   - Injury prevention,
   - Equipment and space needs related to trauma care,
   - Integration of policies and procedures for the facility’s departments and programs to promote the highest quality of trauma care,

d. Meet at least quarterly.

e. Maintain confidential records and minutes of committee proceedings pertaining to the Hospital, and forward a copy of all such records and minutes to the Medical Staff Office.

2.12 Intensive Care Committee (Joint committee)

2.12.1 Participation: The CMO shall appoint one physician who is a member of the active medical staff and one nurse to participate in the Intensive Care Committee. Such appointments shall be made annually.

2.12.2 Duties and Responsibilities:

a. Develop intensive care policies and procedures, a copy of which will be maintained by the designated Hospital physician appointed to the committee.

b. Provide input on training of personnel in special procedures utilized on the unit.

c. Provide input on equipment and space needs, including technical advice on specific systems to be integrated into the unit.

d. Initiate and review audit activities to promote quality care on the unit.

e. Meet at least quarterly.

f. Maintain confidential records and minutes of committee proceedings pertaining to the Hospital, and forward a copy of all such records and minutes to the Medical Staff Office.
SECTION 3. CONFIDENTIALITY, IMMUNITY, AND RELEASES

3.1 Confidentiality of Information

Information submitted, collected, or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of:

- assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of health care provided;
- evaluating current clinical competence and qualifications for Medical Staff appointment/affiliation, or clinical privileges or specified services;
- contributing to teaching or clinical research; or
- determining that health care services were indicated or were performed in compliance with an applicable standard of care,

shall, to the fullest extent permitted by law, be confidential. This information will not be disseminated to anyone other than a representative of the Hospital or to other health care facilities or organizations of health professionals engaged in an official, authorized activity for which the information is needed. Such confidentiality shall also extend to information that may be provided by third parties. Each Practitioner expressly acknowledges that violations of the confidentiality provided herein are grounds for immediate and permanent revocation of Medical Staff appointment and/or clinical privileges or specified services.

3.2 Immunity From Liability

As a condition to applying for Medical Staff membership and/or clinical privileges, every applicant shall agree and give express consent for release of any information regarding the applicant’s professional credentials, licensure, registration, certification, previous clinical privileges and all previous professional activities, medical or psychiatric records impacting on the ability to practice medicine, and criminal or court records. Any act, communication, report, recommendation, or disclosure, with respect to any such practitioner, performed or made and at the request of an authorized representative of this or any other healthcare facility or other facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law. Such privilege shall extend to all members of the Hospital's Medical Staff, Governing Board, and others acting on their behalf, and to third parties who supply such information. "Third parties", herein, means both individuals and organizations from whom information has been requested by an authorized representative of the Governing Board or of the Medical Staff or others acting on their behalf. There shall be absolute immunity, to the fullest extent permitted by law, from civil liability arising from any act, communication, report, recommendation, or disclosure; even where the information involved would otherwise be deemed privileged or confidential. Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other healthcare institution's activities related, but not limited to:

- Applications for appointment/affiliations, clinical privileges, or specified services
- Periodic reappraisals for renewed appointment/affiliations, clinical privileges, or specified services
- Corrective or disciplinary actions
- Hearings and appellate reviews
- Quality improvement or patient safety
- Utilization reviews
- Claims reviews
- Other Hospital department, clinical service or committee activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct
- Peer Review
- Risk Management and liability prevention activities

Acts, communications, reports, recommendations, and disclosures referred to herein may relate to a Practitioner’s professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly affect patient care or professional conduct. Each Practitioner shall, upon request of the Hospital, execute appropriate releases and authorizations in furtherance of this article.

**SECTION 4. REVIEW, REVISION, ADOPTION, AND AMENDMENT**

This Medical Staff Organization and Functions Manual may be amended or repealed by a resolution of the MEC recommended to and adopted by the Board, in whole or in part by one of the following mechanisms:

**These Medical Staff Bylaws Are Hereby Adopted by:**

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<th>Medical Staff President</th>
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<td>Chief Executive Officer</td>
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