Scott and White Memorial Hospital  

and  

Scott, Sherwood and Brindley Foundation  

Medical Staff Bylaws and Rules and Regulations  

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PREAMBLE

WHEREAS, Scott and White Memorial Hospital and Scott, Sherwood and Brindley Foundation is a nonprofit corporation, organized under the laws of the State of Texas; and

WHEREAS, the mission of Scott and White Memorial Hospital and Scott, Sherwood and Brindley Foundation is to provide personalized, comprehensive, high-quality health care enhanced by medical education and research; and

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of health care in the hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital Governing Body, and that the cooperative efforts of the Medical Staff, the Chief of Staff, and the Governing Body are necessary to fulfill the hospital's obligations to its patients;

THEREFORE, the practitioners of this hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws.

CODE OF ETHICS

MISSION STATEMENT: To provide personalized, comprehensive, high-quality health care enhanced by medical education and research.

CORE VALUES STATEMENT: Scott and White Health Professionals are guided by altruism, compassion, and the best interest of the patient.

ETHICS STATEMENT: As an institution and as individuals:

We will always strive to act in the best interests of our patients.

We will respect the dignity, privacy and right to self-determination of all people.

We will act with integrity:

- Our communications will be open, clear, and truthful
- Our interactions will be courteous, compassionate, and fair

GUIDING MOTTO: Cure sometimes, relieve often, comfort always.

DEFINITIONS

A. The Board has determined that the categories of Practitioners eligible for Medical Staff membership are all licensed physicians, dentists, and podiatrists, and other appropriately licensed non-physician practitioners who meet the qualifications, standards, and requirements set forth in these Bylaws. The term "Governing Body" means the Board of Directors of Scott and White Memorial Hospital and Scott, Sherwood and Brindley Foundation. The Board has the authority to appoint other types of non-physician practitioners to the Medical Staff.

B. The term "Medical Staff Executive Committee" means the Executive Committee of the Medical Staff, as described in Article XI, Section 2, of these Bylaws.

C. The term "Chief of Staff" means the individual appointed by the Governing Body to act in its behalf in coordinating the activities of the Medical Staff.
ARTICLE I. NAME
The name of this organization shall be "Medical Staff of Scott and White Memorial Hospital and Scott, Sherwood and Brindley Foundation".

ARTICLE II. PURPOSES
The purposes of this organization are:
A. To ensure that all patients admitted to or treated in any of the facilities, departments, or services of the hospital shall receive quality health care;
B. To assure quality in the professional performance of all practitioners authorized to practice in the hospital through the appropriate delineation of clinical privileges that each practitioner may exercise in the hospital and through an ongoing review and evaluation of each practitioner's performance in the hospital;
C. To initiate and maintain rules and regulations and policies and procedures for self-government of the Medical Staff;
D. To provide a means whereby issues concerning the Medical Staff and the hospital may be discussed by the Medical Staff with the Governing Body and the Chief of Staff;
E. To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill; to cooperate with and support any medical school or other educational institutions in the undergraduate, graduate, or post-graduate educational programs with which this institution may affiliate;
F. To participate in educational programs of the institution;
G. To participate in research programs of the institution, maintaining the standards of such research programs to comply with institutional policies and national guidelines;
H. To participate in and support the charitable and benevolent activities of this institution.

ARTICLE III. MEDICAL STAFF MEMBERSHIP

Section 1. Nature of Medical Staff Membership
Membership on the Medical Staff of Scott and White Memorial Hospital and Scott, Sherwood and Brindley Foundation, is a privilege that shall be extended to professionally competent licensed physicians, dentists, and podiatrists, and other non-physician practitioners who meet the standards, qualifications, and requirements necessary for the operation of this hospital as set forth in these Bylaws. Members of the Medical Staff shall be granted only those privileges that are within the scope of their state licensure. No licensed practitioner is automatically entitled to membership on the Medical Staff or to exercise privileges in this hospital merely by virtue of being licensed to practice in this or any other state, or by membership in any professional organization, or because of privileges held at another health care facility or in another practice setting. Medical Staff membership shall also be determined by demonstrated hospital need and availability of support facilities. The granting of membership or approval of appointment does not automatically confer clinical privileges. Medical Staff "membership" and/or "privileges" are considered as separate requests, as delineated by these Bylaws. Appointment to and membership on the Medical Staff shall confer on the appointee or member only the practice of the clinical privileges and prerogatives as have been granted by the Governing Body through its delegated representative, the Chief of Staff or designee in accordance with these Bylaws.

Section 2. Qualifications for Membership
a) Licensure by the State of Texas is a prerequisite for Medical Staff membership.
b) For the purposes of these Bylaws, a temporary permit issued by the appropriate
State of Texas licensing board shall constitute a license to practice until the permanent license is issued.

c) Medical Staff members must be committed to and capable of assuring continuous delivery of integrated medical and surgical services, and must document their background, experience, training, current competence, health status, adherence to the ethics of their profession, their good reputation, and ability to work with others, with sufficient adequacy to assure the Medical Staff and Governing Body that any patient treated by them will receive quality health care. Physicians who have an MD/DO or equivalent degree who are members of the Active and Courtesy Medical Staff must be current in their board certification in the field of medicine in which they are practicing by a recognized board of the American Board of Medical Specialties, Royal College of Physicians and Surgeons of Canada, an American Osteopathic Specialty Board, American Dental Association, The American Board of Podiatric Surgery, or American Board of Podiatric Orthopedics. Board certification status must be attained within five [5] years of the successful completion of a residency or fellowship program in the primary practice specialty. Failure to maintain Board certification will be considered a voluntary resignation, upon expiration of the appointment term; unless, the member is in active pursuit of re-certification and requests an extension prior to the last scheduled meeting of the Credentials Committee prior to expiration of the appointment term. The Credentials Committee will review requests for extensions, in order for the requestor to complete the re-certification process, and will make an individual determination prior to expiration of the appointment term. Exceptions to this requirement for Active or Courtesy staff may be granted upon recommendation of the Department Chair and Chief of Staff.

d) Continuing education of all Medical Staff members, resident physicians, medical students, and support health care practitioners is intrinsic to the delivery of quality health care within Scott and White Memorial Hospital. Medical Staff are expected to participate in the educational activities of their respective departments under the jurisdiction of the Research and Education Division of the Hospital/Foundation.

e) Establishment and maintenance of appointment to the faculty of The Texas A&M University System Health Science Center College of Medicine shall be a condition precedent to membership on the Hospital Medical Staff, or as approved by the Chief of Staff, except for Honorary/ Emeritus, Consulting and Scott and White Resident Physicians in good standing at programs sponsored by SWMH who are Courtesy Staff. When a practitioner ceases to be a member of the faculty of The Texas A&M University System Health Science Center College of Medicine, appointment to the Medical Staff of Scott and White Memorial Hospital shall terminate simultaneously with the termination of that faculty status and with concurrence of the Governing Body.

f) Acceptance of membership on the Medical Staff shall constitute the Medical Staff member's pledge to make every reasonable effort to strictly abide by the principles and code of ethics of the Medical Staff members’ professional association and shall abide by the Bylaws and Rules and Regulations governing this institution.

g) Each member of the Active Medical Staff shall maintain at all times medical malpractice insurance coverage or liability coverage under an actuarially sound and funded self-insurance program of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate or be covered by the
Scott and White Corporate Insurance Plan. Members of the Courtesy and Consulting Medical Staff in high-risk practice areas, as determined by Risk Management, shall maintain professional malpractice insurance coverage of one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate or be covered by the Scott and White Corporate Insurance Plan, and all others a minimum of two hundred thousand dollars ($200,000) per occurrence and six hundred thousand dollars ($600,000) aggregate by a carrier acceptable to Scott and White or be covered by the Scott and White Corporate Insurance Plan.

h) Medical Staff members shall conduct themselves in a professional, cooperative, courteous and reasonable manner and refrain from disruptive behavior or acting in a manner unbecoming of practitioners or in a manner which threatens a safe, cooperative and professional healthcare environment.

Section 3. Conditions and Duration of Appointment

a) Initial appointments and reappointments to the Medical Staff shall be made by the Governing Body. The Governing Body shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Medical Staff as provided in these Bylaws; provided that in the event of unwarranted delay on the part of the Medical Staff, the Governing Body may act without such recommendation on the basis of documented evidence of the applicant's or Medical Staff member's professional and ethical qualifications obtained from reliable sources other than the Medical Staff. For the purposes of this section, unwarranted delay generally means one hundred twenty (120) days from the date the fully completed application has been received by the Medical Staff.

b) Initial appointments for Active or Courtesy Hospital Medical Staff will be provisional for six (6) months. Reappointment will be biennial starting with the next scheduled department or division reappointment date, which follows the date upon which the provisional period ends. Provisional Medical Staff members shall be assigned to a department where their performance shall be observed by the chairperson of the department, or designee, to determine the eligibility of such provisional members for appropriate Medical Staff membership. The provisional period is not required for physicians who have retired or resigned from the Hospital Active or Courtesy Medical Staff within the past two (2) years, and have been appointed to the PRN Staff. The expiration date of appointment shall be considered the last day of the month in which reappointment is due. If an application for reappointment has not been fully processed by the expiration date of the member's appointment, the staff member's membership status and clinical privileges will be administratively suspended until such time as the processing is completed. Such a suspension is not reportable to the National Practitioner Data Bank or licensing boards.

c) Every application for Medical Staff membership shall be signed by the applicant and shall contain the applicant's specific acknowledgment of each Medical Staff member's obligation to provide continuous patient care and supervision of patients; to abide by the Medical Staff Bylaws, Rules and Regulations; to accept committee assignments and to accept a fair share of the emergency and indigent patient care and education and teaching responsibilities, as outlined in the Rules and Regulations.
d) No person otherwise qualified as provided by these Bylaws shall be denied appointment or reappointment to membership on the Medical Staff because of race, creed, color, sex, or national origin, nor shall any privileges be reduced or withdrawn for said reasons. Credentialing or re-credentialing decisions are not based on an applicant's sexual orientation, or solely on the type of procedure or patients in which the practitioner specializes or Board certification status.

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

Section 4. History and Physical Examinations
Documentation must be present in the medical record that a history and physical examination has been performed, by a qualified licensed practitioner, no more than thirty (30) days prior to an elective procedure or admission. For unscheduled admissions, the H&P must be completed within twenty-four (24) hours after admission, indicating any subsequent changes or no changes. If the H&P was not completed after registration, it must be completed and/or updated immediately prior to a surgery or procedure requiring anesthesia. The pertinent elements of the history and physical may vary by setting or level of care, treatment and service. The elements of the history and physical include current and relevant prior medical history, relevant physical examination, diagnosis or differential diagnosis, and treatment plan. When the history and physical is done as a clinic note, this note may be used as part of the hospital admission documentation. The practitioner performing an H&P prior to admission need not be credentialed and privileged by Scott & White. However, the required update to the H&P upon the patient’s admission (interval H&P) must be performed and authenticated by a member of the Medical Staff who is a Texas licensed physician, according to the privileges granted within 24 hours after admission. In a case where the patient is going to surgery, the interval note and the pre-anesthesia assessment could be accomplished as a combined activity.

ARTICLE IV. 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 designation of Honorary/Emeritus Medical Staff may consist of licensed physicians and dentists and appropriately licensed non-physician 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 designees, as this designation is not a category of membership shall not be eligible to admit patients or treat patients, vote, hold office, or serve on standing Medical Staff committees, nor will its designees have the responsibilities herein delineated for practitioners assigned to a membership category. They shall have no assigned duties.

Section 3. The Active Medical Staff
The category of Active Medical Staff may consist of licensed physicians and dentists and
appropriately licensed non-physician practitioners who admit, or refer for admission, ninety percent (90%) of their hospitalized private patients to a Scott & White hospital, who are located close enough to the hospital to provide for continuous care to their patients, and 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. Members of the Active Medical Staff shall be appointed to, and clinical privileges determined by, a specific department, and they 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. If not eligible or certified, an exception may be made by the Chief of Staff. Those Active Medical Staff members without sufficient volumes of patient care involvement per appointment period, therefore hindering ongoing professional practice evaluations, may be required to provide case documentation from their office, hospitals, or other facilities, whichever appropriate, as approved by the Medical Staff. 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 licensed physicians and dentists and appropriately licensed non-physician practitioners qualified for Medical Staff membership who occasionally admit patients to the hospital. Courtesy Medical Staff members shall be appointed to and clinical privileges determined by a specific department but shall not be eligible to vote or hold office in the Medical Staff organization. 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 Courtesy Medical Staff upon recommendation of their program director and concurrence of the Department Chair and the Legal Department. Members of the Courtesy Medical Staff shall be required, as delegated by the department chairperson, to participate with other members of the Medical Staff in handling the emergency, indigent patient, education and teaching responsibilities. Members of the Courtesy Medical Staff may serve on the various committees of the Medical Staff. They may attend Medical Staff meetings. Courtesy Medical Staff will be board certified or board eligible. If not eligible or certified, an exception may be made by the Chief of Staff. If a practitioner is without sufficient volumes of patient care involvement per appointment period, therefore hindering ongoing professional practice evaluations, he/she will be required to provide case documentation from his/her office, hospital, or other facilities, 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 a low/no volume provider.

Section 5. The Consulting Medical Staff
The category of Consulting Medical Staff may consist of licensed physicians and dentists and appropriately licensed non-physician practitioners who have been requested and are willing to serve in such capacity. Consulting Medical Staff may include PRN, Locum Tenens or Temporary Staff. Clinical privileges will be determined by the department to which they are appointed. Their duties shall be to provide services in the care of patients at the request of any member of the Active Medical Staff, or when consultation is required. Consulting Medical Staff shall not be eligible to admit patients, hold office, vote, or serve on standing Medical Staff committees. Consulting Medical Staff will be board certified or board eligible. If not eligible or
Section 6. Consulting without Clinical Privileges
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. Physicians and Students In Training
- Physicians in training will not be granted active membership and/or privileges on the medical staff.
- All physicians in training will be assigned to the appropriate Department and will be under the direct supervision of the Department Chair or their designee.
- 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.
- Oversight and credentialing of physicians in training is delegated to the Office of Graduate Medical Education and to the Department Chair.
- 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 Memorial Hospital.
- Residency review is delegated to the Graduate Medical Education Committee, including compliance with residency review committee citations.

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 8. Allied Health Professionals
Allied Health Professionals ("AHPs") are those who, although not eligible for medical staff appointment, may be permitted to participate in hospital patient care within defined limits. They may not independently admit or care for hospital patients and must always be under the supervision of physician who has been accorded privileges to provide such care in the hospital. AHP’s shall practice solely within the scope of their license or certification and applicable state and federal laws. The supervising physician shall monitor on an ongoing basis the clinical competence and professional conduct of the AHP and assume full responsibility for their clinical practice within the hospital. Although AHPs may be employees of Scott & White, they do not have any status on the medical staff and are not entitled to the procedural rights provided medical staff members in Article VIII of the bylaws. However, an AHP may appeal denial, suspension or termination of their membership pursuant Scott & White Human Resources policies and procedures.

Section 9. The Provisional Staff
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 Article VI, Section 1g. 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 and grant full privileges. Provisional Medical Staff must be current in their board certification in the field of

certified, an exception may be made by the Chief of Staff. PRN, Locum Tenens, or Temporary staff may admit patients upon the recommendation of the Department Chair and Chief of Staff.
medicine in which they are practicing by a recognized board of the American Board of Medical Specialties, Royal College of Physicians and Surgeons of Canada, an American Osteopathic Specialty Board, American Dental Association, The American Board of Podiatric Surgery, or American Board of Podiatric Orthopedics or in the process of obtaining such board certification. Exceptions to this requirement for Active or Courtesy staff may be granted upon recommendation of the Department Chair and Chief of Staff.

Section 9. Leave of Absence

A staff appointee who wishes to obtain a voluntary leave of absence must provide written notice to the Chief of Staff. 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 express permission by the Board of Directors. If the staff appointee is scheduled to be reappointed while on approved leave of absence, the reappointment process will be postponed until they have returned from leave of absence. Requests for leave must be forwarded with a recommendation from the Medical Staff Executive Committee and affirmed by the Board of Directors. While on leave of absence, the staff appointee may not exercise clinical privileges or prerogatives and has no obligation to fulfill medical staff responsibilities.

At least thirty (30) calendar days prior to the termination of the leave, or at any earlier time, the staff appointee may request reinstatement by sending a written notice to the Chief of Staff. In the event that the leave is for health reasons, a release from the treating physician may be required prior to reinstating medical staff membership and privileges. The staff appointee must submit a written summary of relevant activities during the leave if the Medical Staff Executive Committee or Board of Directors so requests. The Medical Staff Executive Committee makes a recommendation to the Board of Directors concerning reinstatement, and the applicable procedures concerning the granting of privileges are followed. If the practitioner’s most recent granting of membership and/or privileges expires 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.

ARTICLE V. PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

Section 1. Application for Medical Staff Membership

a) All applications for appointment to the Medical Staff shall be in writing, shall be signed by the applicant, and shall be submitted on the Texas Standardized Credentialing application form and other requested forms. The applicant shall provide sufficient information to document competency, clinical judgment, background, character, professional training, experience, graduate medical education, board certification, malpractice insurance, claims, and other relevant information as requested, including a consent to release such information. The applicant shall list full and complete details regarding recommended psychiatric therapy for any conditions which may affect the applicant’s ability to practice medicine or abide by these Bylaws.

b) The applicant shall have the burden of producing adequate information for a proper evaluation of competence, character, ethics, health status, and other qualifications by providing sufficient documentation and providing the number of procedures and outcomes, and for resolving any doubt about such qualifications. No applicant shall be eligible for Medical Staff membership who has been convicted of a crime of the grade of felony or a crime of a lesser degree that involves moral turpitude.
c) The completed application shall be submitted to Medical Staff Services of Hospital Administration. After collecting the references and other materials deemed pertinent, the application will be transmitted with all supporting materials to the Credentials Committee for evaluation.

d) By applying for appointment to the Medical staff, each applicant thereby signifies a willingness to appear for interviews in regard to the application; authorizes the hospital to consult with members of Medical Staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on the applicant's competence and character, including mental and emotional stability and ethical qualifications; consents to the hospital's inspection of all records and documents that may be material to the evaluation of professional qualifications and competence to carry out the clinical privileges requested, as well as moral and ethical qualifications for Medical Staff membership; releases from any liability the Governing Body, the Chief of Staff, their authorized agents or representatives, and all members of the Medical Staff and Hospital Staff who have committee or other responsibility for collecting and/or evaluating the applicant's credentials and/or acting upon the application for their acts performed in connection with evaluating the applicant's credentials; and releases from liability all individuals and organizations who provide information to the hospital concerning the applicant's competence, background training, experience, health, reputation, ethics, character and other qualifications for Medical Staff membership and clinical privileges, including otherwise privileged or confidential information. This is an absolute release of liability, including, but not limited to, any alleged damages related to breach of confidentiality, defamation, slander, interference with contract or business, invasion of privacy, mental anguish, and all other damages.

e) The application form shall include a statement that the applicant has received a copy of the Bylaws, Rules and Regulations of the Medical Staff, and by signing the statement, the applicant agrees to be bound by the terms thereof without regard to whether or not membership and/or clinical privileges are granted in all matters relating to consideration of the application.

Section 2. Appointment Process

a) Within ninety (90) days after receipt of the completed application for membership and licensure by the State of Texas, the Credentials Committee shall make a written report of its investigation to the Medical Staff Executive Committee. Prior to making this report, the Credentials Committee shall examine the evidence of the character, professional competence, qualifications, and ethical standing of the applicant and shall determine whether the applicant has established and meets all necessary qualifications for the category of Medical Staff membership and the clinical privileges requested. The information to be examined may include, but is not limited to references given by the applicant, other sources such as peer review, and appraisal from the department in which privileges are sought. Every department in which the applicant seeks clinical privileges shall provide the Credentials Committee with specific written recommendations for delineating the applicant's clinical privileges, and these recommendations shall be made part of the report. The Credentials Committee shall transmit the completed application and its report to the Medical Staff Executive Committee with one of three (3) recommendations; for provisional appointment to the Medical Staff; against the application for appointment to the Medical Staff; or for deferral of the application for further consideration.
b) Following its next regular meeting after receipt of the application and the Credentials Committee report and recommendation, the Medical Staff Executive Committee shall consider the application and recommend to the Governing Body one of three (3) actions; provisional appointment of the applicant to the Medical Staff; rejection of the application for Medical Staff membership; or deferral of the application for further consideration. All recommendations for appointment to the Medical Staff must specifically recommend the clinical privileges to be granted. Privileges may be qualified by special requirements of supervision and reporting relating to such clinical privileges.

c) When the Medical Staff Executive Committee recommends that the application be deferred for further consideration, it must be followed up within sixty (60) days with a subsequent recommendation for either provisional appointment with specified clinical privileges, or for rejection for Medical Staff membership.

d) When the recommendation of the Medical Staff Executive Committee is favorable to the application, the Chief of Staff shall promptly forward the application, together with all supporting documentation, to the Governing Body.

e) When the recommendation of the Medical Staff Executive Committee is adverse to the application, either in respect to appointment or clinical privileges, the Chief of Staff or designee shall promptly notify the applicant in writing of the action, including a reason for denial or restriction of privileges not later than the 20th day after the date on which the final action is taken.

f) At its next regular meeting after receipt of a favorable recommendation, the Governing Body shall act in the matter. If the Governing Body's decision is adverse to the application with respect to either appointment or clinical privileges, the Chief of Staff or designee shall notify the applicant in writing of the action, including a reason for denial or restriction of privileges not later than the 20th day after the date on which the action is taken.

Section 3. Reappointment Process

a) At meetings prior to the scheduled Governing Body meetings in the Medical Staff year [February 1 - January 31], the Credentials Committee shall review all pertinent information available on each practitioner scheduled for biennial appraisal, to determine its recommendations for reappointment to the Medical Staff and for the granting of clinical privileges for the ensuing period, and shall transmit its recommendation in writing to the Medical Staff Executive Committee. Where the recommendation is against reappointment, the reason for such recommendation shall be stated and documented.

b) Each recommendation concerning the reappointment may be based upon the Continuous Quality Improvement Process and peer review, professional competence, practitioner-specific data, experience, and clinical judgment in the treatment of patients, character, ethics and conduct, professionalism, additional training, board certification, reputation, health status, licensure status, attendance at Medical Staff meetings and participation in Medical Staff affairs, compliance with Medical Staff Bylaws, Rules and Regulations, cooperation with hospital personnel, use of the hospital's facilities for patients, relations with other practitioners, and general attitude toward patients, the hospital, and the public, and any other factor appropriate for the furtherance of the
purposes of the hospital. The reappointment form will document the Department Chairperson’s review of the above criteria. A record of periodic reappointment will be kept in each practitioner’s credentials file.

c) Prior to the scheduled Governing Body meetings in the Medical Staff year, the Medical Staff Executive Committee shall make written recommendation to the Governing Body, through the Chief of Staff, concerning the recommendations for reappointment, recommendations against reappointment and/or recommendations for clinical privileges of practitioners then scheduled for periodic appraisal. Where the Medical Staff Executive Committee recommends against reappointment, a reason for such recommendation shall be stated and documented.

d) Thereafter, the procedure provided in Section 2 of this Article V, relating to recommendations on applications for initial appointment shall be followed.

ARTICLE VI. CLINICAL PRIVILEGES

Section 1. Application for Clinical Privileges

a) Every practitioner practicing at this hospital by virtue of Medical Staff membership or otherwise shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted by the Governing Body, except as provided in Sections 2, 3, and 4 of this Article VI. Individuals other than members of the Medical Staff have responsibilities and provide patient care or services at Scott and White Memorial Hospital within the scope of their licensure, registration, or certification. These support health care practitioners are identified and responsibilities outlined in each departmental policy and procedure manual.

b) Every initial application for clinical privileges must delineate specific clinical privileges desired by the applicant. The evaluation of such requests shall be based in part on the recommendation(s) from a peer in the same professional discipline. These requests shall also be based on demonstrated hospital need and availability of support facilities, the applicant's licensure, registration, certification, quality of education and continuing education, relevant training, experience, demonstrated and current competence, physical, intellectual, and emotional capacity, liability coverage, malpractice allegations, claims or suit history, ability to meet geographic requirements, references and other relevant information, including an appraisal by the department and/or division in which such privileges are sought. The applicant shall have the burden of establishing the qualifications by sufficient documentation and by providing information on the number of procedures performed, outcomes and demonstrated competency in the privileges requested. Privileges for each department shall be outlined and maintained in the departmental policy and procedure manual and a list of such privileges also maintained in Hospital Administration.

c) The scope and extent of procedures that each practitioner may perform shall be specifically delineated and granted in the same manner as all other privileges. Procedures performed by all practitioners shall be under the overall supervision of the chairperson of the department or designee. If the scope of a Practitioner's license does not permit him to render all services required for the proper care of a patient, the grant of Clinical Privileges to such Practitioner shall be conditioned upon his arranging for
another Practitioner having the necessary license and Clinical Privileges to render such services. The latter Practitioner's judgment and order shall prevail in areas to which the former Practitioner's license does not extend. The special conditions attached to a Practitioner's grant of Clinical Privileges shall be articulated in detail in the letter or notice to the Practitioner communicating the grant of Clinical Privileges. The non-Physician Practitioner shall only be responsible for that part of his patient's history and physical examination relating to his area of expertise granted by the scope of his license.

d) Requests for clinical privileges shall be processed in a manner as described in Article V.

e) Restrictions of clinical privileges may be based upon insufficient number of procedures, insufficient information on or documentation of poor outcomes, involvement in professional liability action, unethical or unprofessional conduct, current competence, physical, intellectual, and emotional capacity, failure to adhere to the Bylaws, Rules and Regulations, previous or current challenges to licensure, registration, or certification, or loss of clinical privileges or Medical Staff membership at another institution, or any item necessary for qualification for Medical Staff membership or performance of such duties. Consent to inspect relevant records will be required from the applicant.

f) No one specific practitioner, group of practitioners, or department will have exclusive authority over any clinical service in the management of jurisdictional conflicts.

g) Clinical privileges will be provisionally granted for a period of six (6) months during which time the department chairperson or designee shall monitor the practitioner's performance. At the end of this provisional period, the department chairperson or designee shall evaluate the practitioner's performance and make recommendation for continuation of the provisional period or for granting privileges biennially. Privileges are granted for a period of up to two (2) years and reviewed biennially. Additional privileges may be requested at any time by memo to the Department Chairperson. The request shall be reviewed and, when approved by the Department Chairperson, forwarded to Medical Staff Services of Hospital Administration for review by the Credentials Committee. Recommendations and actions will follow the processes outlined in Article V. If final action by the Board of Directors is approval of additional privileges, Medical Staff Services will include such approved privileges in the medical staff member's current clinical privileges list.

h) A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

Section 2. Temporary Privileges

a) Temporary clinical privileges shall be granted to fulfill an important patient care need that cannot be otherwise met by the existing members of the Medical Staff. In granting temporary privileges, special requirements may be imposed in order to monitor and assess the quality of care rendered by the Practitioner exercising such privileges. A Practitioner shall not be entitled to the procedural rights afforded by the Bylaws because of his/her inability to obtain temporary privileges or because of any termination of temporary privileges. Temporary privileges may be granted by the Chief Executive Officer with a recommendation from the Chief of Staff and the Chief of the Department to which the applicant has applied. An appropriately licensed Practitioner may be granted temporary privileges for a period not to exceed 120 days, at which time, the temporary clinical privileges will expire, without opportunity for appeal or extension. In such cases,
the applicant shall act under the supervision of the Chairman of the Department to which he is assigned. The clinical privileges being granted temporarily will be specifically delineated on the approval form.

b) Conditions for Granting Temporary Privileges

[1] **Pendency of Application:** After the receipt, and processing, of a complete application for Medical Staff membership and privileges, as defined in the Medical Staff Bylaws and credentialing policy, including a written request for temporary privileges, an applicant may be granted temporary clinical privileges, following positive recommendations from his Department Chair/Division Director and the Credentials Committee until the Board of Trustees renders its final decision. The temporary privileges expire upon the Board’s final decision or 120 days, whichever is less.

[2] **Care of Specific Patient(s):** Temporary privileges may be granted on a case-by-case basis when an important patient care need justifies the authorization to practice, for a limited period of time as defined herein, while full credentials information is verified and approved. After receipt of a written request for temporary privileges, a Practitioner qualified as below may be granted temporary privileges if the Practitioner has a specific skill not possessed by a privileged Practitioner, and the specific skill is needed by a specific patient, authorization may be granted to provide care for that specific patient. Temporary privileges granted under this condition shall not exceed the length of stay of the specific patient or one hundred and twenty (120) consecutive days, whichever is less. The following qualifications/verifications must be met:
   [i] demonstrate that he possesses a current license to practice in Texas,
   [ii] a current and unrestricted DEA registration and DPS,
   [iii] evidence of current competence related to the temporary privileges requested, and
   [iv] documentation of professional liability insurance coverage as required by the Board.

[3] **Visiting Physician:** Temporary privileges, without membership, may be granted to Physicians for the purpose of providing or receiving educational, instructional, or proctorship services. In order to be considered for this category, the applicant must:
   [i] NOT have any medical license that is under restriction, disciplinary order, or probation in another state, territory, or Canadian province;
   [ii] Be approved by the Texas Medical Board [TMB] for a Visiting Physician permit;
   [iii] Be 100% supervised in all patient care by a Physician with an unrestricted license in Texas who is a Medical Staff member (the supervising physician shall hold privileges in a specialty appropriate to the educational services being provided);
   [iv] Present written verification from the Physician who will be supervising the applicant that the Physician will provide continuous supervision of the applicant; and,
   [v] Present written verification from the supervising Physician as to the purpose for the requested permit.

Visiting Physician permits shall be valid for no more than ten (10) working days, and for a specified locale and purpose. This type of temporary privilege can be extended if the applicant shows good cause for why the extended time is needed and is approved by the TMB for a longer duration.
c) Qualifications for temporary privileges shall be verified from a primary source and documented. The National Practitioner Data Bank shall be queried prior to the granting of temporary privileges. Additionally, the applicant’s status as an Ineligible Person shall be verified via the OIG Sanction Report, the GSA List, and the Texas Department of Health and Human Services Sanction List. If the applicant is excluded from such participation, temporary privileges shall not be granted; any exclusion subsequent to having been granted temporary privileges shall result in immediate termination of such privileges. When applying for temporary privileges, each applicant shall agree to be bound by the Medical Staff Bylaws, Rules and Regulations, departmental rules and regulations, and applicable Hospital policies.

d) Special requirements of supervision and reporting may be imposed by the department chairperson concerned on any practitioner granted temporary privileges. Temporary privileges may be immediately terminated by the Chief of Staff upon notice to practitioner and to the Medical Staff Executive Committee.

e) On the discovery of any information or the occurrence of any event of a professionally questionable nature about a Practitioner's qualifications or ability to exercise any of the temporary privileges granted, the CEO, after consultation with the Chief of Staff and Department Chairman responsible for supervision, may terminate privileges, and such decision shall be final and not subject to appeal. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the practitioner, the termination may be imposed by any person entitled to impose a precautionary or summary suspension pursuant to Section 2, a, of Article VII of these Bylaws, and the same shall be immediately effective. The appropriate department chairperson or, if absent, the chairperson of the Medical Staff Executive Committee shall assign a member of the Medical Staff to assume responsibility for the care of such terminated practitioner's patient(s) until they are discharged from the hospital.

Section 3. Expedited Credentialing

The Board of Directors may delegate to a committee, consisting of at least two Board of Directors members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and the Medical Staff Executive Committee and there is no evidence of any of the following:

a) current or previously successful challenge to any license or registration;

b) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or

c) a final adverse judgment in a professional liability action.

Section 4. Emergency Privileges

In case of emergency, any licensed physician or dentist, or appropriately licensed non-physician practitioner, to the degree permitted by license and regardless of service or staff status or lack of it, shall be permitted to provide necessary emergent care. Licensed Independent Practitioners who are not members of the Scott & White Memorial Hospital (SWMH) Medical
Staff and who do not already possess clinical privileges at the Hospital may be assigned disaster responsibilities during an emergency so long as the following two conditions are present:

1. the Emergency Management Plan has been activated, and
2. the Hospital is unable to meet immediate patient needs.

An emergency is defined as any occurrence that inflicts destruction, harm or distress, and that creates healthcare demands that exceed the capabilities of the Hospital and/or the Medical Staff. Such occurrence may be due to a natural disaster or a man-made disaster, and may be an officially declared emergency, whether it is local, state or national. Any Licensed Independent Practitioner providing patient care must be granted disaster responsibilities prior to providing patient care, even in a disaster situation.

Section 5. Special Temporary Privileges

In the case of donor organ retrieval for organ transplantation involving a certified organ and/or tissue donor, a Practitioner not a member of this Medical Staff, may automatically be granted permission to retrieve the organ and/or tissue by submitting their medical license number to Surgical Services. Surgical Services will then forward this information to the Medical Staff Services Department.

ARTICLE VII. CORRECTIVE ACTION

Section 1. Professional Conduct and Clinical Privileges

a) Whenever the activities or professional conduct of any practitioner with clinical privileges are considered to be lower than the standards or aims of the Medical Staff, or disruptive to the operations of the hospital or the work of others, or detrimental to patient safety, or detrimental to quality patient care; corrective action against such practitioner may be requested by any officer of the Medical Staff, by the chairperson of any department, by the chairperson of any standing Medical Staff committee, a Medical Director, the Chief of Staff, or by the President of the Governing Body. All requests for corrective action shall be made to the Chief of Staff with notification to the appropriate Department Chairperson and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request.

b) An adverse professional review action may be taken based on:
   1. The reasonable belief that the action was in the furtherance of quality health care or in the furtherance of upholding the requirements of the Medical Staff, and
   2. After a reasonable effort to obtain the facts of the matter, and
   3. After adequate notice and hearing procedures are afforded to the practitioner involved or after such other procedures as are fair to the practitioner under the circumstances, and
   4. In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts.

Section 2. Precautionary or summary suspension

a) The Chief of Staff, the chairperson of the appropriate department, or the President of the Governing Body shall each have the authority whenever action must be taken immediately, in the best interest of patient care, or the health of any individual, whenever
a practitioner has demonstrated willful disregard of Bylaws, Rules and Regulations or hospital policies; or whenever conduct may require immediate action to protect patients, employees or other persons; to invoke a precautionary or summary suspension of all or any portion of the clinical privileges of a practitioner. Such precautionary or summary suspension shall be effective immediately. Subsequent notice will be provided to the practitioner.

b) A precautionary or summary suspension will be reported to the Chief of Staff. If the Chief of Staff or the Governing Body’s recommendation is not adverse to the practitioner, there is no right to a hearing. If continued adverse professional review action is recommended, the hearing process will be followed as outlined in Article VIII.

c) Immediately upon the imposition of a precautionary or summary suspension, the Chief of Staff or the appropriate department chairperson shall have authority to provide alternate medical coverage for hospitalized patients of the suspended practitioner.

Section 3. Administrative Suspension
A. An administrative suspension in the form of withdrawal of a practitioner’s privileges, effective until medical records are completed, may be imposed after a warning of delinquency for failure to complete medical records. The Director of the Department of Health Information Management shall notify the practitioner of the delinquency status as well as the Chairperson of the Health Information Management Committee, the Chairperson of the appropriate Department, and the Chief of Staff. The Chief of Staff may take further appropriate action, including but not limited to temporary suspension. A suspension under this provision does not entitle the practitioner to a hearing.

B. An administrative suspension of a practitioner’s privileges will automatically be imposed if their license has been allowed to expire. A license will be considered expired at midnight on of the day following the expiration date printed on the license. Reinstatement of privileges will occur once the license has been renewed and is considered to be in good standing. If the staff appointee was scheduled to be reappointed during the period that their license was expired, they will be required to reapply as an initial applicant.

Section 4. Automatic Suspension
Action by a state health agency to revoke or suspend a practitioner's professional license, registration, or certification, without probation, or conviction of a felony shall automatically suspend the practitioner's clinical privileges. Such a suspension does not entitle the practitioner to a hearing, as the practitioner no longer meets the basic qualifications for Staff membership. If the state health agency places the practitioner on probation, the practitioner will be evaluated as outlined in Article V and VI.

ARTICLE VIII. HEARING AND APPELLATE REVIEW PROCEDURE

Section 1. Right to Hearing Procedure
a) A physician may waive notice of a hearing review and may waive a hearing.

b) This section is not applicable to a situation when privileges are affected by an administrative decision of the hospital.
c) Failure to request a hearing review in the manner and within the specified time period shall constitute a waiver of the right to a hearing.

d) There is no right to notice, or a hearing when there is no adverse professional review action taken or recommended, or in the case of a suspension or restriction of clinical privileges, for a period of not longer than fourteen (14) days, during which an investigation is being conducted to determine the need for a professional review action; or in the event of automatic suspension or restriction of clinical privileges or as otherwise outlined in the Bylaws.

e) In the event a member of the staff ends employment with Scott and White Clinic, either by resignation or retirement or termination, privileges shall terminate simultaneously without any notice or hearing requirements.
Section 2. Request for Hearing
A practitioner who is entitled to a hearing will be provided notice by the Chief of Staff or designee of any adverse professional review action or recommendation regarding the appointment to or status as a member of the Medical Staff, including reappointment, suspension, termination, modification or revocation of the practitioner’s privileges.

Section 3. Notice of Hearing
a) The notice of hearing to the practitioner may include:
   1. That a professional review action has been taken or has been proposed to be taken against the practitioner;
   2. Reason for the action or proposed action;
   3. That the practitioner may request a hearing on the proposed action or the action taken;
   4. That such request for hearing must be made in writing to the Chief of Staff and delivered to the Chief of Staff within thirty (30) days from the date of the notice to the practitioner; and
   5. A summary of the conduct of the hearing.

b) The practitioner requesting the hearing must provide written notice to the Chief of Staff as to who will be present in their behalf at the hearing and a list of witnesses and must submit documents to be used at the hearing no later than five (5) days prior to the hearing.

c) If a hearing is requested on a timely basis, the practitioner involved will be given notice stating:
   1. The place, time, and date of the hearing, which date shall not be less than thirty (30) days after the date of the notice, and
   2. A list of the witnesses (if any) expected to testify at the hearing on behalf of the hospital.

Section 4. Composition of Hearing Committee
If a hearing is requested on a timely basis:
   a) The Hearing Committee will be appointed by the Chief of Staff or designee.
   b) The hearing shall be held at a time as determined by the Chief of Staff.
   c) The practitioner may request that a representative of the practitioner’s specialty or similar area, if available, be part of the hearing committee.
   d) The Chief of Staff will choose the format which may include:
      1. Before an arbitrator mutually acceptable to the practitioner and the Chief of Staff.
      2. Before a hearing officer appointed by the Chief of Staff, or
      3. Before a panel of individuals appointed by the Chief of Staff.

Section 5. Conduct of Hearing
a) The right to a hearing may be forfeited if the practitioner fails, without good cause, to appear and proceed at such hearing. Such failure shall constitute a waiver of this right, and the practitioner will be deemed to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect.

b) In the hearing the affected practitioner involved has the right:
1. To representation by an attorney or other person of the practitioner’s choice
2. To have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated with the preparation thereof.
3. To call, examine and cross-examine witnesses.
4. To present evidence determined to be relevant by the hearing officer or arbitrator or chairperson of the hearing, regardless of its admissibility in a court of law.
5. To submit a written statement at the close of the hearing.

c) Upon completion of the hearing, the practitioner involved has the right to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations and to receive a written decision of the hospital, including a statement of the basis for the decision.

d) Postponement of hearings beyond the time set forth in these Bylaws shall be made only with the approval of the Chief of Staff. Granting of such postponement shall only be for good cause shown and at the sole discretion of the Chief of Staff.

e) Either a hearing officer, if one is appointed or the chairperson of the hearing committee or designee shall preside over the hearing to determine the order of procedure during the hearing.

f) The affected practitioner shall be responsible for supporting any challenge to the adverse recommendation or decision by presenting relevant oral or written evidence.

g) If the practitioner does not testify in his or her own behalf, the practitioner may be called and examined as if under cross-examination. The hearing committee may order that oral evidence be taken only on oath or affirmation administered by any person entitled to notarize documents in Texas.

h) The hearings provided for in these Bylaws are for the purpose of resolving, on a professional basis, matters bearing on professional competency, ethics, conduct, and qualifications.

i) The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened.

j) The hearing committee shall make written report and recommendation and shall forward the same together with the hearing record and all other documentation to the Chief of Staff or to the Governing Body, whichever is appropriate. The Chief of Staff will make a final recommendation and report same to the Governing Body for approval. Such decision is final.

k) The practitioner will be notified in writing of this decision.

l) The Hearing Committee may report to licensing and appropriate authorities serious quality deficiencies resulting in suspension or termination due to quality of care concerns.
Section 6. Appellate Review Procedure

6.1 Time for Appeal
Within ten (10) calendar days after notice of the hearing committee’s recommendation, either the Practitioner or the Chief of Staff or Medical Staff Executive Committee 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 by the Practitioner within ten (10) calendar days as provided herein, the Practitioner shall be deemed to have accepted the recommendation involved, and the hearing panel’s report and recommendation shall be forwarded to the Governing Body for final action.

6.2 Grounds for Appeal
The grounds for appeal shall be limited to the following:
   6.2.1 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
   6.2.2 The recommendation of the hearing panel was not supported by sufficient evidence based upon the hearing record.

6.3 Time, Place and Notice
Whenever an appeal is requested as set forth in the preceding sections, the President of the Governing Body 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 Body for good cause may extend the time for appellate review.

Section 7. Final Decision
Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than on hearing or appellate review on any matter which shall have been subject of an appeal. In the event that the Governing Body’s ultimate decision is adverse to the practitioner, that individual may not apply within five (5) years for Medical Staff appointment or for those clinical privileges at this Hospital unless the Governing Body provides otherwise.

ARTICLE IX. OFFICERS

Section 1. Officers of the Medical Staff
The officers of the Medical Staff shall be Chief of Staff, Associate Chief of Staff, and Secretary.

Section 2. Qualifications of Officers
Officers must be members of the Active Medical Staff in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

Section 3. Appointment of Officers
Officers shall be appointed by the Governing Body at its annual meeting upon the recommendation of the Board of Directors which is comprised of elected representatives of the Medical Staff. Each shall hold office until the next annual meeting of the Governing Body or
Section 4. Term of Office

All officers shall serve a one-year term from the appointment date or until a successor is named. Officers shall take office on the first day of February.

Section 5. Removal from Office

Officers may be removed from office at any time by action of the Medical Staff Executive Committee or Governing Body for not fulfilling the duties of the Office held as outlined in the Scott and White Memorial Hospital and Scott, Sherwood and Brindley Foundation Medical Staff Bylaws and Rules and Regulations. Removal of an officer from office may be recommended by a two-thirds majority vote of all Active Medical Staff members, but no such removal shall be effective unless and until it has been ratified by the Medical Staff Executive Committee and by the Governing Body.

Section 6. Vacancies in Office

Vacancies of the Officers of the Medical Staff will be filled by the Governing Body. If there is a vacancy in the office of Chief of Staff, the Associate Chief of Staff shall temporarily act as Chief of Staff until a successor is appointed by the Governing Body.

Section 7. Duties of Officers

a) CHIEF OF STAFF: The Chief of Staff shall serve as the chief administrative officer of the Medical Staff to:

1. Call, preside at, and be responsible for the agenda for all general meetings of the Medical Staff
2. Serve as Chairperson of the Medical Staff Executive Committee
3. Serve as ex-officio member of all other Medical Staff Committees, without vote
4. Be responsible for the enforcement of the Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions when indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner
5. Present the views, policies, needs, and grievances of the Medical Staff to the Governing Body and to the Executive Committee of the Governing Body
6. Receive and interpret the policies of the Governing Body to the Medical Staff and report to the Governing Body on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide health care
7. Assure, prioritize and promote a strong and effective continuing medical education program for the Medical Staff, based in part on findings of performance improvement activities
8. Represent the Medical Staff in its external professional and public relations

b) ASSOCIATE CHIEF OF STAFF: The Associate Chief of Staff shall be a member of the Medical Staff Executive Committee. The Associate Chief of Staff shall assist the Chief
of Staff in carrying out the duties as outlined above. When a vacancy occurs in the office of Chief of Staff, the Associate Chief of Staff will act as Chief of Staff until a successor is appointed by the Governing Body.

c) **SECRETARY:** The Secretary shall be a member of the Medical Staff Executive Committee and assist the Chief of Staff in the performance of duties as requested.

**ARTICLE X. DEPARTMENTS, DIVISIONS, AND SECTIONS**

**Section 1. General**

The Medical Staff, for purposes of organization, responsibilities, and privileges, is divided into the following departments: Anesthesiology, Dermatology, Emergency Medicine, Family Medicine, Medicine, Neurological Surgery, Neurology, Obstetrics and Gynecology, Occupational Medicine, Ophthalmology, Orthopaedic Surgery, Pathology, Pediatrics, Physical Medicine and Rehabilitation, Psychiatry, Radiology, Radiation Oncology, and Surgery. The number and composition of the various departments, divisions, and sections may be decreased, increased, or modified in any manner by resolution of the Governing Body without the necessity of amending these Bylaws for such purposes.

**Section 2. Responsibility**

Each Department shall be the responsibility of a department chairperson, each division of a division director, and each section of a section chief appointed as outlined in these Bylaws.

**Section 3. Department Chairperson**

Each department shall be organized as a department of the Medical Staff and shall have a department chairperson who shall be responsible through the Medical Staff Executive Committee to the Chief of Staff for the functioning of the department. The chairperson of each department shall be appointed by the Governing Body at its annual meeting. The chairperson shall serve for a period of one year from February 1 through January 31, or until a successor is appointed. Selection of an individual for such appointment shall be based upon qualifications as they relate to training, experience, and demonstrated administrative ability and leadership. The chairperson shall be a member of the Active Medical Staff and be board certified. Exception to this rule will be at the discretion of the Chief of Staff. In the event of a new department or a situation in which, in the opinion of the Governing Body, a desired chairperson cannot meet these qualifications, the Governing Body may make such appointment it deems advisable without the necessity of amending these Bylaws. Removal of a chairperson from office may be recommended by a two-thirds majority vote of all Active Medical Staff members of the department, but no such removal shall be effective unless and until it has been ratified by the Medical Staff Executive Committee and by the Governing Body.

The duties of a department chairperson shall include:

- Formulate the Rules and Regulations relating to the various professional activities within the department and ensure that these Bylaws, Rules and Regulations are followed. Maintain an active liaison with the appropriate hospital authorities concerning these duties.
- Submit recommendations to the Medical Staff Executive Committee for appointment, reappointment, extension or limitation of privileges, for members of the department as outlined in Article V and Article VI. Recommend criteria for clinical privileges that are relevant to the care provided in the department. The list of clinical privileges for each practitioner within the department will be maintained by the department chairperson.
• Determine the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment and services.

• Assure the implementation of a planned and systematic quality assessment, patient safety and risk management program for monitoring and evaluating the quality and appropriateness of care and treatment of patients served by the department and the clinical performance practiced in the department. If such program is not sufficient to adequately improve a member of the department’s performance, the Department Chairperson will engage in a timely focused review process of a practitioner’s performance. When appropriate, as part of the quality improvement process, the Department Chairperson may make a request to the Chief of Staff for external reviewers.

• Assist with the development and supervision of medical students, residents, continuing medical education, and research programs within the department.

• Assist with the development and administration of training programs for support of healthcare practitioners within the department.

• Assist with the orientation and continuing education in the department.

• Assess and recommend off-site sources for needed patient care, treatment, and services not provided by the department or organization.

• Coordinate and integrate interdepartmental and intradepartmental services.

• Recommend a sufficient number of qualified and competent persons to provide care, treatment, and services.

• Establish teaching and service responsibilities within the department and prepare schedules and assignments. Delegate the various responsibilities and authority necessary for the proper function of the department, including appointment of essential committees.

Section 4. Functions of Department

a) Every department shall establish its own criteria, consistent with the policies of the Medical Staff and of the Governing Body, for the granting of clinical privileges and assignment of responsibilities within the department.

b) Each department shall establish an ongoing quality improvement program designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care and resolve identified problems. Each department will hold regular meetings as specifically outlined in the Rules and Regulations of each department to consider findings from the ongoing monitoring of cases against predetermined quality indicators, discuss any problems noted through the review of patient records and evaluate the quality and appropriateness of care and treatment provided and document findings in the minutes of these monthly departmental meetings. Quality improvement activities will be coordinated with the responsibilities of the Medical Staff Quality Improvement Committee as outlined in Article XI, Section 15.

c) Minutes of departmental meetings shall be submitted to the Medical Staff Executive Committee detailing activities.

Section 5. Divisional Organization
Each division shall be organized within the department and shall have a division director who
shall be responsible to the department chairperson for the functioning of the division and shall have general supervision of the clinical and administrative work within the division. The division director shall be a member of the Active Medical Staff and be board certified. Exception to this rule will be at the discretion of the Chief of Staff. The division director shall be appointed by the Governing Body at its annual meeting.

Section 6. Sectional Organization
Each Section shall be organized within the division and department and shall have a section chief who shall be responsible to the division director and department chairperson for the functioning of the section and shall have general supervision over the clinical and administrative work within the section. The chief of the section shall be a member of the Active Medical Staff and qualified by training, experience, and administrative ability for the position. Appointment of the section chief shall be made by the Governing Body at its annual meeting.

ARTICLE XI. COMMITTEES

Section 1. Designation and Substitution
1.1 There shall be a MSEC and such other standing, joint and special committees as established by the MSEC and enumerated in the Bylaws. The MSEC may appoint ad hoc committees as necessary to address time-limited or specialized tasks as a subsection of MSEC.

Section 2. General
These standing committees of the hospital operate to assist in the fulfillment of the Scott and White mission. This may include, but is not limited to, review of patient care, quality review, patient safety evaluation, risk management activities, oversight supervision, and evaluation of the appropriateness, and quality of care and 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. These committees shall be standing committees of Scott and White Memorial Hospital and entitled to all privileges and powers thereof. 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 and reports or communications made to these committees, including those described above, are confidential and privileged in all respects. These committees may claim all legal privileges against disclosure and subpoena provided by Texas and Federal law. These privileges also apply to all prior actions and investigations by any predecessor committee. All Medical Staff committees and members, including the chairpersons, shall be appointed by the Chief of Staff, with concurrence of the Medical Staff Executive Committee and the Governing Body. Minutes of all committee meetings are deemed confidential and privileged.

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 MSEC. 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 S&W Hospital-Round Rock and any of its qualified affiliates; and any other Scott & White Memorial Hospital qualified affiliates.

a. Pharmacy and Therapeutics Committee (7)
b. Infection Control Committee (5)
c. Transfusion Committee (10)
d. Quality and Patient Safety Council (20)
e. Peer Review Oversight Committee
f. Bioethics Committee (14)
g. Physician Advocacy and Wellness Committee
h. Trauma Committee (17)
i. Intensive Care Committee (6)

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 and reports or communications made to these committees, including those described above, 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 of Staff, with concurrence of the Medical Staff Executive Committee and the Governing Body. The Chief Executive Officer shall be an ex-officio member of all committees. The Chief Executive Officer may designate another senior administrative member to attend any meeting in his/her place.

Section 3. Medical Staff Executive Committee
a) Composition
The Medical Staff Executive Committee (MSEC) shall consist of the officers of the Medical Staff and the chairpersons of each department. The Chief of Staff shall act as chairperson of this committee. The elected Board of Directors shall serve on the MSEC in an ex officio capacity. Representatives from Hospital Administration shall act as ex-officio members of the Medical Staff Executive Committee. The Chief of Staff may appoint, on an ad hoc basis, representatives of Medical Staff committees to attend Medical Staff Executive Committee meetings.

b) Duties
- Be directly accountable to the Governing Body by making recommendations relative to Medical Staff matters.
- Provide liaison between the Medical Staff and Governing Body.
- Represent and act on behalf of the Medical Staff between scheduled meetings, subject to such limitations as may be imposed by these Bylaws.
- Implement policies or other directives of the Medical Staff Executive Committee that are not the responsibility of departments. The Hospital Executive Director or designee will be responsible to coordinate and implement these policies with appropriate administrative personnel throughout the institution.
- Fulfill the Medical Staff's accountability to the Governing Body for the quality of medical care rendered.
- Approve, implement, support, and direct the Continuous Quality Improvement Process, and ensure that the institution's Quality Improvement Plan is effective and appropriate; receive and act upon quality improvement reports.
- Ensure that the Medical Staff is kept abreast of the accreditation status of the hospital.
• Review and approve recommendations of the Credentials Committee regarding privileges and appointment of applicants to the Hospital Medical Staff.
• Review and acts on reports of medical staff committees, departments, and other assigned activity groups.
• Ensure professional conduct and competent clinical performance of all practitioners with clinical privileges. Initiate and/or participate in corrective or review measures, when warranted.
• Receive reports from Risk Management in order to identify problems, stimulate discussion and coordinate corrective action between departments.
• Initiate and/or participate in corrective or review measures, when warranted.
• Report at each general Medical Staff meeting.
• Meet regularly, and no less frequently than quarterly.
• Maintain attendance records.
• Maintain minutes.
• Forward copies of minutes to the Governing Body.

Section 4. Credentials Committee
a) Composition
The Credentials Committee shall consist of at least five (5) members of the Active Medical Staff and shall be appointed by the Governing Body at its annual meeting. The Chairperson shall be appointed by the Chief of Staff.

b) Duties
• Review credentials of applicants and make recommendation for membership and/or delineation of clinical privileges in compliance with Article V and VI of these Bylaws.
• Oversight and credentialing of residents is delegated to the Office of Graduate Medical Education and to the Department Chairperson. This activity is an approved Hospital Medical Staff Committee and a Peer Review Committee, and such committees or activities are privileged and confidential.
• Report to the Medical Staff Executive Committee on each applicant for Medical Staff membership and/or requests for clinical privileges, including specific consideration of the recommendations from the appropriate department in which such applicant requests privileges.
• Periodically review information, such as Continuous Quality Improvement and peer review, regarding practitioner’s professional competency and make recommendations for the granting of clinical privileges, reappointments and assignment of practitioners to the appropriate department, division, or section, as provided in Articles V and VI of these Bylaws.
• Investigate any reported breach of ethics.
• Review any submitted reports that pertain to fulfilling the duties of the committee.
• Meet as called by the committee chairperson.
• Maintain attendance records.
• Maintain minutes.

Section 5. Cancer Committee
a) Composition
The Cancer Committee shall be composed of representatives from the Active Medical Staff involving specialties participating in the care of cancer patients, as well as representatives from ancillary services contributing significant support to this mission. The latter should include representatives from Tumor Registry Nursing, Pharmacy, Biostatistics and Quality Improvement. Recommendations by accrediting agencies may serve as guidelines for the constitution of this committee. The committee shall be appointed by the Chief of Staff, with
b) Duties
- Responsible for supervision and surveillance of the institutional cancer program by performing an audit role regarding patient care and by actively supervising the cancer data base for quality control of abstracting, staging, and reporting.
- Evaluate and assist in development of new cancer programs.
- Ensure that patients have access to consultative services in all disciplines.
- Provide continuing education to the Medical Staff and support staff regarding the entire spectrum of cancer.
- Report annually to the Medical Staff on work of the committee and the yearly statistics of the Tumor Registry.
- Forward copies of reports to the Medical Staff Executive Committee and Hospital Administration.
- Meet at least quarterly or more frequently as called by the chairperson.
- Maintain attendance records.
- Maintain minutes of meetings.

Section 6. Infection Control Committee
a) Composition
The Infection Control Committee shall be composed of the Hospital Epidemiologist, Active Medical Staff to represent Hospital and Ambulatory Care, the Infection Control Practitioners, and representatives from the following: Clinic, Regional Clinics, Bryan/College Station Facilities, Dialysis, Home Care, Long Term Care, Regional Hospitals, Administration, Nursing, Microbiology, Employee Health, Safety and Engineering/Support Services as necessary and a physician, nurse and/or pharmacist from S&W Hospital-Round Rock. A quorum of the Committee will consist of the Hospital Epidemiologist, at least one member of the Infection Control Team, at least one member of the Medical Staff, and at least five additional members of the listed representatives. The committee shall be appointed by the Chief of Staff, with concurrence of the Medical Staff Executive Committee and Governing Body.

b) Duties
- Authority is given to the committee through the Hospital Epidemiologist and/or the Infection Control Practitioners to make the necessary decisions or take appropriate actions if there is deemed to be a danger to patients or employees related to infections or infection control.
- Initiate appropriate infection control measures or studies.
- To maintain Quality Improvement through an organization-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 evaluate 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 S&W affiliated patient care areas,
  - evaluating trends and issues related to the Employee Health, Program
  - reviewing pertinent findings from other committees,
• complying with applicable Joint Commission [TJC] Standards.
  • Meet not less than every two months.
  • Maintain attendance records.
  • Maintain minutes of meetings.

Section 7. Intensive Care Committee
a) Composition
The Intensive Care Committee shall be composed of at least five (5) members of the Active Medical Staff with representation from Anesthesiology, Cardiology, Pediatrics, Pulmonary Diseases, and Surgery. There shall be a chairperson, vice-chairperson, and a medical director. The chairperson shall request ex-officio members to represent Hospital Administration, Nursing Administration, the Intensive Care head nurse, the chief medical resident, and a physician, nurse and/or pharmacist from the S&W Hospital-Round Rock. The committee shall be appointed by the Chief of Staff, with concurrence of the Medical Staff Executive Committee and Governing Body.

b) Duties
  • Develop intensive care policies and procedures, a copy of which will be maintained by the Committee Chairperson.
  • Coordinate training and certification of personnel in special nursing procedures utilized on the units.
  • Coordinate equipment and space needs including technical advice on specific systems to be integrated into units, this function to include liaison with the Departments of Engineering & Purchasing.
  • Initiate and review audit activities to assure quality care on the units.
  • The medical director will:
    • Work in close liaison with the unit head nurse.
    • Serve as liaison officer with primary care physicians caring for patients on the units in day-to-day problems which cannot be easily resolved by the unit head nurse.
    • Be assisted by the surgical member in liaison activities.
  • The Intensive Care Committee shall:
    • Meet every three (3) months or as called by the chairperson.
    • Maintain attendance records.
    • Maintain minutes of meetings.

Section 8. Laboratory Practices Committee
a) Composition
The Laboratory Practices Committee shall consist of representatives from some Scott and White CLIA Independent Laboratory (Special Hematology, Stem Cell Transplantation, Pulmonary, Dialysis and Nuclear Radiology) and from Anesthesiology, Surgery, Emergency Medicine, Family Medicine, Pediatrics, Clinical and Anatomic Pathology. The chairperson shall request ex-officio members as necessary. The committee shall be appointed by the Chief of Staff, with concurrence of the Medical Staff Executive Committee and Governing Body.

b) Duties
  • Evaluate quality concerns about tests performed outside of central laboratory and recommend improvements when appropriate.
  • Evaluate and act upon proposals for near patient testing. Evaluation will include assessment of both methods and/or equipment and financial implications. No new testing program will be introduced without this committee’s review.
• Assess concerns about compliance with all regulations and standards at all testing sites.
• Evaluate, through objective studies, appropriateness of lab utilization by physicians at all testing sites.
• Advise laboratory of medical care requirements impacting laboratory test selection, result timeliness, cost and other appropriate parameters.
• Support evaluation of new technology/methodologies for clinical laboratory testing.
• Standardize lab method/procedures throughout the organization as required for patient care needs at minimal cost.
• Provide other advice or constructive criticism to lab as needed.
• Meet on alternate months (February, April, June, August, October, December) or as called by the chairperson.
• Maintain minutes of meetings.

Section 9. Health Information Management Committee
a) Composition
The Health Information Management (HIM) Committee serves as a system-wide committee within the Scott & White health care delivery enterprise. The HIM Committee shall be comprised of Active Medical Staff, nursing and administrative representatives from the various acute care facilities. The committee shall be appointed by the Chief of Staff, with concurrence of the Medical Staff Executive Committee and Governing Body.

b) Purpose
The purview of the system-wide HIM Committee includes paper-based and electronic medical records. The purpose of the system-wide HIM Committee is twofold. First, to ensure uniformity and standardization of medical record document formats and content. Second, to ensure uniformity and standardization of medical record document management practices. The HIM Committee shall promote uniformity and standardization of documentation with the goal of minimizing patient practice variations and enhancing patient safety. The HIM Committee shall promote standardization of medical record document management with the goal of minimizing delay of information flow or incomplete information.

c) Duties
• Plays a key role in defining the legal medical record as the health system transitions from paper-based medical records to an electronic medical record.
• Ensure that the definition of the legal medical record supports the decision-making process for the care and treatment of patients, reimbursement of services rendered, and research efforts.
• Promotes medical record completion that is both timely and adheres to all regulatory and accreditation requirements.
• Provides policies and procedures for protecting personal health information (PHI) as well as the security and confidentiality of paper-based and electronic medical records.
• Oversees the medical record forms approval sub-committee.
• Meets at least quarterly or as called by the Chair.
• Maintains attendance records and meeting minutes.

Section 10. System Pharmacy and Therapeutics Committee
a) Composition
The Pharmacy and Therapeutics Committee shall be composed of at least twelve members of the active medical staff representing various medical specialties and representatives from:
The chairperson shall request ex-officio members to represent Pharmacy, Nursing, Hospital Administration. The committee shall be appointed by the Chief of Staff, with concurrence of the Medical Staff Executive Committee and Governing Body.

**b) Duties**

1. Direct & coordinate subcommittee efforts as follows:
   - Maintain a system-wide drug formulary which promotes the safe and effective use of FDA-approved medications via the P&T Formulary Subcommittee
   - Evaluate medication use via the MUE Subcommittee
   - Evaluate trends/changes in high-cost medication use via the Drug Therapy Task Force.

2. Design and monitor system-wide medication safety initiatives including TJC medication-related “National Patient Safety Goals”:
   - Unacceptable Abbreviations in Medication Orders
   - Look Alike/Sound Alike (LASA) Drugs
   - High Risk Drugs & Standardization
   - Medication Labeling in Procedure Areas
   - Medication Reconciliation

3. Improve medication safety by:
   - reviewing reported medication errors, trends & establishing prevention strategies
   - establishing processes for high risk medications

4. Monitor and take action to improve safety & compliance efforts in medication processes & standards, including oversight of:
   - Medication allergy documentation (hospitals & clinics)
   - Medication preparation within and outside the pharmacy
   - Medication labeling in general and on sterile fields specifically (hospitals & clinics)
   - Conscious sedation drug safety (hospitals & clinics)
   - Medication storage and inspection, including samples (hospitals & clinics)
   - Medication security during transport (hospitals & clinics)
   - Controlled substances documentation and waste (hospitals & clinics)
   - Controlled substances audits and diversion (hospitals & clinics)
   - Prescriber & staff education on medications & monitoring findings (hospitals & clinics)
   - Patient education on medications (hospital & clinics)
   - Medication order review for appropriateness, medical necessity, completeness, and safety (hospitals & clinics)
   - Medication use beyond the scope of labeled indications (hospitals & clinics)
   - Medication administration & documentation (hospitals & clinics)
   - Vaccine administration documentation (hospitals & clinics)
   - Non-formulary medications and medications brought from home (hospitals & clinics)
   - Verbal orders (hospitals & clinics)
   - Pyxis overrides (hospitals)
• Medication order entry verification (hospitals)
• Physician MAR review (hospitals)
• Drug-drug and drug-food interactions (hospitals & clinics)
• Review of internal adverse drug events (hospitals & clinics)
• Review of external adverse drug events and medication safety findings (e.g., ISMP Alerts, FDA alerts, MedWatch alerts, and AHRQ reports (hospitals & clinics)

5. Plan, design, implement and monitor system-wide interdisciplinary policies and procedures, drug use algorithms, and protocols related to medication use.
  • The P&T Committee will review new and existing therapies using criteria based on efficacy, safety and quality and work with prescribers to design protocols and practices based on these findings.

6. In conjunction with Risk Prevention staff, provide unit based and practitioner based data in medication use and safety to identify trends and take action as appropriate.

7. Integrate monitoring findings with Medical Staff Peer Review process as appropriate

Section 11. Transfusion Committee

a) Composition
The Transfusion Committee shall consist of at least six (6) members of the Active Medical Staff with representation from Clinical Pathology (Director of the Blood Bank), Anesthesiology, Medicine, Surgery, Obstetrics and Gynecology, and Pediatrics. The chairperson will be selected for a two (2) year term from the membership. The chairperson shall request ex-officio members to represent Hospital Administration, Nursing, Medical Record Department, and a physician, nurse and/or pharmacist from the S&W Hospital-Round Rock. Terms of appointment shall be for two (2) years and staggered to provide continuity of responsibilities. The committee shall be appointed by the Chief of Staff, with concurrence of the Medical Staff Executive Committee and Governing Body.

b) Duties
To maintain a Quality Improvement Program:
• Review records of transfusions of blood and blood components and derivatives given in the hospital and Blood Bank area.
• Develop and recommend policies and procedures relating to the distribution, handling, use, and administration of blood and blood components.
• Review the adequacy of transfusion services to meet patient needs.
• Review ordering practices for blood and blood products.
• Develop valid clinical criteria to be used in the screening process and in the more intensive evaluation of known or suspected problems in usage.
• Investigate all transfusion reactions for possible causes and make recommendations for the improvement of blood and transfusion practices.
• Review all cases of blood transfusion associated diseases identified following transfusion.
• Make recommendations and written reports to the Medical Staff Executive Committee concerning the proper use of blood and blood components and derivatives in the hospital; the formulation of these policies shall be consistent with good medical practice and the committee shall be guided by the Standards of the American Association of Blood Banks and other authorities recognized in this field
• Meet every three (3) months or as called by the chairperson.
• Maintain attendance records.
• Maintain minutes of meetings.

Section 12. Operating Services Committee
a) **Composition**
The Operating Services Committee shall consist of directors of the divisions within the Department of Surgery, Chairperson of the Department of Anesthesiology, Director of the Division of Gynecology, Nursing Director of Perioperative Services and the Chief of the Section of Podiatry. The chairperson shall request ex-officio members to represent Hospital Administration and Nursing. The committee shall be appointed by the Chief of Staff, with concurrence of the Medical Staff Executive Committee and Governing Body.

b) **Duties**
- Oversee the operating room services and confirm adherence to customary standards of practice in an operating room environment.
- Recommend, review, and update policies for operating room services.
- Assist with staffing patterns.
- Review the operating room budget and assess the need for space and equipment.
- Establish a plan for space utilization and a schedule for operating procedures to provide equal opportunity for surgical staff members.
- Meet monthly or as called by the chairperson.
- Maintain attendance records.
- Maintain minutes of meetings.

### Section 13. Quality Patient Safety Councils

(a) **Composition**
The System and Primary Quality and Patient Safety Councils’ membership includes medical staff, administrative leadership, and other staff as appointed.

(b) **Duties**
- Responsible for the annual determination of organizational quality and patient safety priorities and goals, assuring progress towards achieving the goals, and addressing barriers, either individual or system, that would prevent achievement of the goals.
- Oversee the quality and safety of patient care in the hospital, ambulatory, and post acute settings.
- Determine organizational quality and patient safety priorities and goals, assuring progress towards achieving the goals, and addressing barriers, either individual or system, that would prevent achievement of the goals.
- Provide leadership and direction of the Medical Staff and Allied Health Peer Review processes.
  a. A Subcommittee of the QPSC composed of Trustee members of the QPSC as well as members of the medical staff will serve as the delegated entity of the Board of Directors to receive and act on the report of the Credentials Committee dealing with the medical staff and allied health practitioners. The Subcommittee will provide to the Credentials Committee direction on issues relating to Quality and Patient Safety that should be considered in the Peer Review processes of credentialing and privileging.
  b. In the event of unanticipated adverse outcomes or the introduction of new priorities for quality and patient safety, the QPS Councils identify, plan, design and implement new strategies for the improvement of patient care.

(c) **Meeting Frequency**
The QPS Councils meet at least quarterly.

### Section 14. Medical Staff Bylaws, Rules & Regulations Review Committee

(a) **Composition**
The Medical Staff Bylaws, Rules and Regulations Review Committee shall consist of at least
three (3) members of the Active Medical Staff, one of whom shall be appointed chairperson and one to represent the Governing Body. Other members shall include representatives of Legal Counsel, Hospital Administration and Medical Staff Services. The chairperson shall request ex-officio members as necessary. The committee shall be appointed by the Chief of Staff, with concurrence of the Medical Staff Executive Committee and Governing Body.

b) Duties
- Review and ensure the Medical Staff Bylaws, Rules and Regulations reflect the hospital's current practices.
- Review and assure the Medical Staff Bylaws, Rules and Regulations are in compliance with TJC and other regulatory agencies.
- Develop appropriate revisions to the Medical Staff Bylaws, Rules and Regulations.
- Recommend appropriate revisions to the Medical Staff Executive Committee.
- Present recommendations to the Medical Staff for consideration.
- Assist departments in maintaining compliance with TJC through review, education, and recommendation.
- Meet periodically or as called by the chairperson.
- Maintain attendance records.

Section 15. Bioethics Committee
a) Composition
The Bioethics Committee shall consist of ten (10) members of the Active Medical Staff and representatives from non-medical staff, the College of Medicine, and the community to ensure appropriate diversity. As necessary, representatives from S&W Hospital-Round Rock may participate on the committee. The committee shall be appointed by the Chief of Staff, with concurrence of the Medical Staff Executive Committee and Governing Body. Membership should ensure that the Bioethics Committee meets the core competencies for health care ethics consultations promulgated by the American Society for Bioethics and Humanities.

b) Duties
- Education of committee members, Scott and White staff, patients, and the community.
- Serving as an advisory body for patient care and business policies.
- Providing ethics consultations and reviews.

Section 16. Neonatal Intensive Care Committee
a) Composition
The Neonatal Intensive Care Committee shall be composed of at least three (3) members of the Active Medical Staff with representation from Obstetrics and Neonatology. Other members shall include the head nurse over the NICU, a Nursing representative, and a representative from the Respiratory Therapy Department. Ex-officio members will include Hospital Administration representatives and Nursing Administration representatives. The committee shall be appointed by the Chief of Staff, with concurrence of the Medical Staff Executive Committee and Governing Body.

b) Duties
- Review NICU policies and procedures.
- Coordinate equipment and space needs.
- Provide communication channel between NICU and Obstetrics, and NICU and Respiratory Therapy.
- Be responsible for resolving operational problems in the NICU.
- Meet every three (3) months or as called by the chairperson.
- Maintain minutes of meetings.
Section 17. Pediatric Intensive Care Unit Committee
a) Composition
The Pediatric Intensive Care Unit Committee shall be composed of the Pediatric Intensive Care Unit Staff, Pediatric Surgery Staff, Pediatric Intensive Care Unit Head Nurse and a representative from Respiratory Therapy. The Pediatric Intensive Care Unit Medical Director will serve as chairperson with automatic membership to the personnel listed above. The Chairperson shall request ex-officio members as necessary. The committee shall be appointed by the Chief of Staff, with concurrence of the Medical Staff Executive Committee and Governing Body.

b) Duties
- Review policies and procedures as pertaining to pediatric patients in the Intensive Care Unit areas excluding Neonatal Intensive Care Unit.
- Coordinate equipment and special needs for pediatric patients in the ICU areas, excluding NICU, reporting these needs to the Hospital ICU Committee and the Department of Pediatrics.
- Respond to operational problems in the ICU areas pertaining to pediatric patients.
- The Chairperson shall be responsible for insuring pediatric physician staff coverage of PICU patients, setting schedules and on-call coverage of PICU.
- Monitor Pediatric Advanced Life Support Classes.
- Meet quarterly or as called by the Chairperson.
- Maintain minutes of meetings.

Section 18. Trauma Committee
a) Composition
The Trauma Committee shall be appointed by the Chief of Staff, with concurrence of the Medical Staff Executive Committee and Governing Body. The Committee shall be composed of members of the medical staff who represent and play a major role in the Hospital's Trauma Program and a physician from the S&W Hospital-Round Rock. The chairperson shall be the Trauma Medical Director or designee. The chairperson will recommend an individual to serve as a vice-chairperson. The Trauma Program Manager will serve as a member of the committee.

b) Duties
- Approve guidelines, procedures and policies regarding Trauma Care at Scott and White Memorial Hospital and Clinic.
- Receive and review recommendations, reports and minutes from the Trauma Program Improvement Committee and all other Trauma Sub-committees.
- Provide for coordination and interdisciplinary oversight of all issues related to trauma to include:
  i. Trauma Research.
  ii. Continuing Trauma Medical Education.
  iii. Trauma Credentialing.
  v. Equipment and space needs related to trauma care.
  vi. Integration of policies and procedures for the hospital's departments and programs to ensure the highest quality of trauma care.
  vii. A Quality Improvement Program will be ongoing.
- The Committee meets monthly or as called by the Chairperson.
- Minutes are maintained in the Trauma Center Administrative Office.

Section 19. Skilled Nursing Facility Patient Care Committee
a) Composition
The Skilled Nursing Facility Patient Care Committee shall be composed of the Medical Director of the Skilled Nursing Facility, a Santa Fe Internal Medicine Physician, Skilled Nursing Facility Nurse Manager, Director of Medical Information and Record Service, and a representative from Quality Improvement, Utilization Review, Discharge Planning, Social Work, Physical Therapy Services, Nutrition Services and Pastoral Services. The Medical Director of the Skilled Nursing Facility shall serve as chairperson. The chairperson shall request ex-officio members to represent Scott and White Hospital Administration, Financial Services, Assistant Administrator of Nursing, Respiratory Therapy and the Director of Transportation. The committee shall be appointed by the Chief of Staff, with concurrence of the Medical Staff Executive Committee and Governing Body.

b) Duties
To maintain a Quality Improvement Program:

- Review the facility's patient care practices.
- Review reports of ongoing Quality Improvement activities.
- Monitor and address issues of patient care, reimbursement, discharge planning, documentation, and compliance with policies.
- Meet bi-monthly or as called by Chairperson.

Section 20. Patient Safety Council

a) Composition
Membership shall be selected Active Medical Staff, Nursing Staff, Pharmacy Staff, Administrative Staff, Support Staff and Lay Trustee as determined by the Quality Council and Endorsed by the Governing Body.

b) Duties

- Oversee and coordinate the organization’s patient safety efforts.
- Serve as a vehicle to promote awareness of patient safety issues, strategies, and ongoing initiatives.
- Coordinate and develop patient safety metrics that are measured and monitored.
- Serve as a material and knowledge resource for patient safety initiatives.
- Provide periodic reports to the Medical Staff Executive Committee, Quality Council, Departments and other committees.

Section 21. Physician Advocacy and Wellness Committee

a) Composition

The members of the Physician Advocacy and Wellness Committee includes five to eight members of the active medical staff and may include one resident or fellow and members of the medical staff from S&W Hospital-Round Rock. Members of the committee are appointed by the Chief of Staff and are selected for their expertise, experience and willingness to serve on the committee. Terms of appointment are at least two years and staggered. The Chair of the committee is appointed by the Chief of Staff.

Consultants to the committee may include internal and external consultants. Consultants may be recommended by the Chief of Staff, the Physician Advocacy and Wellness Committee Chair, other members of the committee, or a member of the medical staff.

b) Duties

- Accept Scott and White medical staff physician, other senior staff and resident/fellow cases as referred.
- Maintain information and work in confidential manner.
- Provide a support system to Scott and White medical staff physicians, other senior staff and residents/fellows whose medical practice may be or is affected due to...
chemical dependence, physical or mental illness, or disruptive behaviors.

- Promote physician welfare while protecting patients and colleagues.
- As appropriate, receive and consider information related to the physician, investigate, assist, collaborate, conduct intervention, make recommendations to the Chief of Staff for evaluation and rehabilitative programs, assist with reentry, monitoring and recovery, make recommendations to the Chief of Staff regarding leave of absence and practice related changes and communicate with the physician the goal of preventing further incident.
- As appropriate, report internally and externally, maintaining confidentiality to the extent possible.

**Section 22. Professional Review Oversight Committee**

**a) Composition**

The Chairperson of this Committee is the Director of Risk Management and Associate General Counsel. The members of the Committee are appointed by the Chairperson and the President/CEO of Scott and White. The committee members includes President/CEO of Scott and White, Clinic Board Members, Hospital Board Members, Chief of Staff, Medical Director for the Hospital, Medical Director for the Clinic, Chief Administrative Position for the Hospital, General Counsel, Senior Staff Physicians, and the Chief Medical Officer from Scott & White Hospital at Hospitality Medical Center, and others as appointed.

**b) Scope of Committee**

1. Oversight, supervision and implementation of peer review functions, patient relations, patient safety and quality assurance functions for the system.
2. Evaluate appropriateness and quality of medical, nursing and health care services for the system.
3. Evaluate competence and qualifications of Practitioners, nurses, and/or other health care providers within the system.
4. Evaluate merits of complaints regarding patient care, medical, nursing, and/or other health care; and all other complaints or claims for the system.
5. Make determinations and recommendations regarding potential events, complaints, claims and suits for the system.
6. Evaluate accuracy of diagnosis, assessments, observations and reports made to the committee or its agents, members of the committee, the Risk Management and Legal department, assistants, investigators, interveners, attorneys and any other person or department concerning the activities within the realm of the Peer Review Oversight Committee and any potential event, complaint, claim or litigation against or involving the system.
7. Conduct investigations and inquiries to resolve complaints, quality or patient safety concerns, patient relations issues, practice and procedure reviews and the like related to the medical Staff, nursing staff, other health care staff, and any other department or personnel that deal with patient care or facilities management and all other potential events, complaints, claims or suits.
8. This committee may from time to time appoint or request others to conduct a specific investigation or review or action plan.
9. Meet at least monthly.
10. Maintain confidential records and minutes of committee proceedings and maintain these in the Risk Management/Legal Department. All related to this committee’s work is intended to be confidential and privileged to the full extent allowed by law.
Section 23. Allied Health Professional Advisory Committee
(a) Composition
The Allied Health Professional [AHP] Committee shall be composed of representative AHP’s, including, Advance Practice Nurses, Physician Assistants, Licensed Chemical Dependency Counselors, Licensed Professional Counselors, and Licensed Clinical Social Workers, Nursing Administration, and Medical Staff Services. One or more physicians may be invited to participate on the committee.

(b) Duties
- Recommend policies and procedures related to AHPs;
- Evaluate the credentials of AHP applicants and recommend the granting or rescinding of privileges;
- Participate in quality improvement and peer review activities;
- Report activities and recommendations to the Scott & White Memorial Hospital Credentials Committee.

Section 24. Resuscitation Committee
a) Composition
This interdisciplinary committee, comprised of medical staff and other staff members, oversees multiple aspects of emergency resuscitation including but not limited to the equipment, processes, staff knowledge and skills, communication, and peer review of patient occurrences and outcomes. The Chairperson is appointed by the MSEC.

b) Duties
- Responsible for the planning, design, implementation and review of emergency response for patients experiencing a cardiac or respiratory arrest.
- Reviews quality monitoring data and generates policies and procedures related to resuscitation.

c) Meeting Frequency
The committee meets at least semi annually.

Section 25. Other Committees
The Chief of Staff, with concurrence of the Medical Staff Executive Committee, may appoint other committees as deemed necessary to perform the duties and responsibilities of the Medical Staff.

Section 26. Committee Amendments
Committee composition, duties, and other matters relating to their function may be modified with concurrence of the Chief of Staff without the necessity of amending or changing the intent of these Bylaws.

ARTICLE XII: MEDICAL STAFF MEETINGS
Section 1. Annual Meetings
Medical staff meetings will be held in conjunction with the CSO (Clinic Staff Organization) meetings as determined by the Chief of Staff. There will be at least one Medical Staff meeting annually. Programs for such meetings may include various items listed in Section 4 of this Article XII.

Section 2. Special Meetings
a) The Chief of Staff or the Medical Staff Executive Committee may call a special meeting of the Medical Staff at any time. The Chief of Staff shall call a special meeting within thirty (30) days after receipt of a written request for same signed by not less than ten
percent (10%) of the Active Medical Staff.

b) Notice of any special meeting of the Medical Staff may be delivered, either electronically or by mail, to each member of the Active and Courtesy Medical Staffs, not less than two (2) nor more than seven (7) days before the date of such meeting, by or at the direction of the Chief of Staff. The notice of the meeting shall be deemed delivered when deposited to each Medical Staff member as addresses appear in the administrative records of the hospital. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

Section 3. Attendance Requirements
Each member of the Medical Staff is encouraged to attend Medical Staff meetings. Attendance can be in person or by electronically reviewing the minutes of the meeting.

Section 4. Agenda
a) The agenda for a regular Medical Staff meeting may include:
   Administrative
   - Call to order - Declaration of a quorum
   - Acceptance of the minutes of the last regular and of all special meetings.
   - Unfinished business
   - Communications
   - Report from the Governing Body
   - Report from the Chief of Staff
   - Reports from Departments
   - Reports from Committees
   - New business
   Professional
   - Review and analysis of clinical work in the hospital
   - Reports of Medical Staff Committees
   - Discussion and recommendations for improvement of the professional work in the hospital
   - Adjourn

b) The agenda at special meetings shall be:
   - Reading of the notice calling the meeting and declaration of a quorum
   - Transaction of business
   - Adjourn

ARTICLE XIII: COMMITTEE AND DEPARTMENT MEETINGS

Section 1. Committee Meetings
Attendance requirements and procedure for the calling and conducting of committee meetings shall be determined by each committee and shall be in compliance with Article XI of these Bylaws.

Section 2. Department Meetings
Attendance requirements and procedure for the calling and conducting of department meetings shall be determined by each department and documented in the Rules and Regulations of each department. The frequency of departmental meetings shall be determined by the department chairperson to consider findings from the ongoing monitoring and evaluation of the quality and appropriateness of care and treatment provided to patients.
Section 3. Rights of Ex-Officio Members
Ex-officio members of a committee shall serve in an advisory capacity to the committee without vote and shall not be counted in determining the existence of a quorum.
ARTICLE XIV: 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 Body, 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 Body 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 and/or clinical privileges
- Periodic reappraisals for reappointment and/or clinical privileges
- Corrective action, including precautionary or summary suspension
- Hearings
- Quality Improvement, or patient safety
- Utilization reviews
- Other hospital department, service or committee activities related to quality patient care and interprofessional conduct
- Peer Review
- Risk Management

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.

ARTICLE XV: RULES AND REGULATIONS ADOPTION, REVIEW, AND AMENDMENT
Rules and Regulations shall be formed as necessary to supplement the general principles of these Bylaws. These Rules and Regulations shall relate to the proper conduct of the Medical Staff Organization activities as well as define the level of practice that is required of each practitioner in the hospital. The Rules and Regulations shall be reviewed annually and reported to the Medical Staff Executive Committee and Governing Body. The Rules and Regulations shall become effective and a part of these Bylaws when recommended for approval to the Governing Body by the Medical Staff Executive Committee and adopted by the Governing Body. When required, these Rules and Regulations may be amended subject to the recommendation for approval to the Governing Body by the Medical Staff Executive Committee and adopted by the Governing Body.
ARTICLE XVI: BYLAWS ADOPTION, REVIEW, AND AMENDMENT
These Bylaws shall be reviewed annually and reported to the Medical Staff Executive Committee and Governing Body. These Bylaws may be amended following evaluation. Recommendation for approval shall be made to the Governing Body by the Medical Staff Executive Committee. The Medical Staff Executive Committee may defer a proposed amendment to an existing or special committee for study and recommendation. Following recommendation for approval by the Medical Staff Executive Committee, the proposed amendment will be submitted to the Medical Staff for approval. Approval shall be conducted by electronic ballot to all voting members of the medical staff, and shall require favorable vote by two-thirds of the members who have voted within the timeframe allocated for the voting process. The amendment so made shall be adopted when approved by the Governing Body.

ARTICLE XVII: BYLAWS, RULES AND REGULATIONS APPROVAL AND ADOPTION
These Bylaws, together with the appended Rules and Regulations shall be adopted at any regular or special meeting of the Medical Staff and shall replace any previous Bylaws, Rules and Regulations and shall become effective when approved by the Governing Body. Neither body may unilaterally amend the Medical Staff Bylaws.

RECOMMENDED FOR APPROVAL BY THE MEDICAL STAFF ON:

March 29, 2012
Date
Chief of Staff

March 29, 2012
Date
President and CEO
The Hospital cannot and does not practice medicine, and only physicians can practice medicine. Thus, while these rules and regulations may be referred to by physicians and hopefully will be helpful to them, they are in no way binding upon the individual physician in his or her relationship and care for patients.

**GENERAL**

1. These Rules and Regulations are adopted to supplement the Bylaws of the Medical Staff of Scott and White Memorial Hospital and Scott, Sherwood and Brindley Foundation. All practitioners in this institution, upon accepting staff appointment and/or assigned clinical privileges shall abide by these Rules and Regulations. Failure to do so shall constitute a breach of the appointment and/or privilege agreement and subject the offender to such disciplinary action deemed necessary, as provided in the Bylaws of the Medical Staff of Scott and White Memorial Hospital and Scott, Sherwood and Brindley Foundation, as approved and adopted.

2. All Medical Staff members in all departments shall be expected to be familiar with and abide by the Bylaws, Rules and Regulations of the Medical Staff of Scott and White Memorial Hospital and Scott, Sherwood and Brindley Foundation.

3. Application to the Medical Staff and/or requests for clinical privileges will be processed as outlined in Article V and VI. Each practitioner initially applying for Medical staff membership and/or clinical privileges, once application is approved, shall serve a provisional period. All phases of work shall be monitored and periodically reviewed by the appropriate department chairperson, or designee.

4. Medical Staff members appointed to the Active or Courtesy Medical Staff shall have completed an approved residency program and will be board eligible or board certified. Exceptions may be approved by the Department Chairperson and Chief of Staff.

5. The chairperson of each department shall be a member of the Active Medical Staff.

6. All departments shall hold departmental meetings. The Medical Staff members shall be required to attend fifty percent (50%) of the meetings. Minutes of the meetings shall be forwarded to the Medical Staff Executive Committee.

7. Members of the Active and Courtesy Staff may admit patients to the hospital. Active Medical Staff members shall be given priority for non-emergency admissions.

8. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or medical reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible. Practitioners admitting emergency cases shall be prepared to justify to the Chief of Staff and/or Hospital Administration that the emergency admission was medically necessary. The history and physical examination must clearly justify the patient being admitted on an emergency basis, and these findings must be recorded on the patient's record as soon as possible. A practitioner from an appropriate department shall be assigned to the patient in accordance with departmental schedules.
9. Medical Screening Examinations will be performed by qualified medical personnel. “Qualified medical personnel” include physicians [MD/DO], physician assistants, advanced practice nurses and those residents or fellows acting under an appropriately documented Medical Staff member supervision. Appropriate policies, protocols, order sets and clinical competencies, will be established and approved by the medical staff departments to ensure that medical screening examinations are performed appropriately.

10. Areas of restricted bed utilization are:
   - Intensive Care Unit
   - Pediatrics/Nursery
   - Obstetrics
   - Psychiatry
   - Physical Medicine and Rehabilitation
   - Skilled Nursing Facility

   Patients may be admitted without regard to the above restrictions only after consultation with the appropriate department chairperson or designee. The Chief of Staff or Hospital Administration may add, delete, or alter restricted bed utilization when necessary.

11. Members of the Medical Staff are required to support the charitable and emergency patient care and the educational responsibilities of the institution, as assigned by each department chairperson, or designee.

12. All physicians in resident or fellowship training shall be assigned to the appropriate department and will be under the direct supervision of the department chairperson or designee.

13. The term House Staff refers to a Resident participating with an accredited Graduate Medical Education program of Scott & White Healthcare. House Staff may write and/or enter orders for patients if they are providing such medical care under the general supervision of a supervising physician. Orders issued by House Staff may be implemented without the countersignature of the supervising physician. The supervising physician is not required to countersign each order issued by House Staff while operating under the supervising physician’s general supervision.

14. Emergency duty or on-call duty - Provider on-call roster:
   (a) Respective clinical departments, sections, or pertinent sub-specialties provide a monthly call list, providing name of provider and appropriate contact numbers, before the first day of the month.
   (b) Each clinical department, section, or sub-specialty determines requirements for taking ED call for their members. However, 24-hour coverage is mandatory.
   (c) If unavailable, the on-call provider is responsible for ensuring coverage by an appropriate provider of the Medical Staff and for notifying the ED who is to be called.

   Provider responsibilities:
   (a) Be available to provide prompt (within 20 minutes) telephone consultations with Emergency Medicine physicians and other providers utilizing the ED. If the physician on call for the ED anticipates that he/she may be unable to respond to the ED in a timely manner as required, it is his/her responsibility to arrange for back-up coverage.
     i. Escalation in the event a provider on-call does not respond: If the provider fails to
respond to initial attempts to contact him/her (via pager, cell phone, home phone) the Division Director/Chief of Service and/or Department Chairperson will be contacted. If the Division Director/Chief of Service and/or Department Chairperson does not respond, hospital “ESCALATION” Physician and/or Hospital Chief Medical Officer will be contacted.

(b) Provide timely (within 30-minutes) on-site consultation at the request of the Emergency Medicine physician or other provider evaluating a patient in the ED. In the event of dispute, the final decision regarding need for an on-site evaluation rests with the Emergency Medicine physician. In the event the Emergency Medicine physician determines the consultant can see the patient in his private office, the referred patient must be allowed to visit the office at the appointed time regardless of his ability to make payment.

(c) Failure of an attending provider to meet these requirements may result in loss of staff membership or such other disciplinary action.

15. All scheduled absences that involve the duty roster schedule are to be submitted to the appropriate department chairperson or designee at the earliest possible date so that schedules and duty rosters may be arranged to ensure full coverage. The appropriate department chairperson or designee should be notified as soon as possible in the event of emergency or unexpected absences.

16. Attendance requirements for departmental meetings will be outlined in individual departmental Rules and Regulations.

17. Each department shall establish an ongoing quality improvement program designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care and resolve-identified problems. Each department will hold monthly meetings to consider findings from the ongoing monitoring of cases against predetermined quality indicators, discuss any problems noted through the review of patient records and evaluate the quality and appropriateness of care and treatment provided and document findings in the minutes of these monthly departmental meetings. Quality improvement activities will be coordinated with the responsibilities of the Medical Staff Quality Improvement Committee as outlined in Article XI, Section 15, of the Medical Staff Bylaws. 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 the department and reports or communications made to the departments including those described above are confidential and privileged in all respects, and the committee may claim all legal privileges against disclosure and subpoena provided by Texas and Federal law.

18. The department chairperson, with concurrence of the Chief of Staff, will appoint a designee to assume administrative duties in the absence of the department chairperson, division director, or section chief.

19. Patients with communicable diseases will be isolated in accordance with the recommendations of the Center for Disease Control, as published in the current edition of the approved Scott and White Hospital Infection Control Plan. The nurse epidemiologist shall provide information regarding isolation techniques and is authorized to notify the responsible practitioner when the possibility of dissemination of organisms exists. The responsibility for the decision concerning isolation resides with the responsible Medical Staff member.
20. Each practitioner practicing in this hospital by virtue of Medical Staff membership and/or delineation of clinical privileges shall be assigned an appropriate department and shall carry out their activities subject to departmental Rules and Regulations and in conformity with the Medical Staff Bylaws.

- Exercise judgment within their areas of competence, providing a member of the Medical Staff has the ultimate responsibility for oversight of patient care

21. a) An appropriate physician member of the Medical Staff is responsible for the medical care of each patient. Non-physician practitioners, regardless of their medical staff status, shall be permitted to practice within the terms of their licensure, registration, certification, training, and experience only under the supervision or medical direction of an appropriate physician medical staff member.

b) Procedures performed in the ambulatory care setting that may or may not require the use of moderate conscious sedation are not managed by anesthesia. The attending Senior Medical Staff member is responsible to determine the need and/or extent of an appropriate history and physical, based on the condition of the patient and the risk of the procedure to be performed, and in accordance with any related institutional policies.

22. Clinical privileges of a medical staff member may be verified by contacting the appropriate department chairperson or designee. During non-business hours, the Nursing Administrator ("50") on duty will assist in verification of clinical privileges by being responsible to contact the department chairperson or designee or Chief of Staff or Associate Chief of Staff, if necessary.

23. All requests to institute new procedures, change existing procedures or policies shall be directed to and approved in writing by the appropriate department chairperson or designee.

24. Each department will determine policies regarding the granting of clinical privileges. Clinical privileges will be provisionally granted at the time of initial application. These privileges will be monitored and may be modified at the discretion of the appropriate department chairperson, or designee. Clinical privileges will be granted for a two-year (2) period and reviewed biennially.

25. Each department will establish and maintain a Policies and Procedure Manual wherein the clinical privileges for each practitioner in the department are outlined.

26. Standing orders for medication or treatments or procedures to be followed may be formulated by each department with approval of the department chairperson and reviewed as necessary.

27. Contingent upon an order from an approved practitioner for an evaluation and the development of a therapeutic plan of care, licensed physical therapists and occupational therapists, and speech pathologists are authorized by the Medical Staff to write treatment orders, within their scope of practice, as necessary to implement the patient's plan of care for rehabilitative services. Counter signature by a practitioner associated with the patient's care will be obtained within 48 hours of the implementation of the plan of care, if the ordering practitioner is unavailable.

28. The Pharmacy and Therapeutics Committee will formulate and implement an Automatic Stop Order Policy.
HEALTH INFORMATION MANAGEMENT
RULES AND REGULATIONS

1. A member of the Medical Staff shall assure that each patient has a complete and legible medical record. The record may include, but is not limited to, appropriate data required in the care of each patient; and as appropriate, chief complaint, personal history, family history, history of present illness, physical examination, special reports such as consultations, clinical laboratory and radiology services, and others; provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, summary (clinical resume) or discharge note, discharge instructions and autopsy report when performed.

2. Documentation must be present in the medical record that a history and physical examination has been performed, by a qualified licensed practitioner, no more than thirty (30) days prior to an elective procedure or admission. For unscheduled admissions, the H&P must be completed within twenty-four (24) hours after admission, indicating any subsequent changes or no changes. If the H&P was not completed after registration, it must be completed and/or updated immediately prior to a surgery or procedure requiring anesthesia. The pertinent elements of the history and physical may vary by setting or level of care, treatment and service. The elements of the history and physical include current and relevant prior medical history, relevant physical examination, diagnosis or differential diagnosis, and treatment plan. When the history and physical is done as a clinic note, this note may be used as part of the hospital admission documentation. The practitioner performing an H&P prior to admission need not be credentialed and privileged by Scott & White. However, the required update to the H&P upon the patient’s admission (interval H&P) must be performed and authenticated by a member of the Medical Staff who is a Texas licensed physician, according to the privileges granted within 24 hours after admission. In a case where the patient is going to surgery, the interval note and the pre-anesthesia assessment could be accomplished as a combined activity.

3. Pertinent progress notes should be recorded at the time of observation, sufficient to permit continuity of care and transferability. The timeliness of progress notes should be based on the acuity of illness of the patient.

4. Consultation notes should be clearly marked “consultation”, listing the name of the consulting service, and the practitioner who performed the consultation and be authenticated by the practitioner who performed the consultation. The note should contain the nature of the clinical problem being addressed through the consultation, pertinent and physical findings, a diagnosis, if appropriate, and recommendations. There should be documentation by the appropriate medical staff member as to participation in the consultation.

5. A preoperative diagnosis should be recorded prior to surgery. A brief post-operative note will be recorded in the medical record immediately after surgery, containing the following elements:
   - the name of the primary surgeon and assistants,
   - procedures performed and description of each procedure,
   - findings,
   - estimated blood loss,
   - specimens removed,
   - post-operative diagnosis.
A detailed, dictated operative report containing a description of the findings, the
technical procedures used, the specimens removed, the postoperative diagnosis, and the names of the responsible practitioner and assistants performing the procedure should be filed in the hospital record as soon as possible after surgery and authenticated by the surgeon. Minor surgical procedures performed outside the operating room should be clearly documented in the progress notes, by an entry, which contains the pertinent facts and is authenticated by the medical staff member. There should be documentation by the Medical Staff member as to participation in the procedure.

6. Reports of pathology and clinical laboratory examination, radiology and nuclear medicine examinations or treatment, anesthesia records, and any other diagnostic procedures should be completed promptly and filed in the hospital record as soon as possible after completion.

7. The discharge summary (Clinical Resume) should summarize concisely the reason for hospitalization; significant findings, the procedures performed, and treatment rendered; condition of the patient on discharge; final diagnosis; and discharge instructions. The discharge summary should be authenticated by the responsible credentialed Senior Medical Staff member.

8. The Medical Staff should attempt to secure autopsies in all cases of unusual death and of medical-legal and educational interest. Autopsies shall be performed by, or under the supervision of, a pathologist. It is the final responsibility of the pathologist on duty to decide when, if, and under what circumstances autopsies are to be performed. The staff pathologist or designee in charge of the autopsy is responsible for notifying the attending physician of the time the autopsy will be performed. The attending physician or designee is responsible for notifying the residents and medical students on service. The pathologist involved shall have the prerogative of deciding who shall attend the post-mortem examination. Medical-legal autopsies are routinely referred to Medical Examiners. When an autopsy has been performed, the provisional anatomical diagnosis should be recorded on the hospital record within two (2) working days, and the complete protocol should be completed and filed in the hospital record within sixty (60) days unless a special study has been requested.

9. Each user of Electronic Signature Application (ESA) must sign a statement acknowledging that they are the sole user of their ESA assigned password to access, edit and authenticate transcribed reports. These statements are kept on file in Information Systems Security. Original signatures are required on certain documents by regulatory agencies and are listed in a Health Information Management Committee Policy maintained in the Health Information Management Department.

10. The hospital record must be completed within thirty (30) days after the patient is discharged from the hospital. The credentialed Senior Medical Staff member responsible for patient care at the time of discharge is responsible for completion of the hospital medical record.

11. A hospital record should not be permanently filed until it has been completed by the appropriate credentialed Senior Medical Staff member.

12. Records by House Staff and Supervising Physician: There shall be evidence in the medical record that the attending/ supervising physician has been involved in the management of a patient treated by a member of the House Staff.
13. A member of the Medical or Resident Staff should co-sign all orders written by medical students prior to implementation.

14. The hospital record should contain evidence of informed consent for procedures and treatment as required by state law or standards of practice. A list of approved consent forms used at Scott and White Memorial Hospital, in accordance with legal requirements, should be maintained.

15. Patients should be discharged only by a written order of a physician or credentialed member of the Senior Medical Staff. Should a patient leave the hospital against medical advice, or without proper discharge, a notation of the incident should be made in the patient’s hospital record.

16. Whenever patient care responsibilities are transferred to another Medical Staff member, the transferring medical Staff member should immediately enter an order covering the transfer of responsibility to the other medical staff member.

17. All orders for treatment, including verbal orders, should be documented, dated, and signed by the physician/resident writing the order. A verbal order from a physician, although not used routinely, should be considered to be in writing. A verbal order from a physician should be considered to be in writing if dictated to a registered nurse, graduate nurse, licensed vocational nurse, pharmacist, credentialed respiratory therapist, registered dietitian, case managers, utilization reviewers or other personnel as appropriate to their area of responsibility and as authorized by the Medical Staff Executive Committee. Verbal orders/telephone orders must be authenticated within 48 hours of the order being given, but preferably at the time of the next visit of the ordering practitioner, or another practitioner involved in the patient's care, if the ordering practitioner is not available. Telephone orders shall be recorded in the medical record in writing, read back to the practitioner giving the order, signed, and dated by the authorized receiving person.

18. All medical records of patients are the property of the hospital and should not be removed from the hospital premises and facilities except by court order, subpoena, or statute.

19. The use of abbreviations and symbols in the medical record should be minimized by all who document in the medical record and should not include any designated “dangerous” abbreviations. Abbreviations and symbols will not be used when recording final diagnoses and procedures. The Scott & White Memorial Hospital maintains a list of unapproved, dangerous abbreviations.

20. When certain portions of the medical record are so confidential that extraordinary means are considered necessary to preserve their privacy, these portions may be stored separately, provided the complete medical record is readily available when required for current medical care or follow-up, for review functions, or for use in quality improvement activities. The medical record should indicate that a portion has been filed elsewhere, in order to alert authorized reviewing personnel of its existence.

21. Medical Staff members who admit patients to the Skilled Nursing Facility will abide by the policies outlined in the document entitled, “Scott and White Santa Fe Center Skilled Nursing Facility Policy”.

Rules & Regulations 7
DEPARTMENT OF ANESTHESIOLOGY
RULES AND REGULATIONS
1. The Chairperson of the Department of Anesthesiology or designee is responsible for clinical anesthesia delivery as delineated in the Department's Policy and Procedure Manual.
2. The Policy and Procedure Manual of the Department of Anesthesiology shall be reviewed and approved annually by the Medical Staff Executive Committee in accordance with TJC recommendation.
3. A program of continuous improvement will be maintained by the Department of Anesthesiology.

DEPARTMENT OF EMERGENCY MEDICINE
RULES AND REGULATIONS
1. Any patient presenting to the Emergency Medicine Department will be evaluated and, in case of an emergency, treatment will be rendered, unless refused by a mentally competent patient who understands the consequences of his/her refusal.
2. The Emergency Medicine Department will be staffed twenty-four (24) hours a day by a physician member of the Medical Staff who is board certified/board eligible in Emergency Medicine or an appropriate specialty. This physician will remain within the confines of Scott and White when on duty.
3. The Emergency Medicine Department Medical Staff physician has primary responsibility for the care of all patients in the Emergency Medicine Department. This responsibility ends when the patient is admitted to the hospital, discharged from the Emergency Medicine Department, or when primary care is transferred to another specialty service.
4. The Emergency Medicine Department Medical Staff physician on duty shall supervise the activities of the resident staff, students, and health care practitioners working in the department and oversee patient care rendered.
5. In addition to Emergency Medicine Department staff, other Scott and White Medical Staff members may see their patients in the Emergency Medicine Department and have the right to use department facilities and personnel to assist them in patient evaluation & care.
6. When the care of a patient is transferred from the Emergency Department to another service, that service becomes responsible for the disposition of the patient.
7. A Quality Improvement Program will be maintained by the Department of Emergency Medicine.

DEPARTMENT OF FAMILY MEDICINE
RULES AND REGULATIONS
1. Each member of the Department of Family Medicine shall consult appropriate departments when clinically indicated.
2. The Department of Family Medicine will be in compliance with the Infection Control Policy on the Labor and Delivery Suite as adopted by the Department of Obstetrics and Gynecology.
3. A list of privileges and procedures for the Department of Family Medicine will be maintained by the department chairperson or designee.
4. A Quality Improvement Program will be maintained by the Department of Family Medicine.
DEPARTMENT OF MEDICINE
RULES AND REGULATIONS
1. Application for membership in the Department of Medicine must be accompanied by a request for clinical privileges. Members of the department desiring clinical privileges will complete the clinical privilege form at the time of initial application. The directors of the divisions within the Department of Medicine will serve as the Department of Medicine Credentials Committee and will make recommendations regarding the granting of clinical privileges to the hospital Credentials Committee. Modification of clinical privileges may be made by the chairperson of the department as outlined in the Bylaws.
2. Specialized tests, including their interpretation, performed in the following laboratory areas should be under the direction and supervision of the respective division director, section chief, or designee.
   - Cardiology
   - Pulmonary physiology
   - Special hematology
   - Gastroenterology, Physiology
   - Allergy
   - Nephrology
   - Endocrinology
3. A Quality Improvement Program will be maintained by the Department of Medicine.

DEPARTMENT OF NEUROLOGY
RULES AND REGULATIONS
1. The Chairperson of the Department of Neurology, or designee, shall serve as director of the Neurology In-Patient Service and director of the Neurology laboratory.
2. Only members of the Active or Courtesy Medical Staff of the Department of Neurology may admit patients directly to the Neurology Service. Other practitioners wishing to arrange such admissions must first obtain permission from a member of the Active Neurology Medical Staff.
3. A list of clinical privileges and procedures will be maintained by the department chairperson or designee for each member of the Department of Neurology.
4. A Quality Improvement Program will be maintained by the Department of Neurology.

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
RULES AND REGULATIONS
1. All members of the Medical Staff of the Department of Obstetrics and Gynecology shall abide by the Rules and Regulations of the Department of Surgery as related to activities in the Surgical Suite.
2. Applications for membership in the Department of Obstetrics and Gynecology must be accompanied by a request for clinical privileges and procedures. A list of clinical privileges and procedures granted will be maintained by the department chairperson, or designee, for each member of the Department of Obstetrics and Gynecology.
3. A Policies and Procedure Manual for the Department of Obstetrics and Gynecology shall be maintained by the department chairperson or designee.
4. Termination of pregnancy prior to the time of expected infant survival shall be handled in accordance with the laws of the State of Texas.
5. A Quality Improvement Program will be maintained by the Department of Obstetrics/Gynecology.
DEPARTMENT OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE
RULES AND REGULATIONS
1. Each member of the Department of Occupational and Environmental Medicine shall consult appropriate departments when clinically indicated.
2. A list of policies and procedures for the Department of Occupational and Environmental Medicine will be maintained by the department chairperson or designee.
3. A Quality Improvement Program will be maintained by the Department of Occupational and Environmental Medicine.

DEPARTMENT OF ORTHOPAEDIC SURGERY
RULES AND REGULATIONS
1. A list of surgical subspecialty privileges and procedures will be maintained for each individual with clinical privileges in the Department of Orthopaedic Surgery. When indicated by the patient’s condition, appropriate consultations should be obtained.
2. Members of the Department of Orthopaedic Surgery utilizing sedation techniques will have read the approved policy on sedation and maintain privileges in the techniques.
3. A Quality Improvement Program will be maintained by the Department of Orthopaedic Surgery.

DEPARTMENT OF PATHOLOGY
RULES AND REGULATIONS
1. The extent of clinical privileges within the Department of Pathology may be limited by one’s training in the two basic Divisions of Pathology (Anatomic and Clinical) and within the subspecialties of Pathology. This will basically follow the requirements provided by the American Board of Pathology for certification.
2. A Quality Improvement Program will be maintained by the Department of Pathology.
3. Clinical laboratory testing for which the Department of Pathology is responsible will be performed in compliance with all federal regulations currently in force, to include:
   a. Proficiency testing program for all regulated analyses.
   b. Quality control of equipment, reagents and materials.
   c. Acceptable test methods, procedure manuals, test verification, calibration, control procedures and corrective actions.
   d. Requirements for specimen submission and handling test requisitions, records and reports and specimen referral.
   e. Qualified personnel with documentation of competence.
   f. Safety policies and procedures.

DEPARTMENT OF PATHOLOGY
DIVISION OF ANATOMIC PATHOLOGY
RULES AND REGULATIONS
1. A pathologist will be available for consultation at all times during usual operating room hours and on an on-call basis at other times.
2. At the request of the surgeon or other clinicians, pathologists and pathology residents may consult with responsible representatives of the patient undergoing surgery.
3. The decision to utilize procedures such as frozen sections, special histochemical stains, electron microscopy, tissue cultures, immunologic techniques and others in the study of specimens is the responsibility of the pathologists.
4. Consultative services at other health facilities or on specimens removed elsewhere will be done in accordance with the policies established by Scott and White Memorial Hospital and with consideration of ethical concepts of appropriate medical organizations such as the Texas Society of Pathologists.
5. The Medical Staff, in consultation with the pathologists, shall decide when certain
tissues and materials removed from the patient do not warrant gross or microscopic examination by the pathologist, and a written list will be maintained in the Department of Pathology and other appropriate departments. A similar list will designate these and other specimens, which need only gross description and gross diagnosis. Verification of the removal of specimens not submitted shall be documented in the medical record by a clinician. Foreign bodies (for example, bullets) and specimens, which at the time of surgery are known to have legal significance, will be placed in safe keeping and given directly in chain of custody to law enforcement personnel.

6. Necropsies
- Shall be performed by or under the supervision of a pathologist. It is the final responsibility of the pathologist on duty to decide when, if, and under what circumstances autopsies are to be performed. The staff pathologist or designee in charge of the autopsy is responsible for notifying the attending physician of the time the autopsy will be performed. The attending physician or designee is responsible for notifying the residents and medical students on service.
- The pathologist involved shall have the prerogative of deciding who shall attend the post-mortem examination.
- Medical-legal autopsies are routinely referred to Medical Examiners.

7. All gynecologic smears with abnormal findings and all non-gynecologic smears are to be reviewed by a pathologist.

8. Molecular/genetic studies are available. These reports will be handled in compliance with the ethical guidelines of the institution.

9. Safety regulations involving fire, electricity, disposal of infective biological materials and electron microscope radiation hazards, and other significant laboratory hazards will be written and enforced and reviewed annually.

10. Reports will be rendered on a timely basis utilizing, as guidelines, recommendations by accrediting agencies.

11. Retention of records and specimens will meet those recommended by the appropriate agencies.

DEPARTMENT OF PATHOLOGY
DIVISION OF CLINICAL PATHOLOGY
RULES AND REGULATIONS

1. The Division of Clinical Pathology is responsible for providing a comprehensive schedule of medically indicated chemical, hematological, serological, immunological, and microbiological tests. Testing and appropriate interpretation will be accomplished promptly and proficiently. Educational facilities will be made available for professional, resident, and clinical staff, as well as any affiliated education programs. Research and development facilities, particularly when related directly or indirectly to patient evaluation needs, will be provided.

2. The Chairperson of the Department of Pathology and the director of the Division of Clinical Pathology will be responsible for assuring that sufficient personnel, space, equipment, and supplies are available to perform testing properly.

3. During regular working hours and during non-duty or on-call hours, the various sections of this division will provide competent professional staffing for the purpose of both technical and clinical consultation. To this end, a duty roster of residents and Medical Staff members on call will be maintained by the division director.

4. The professional staff on duty will be directly responsible for making technical and professional decisions and for initiating actions as deemed essential and necessary during their tour of duty. Their action in these matters will be governed by:
   - Institutional policy
   - Departmental and/or Divisional Rules and Regulations.
   - Departmental, Divisional, and Sectional Policies and Procedures
5. The professional laboratory staff is responsible for determining test procedures adopted and the techniques employed. Medical Staff practitioners should be encouraged to offer observations and suggestions, but the final decision as to the most satisfactory method for the performance of any given test rests with the division director.

6. The Medical Staff will determine which, if any, laboratory studies are routinely required on admission of a patient.

7. The decision for types of tests to be requested in the evaluation of any given patient is the responsibility of the attending Medical Staff practitioner. However, it is the duty of the laboratory staff to review all test results and to offer to the requesting practitioner-pertinent observations, suggestions, or recommendations that may be useful in clarification, verification, or more precise interpretation of the results obtained.

8. In the capacity of a reference laboratory, the representatives of this division are authorized and expected to supervise technical performance of procedures and to provide appropriate consultation or interpretation for laboratory work performed on patients not registered in this hospital.

9. The professional staff of the laboratory may, at their discretion, elect to perform analyses of a different nature or type from those originally requested by the practitioner, in order to clarify test findings. Whenever possible, this should be done with the consent and cooperation of the requesting practitioner.

10. The Division of Clinical Pathology Policy and Procedure Manual will contain detailed information regarding:
   - STAT laboratory procedures
   - Laboratory tests requisitions
   - Methods of specimen procurement
   - Transmission of written reports of laboratory tests
   - Criteria for immediate notification of test results in excess of critical limits
   - Verification of reports and placement of reports on the medical record
   - Reporting of reference laboratory results
   - Obtaining reference laboratory approval
   - Maintenance of records for specimen accession and copies of reports
   - Availability of test reports and/or log book records.

11. A member of the staff of the Division of Clinical Pathology shall be designated by the director of the division, with concurrence of the chairperson of the Department of Pathology, as Quality Improvement Officer.

12. A member of the staff of the Division of Clinical Pathology shall be designated by the director of the division, with concurrence of the chairperson of the Department of Pathology, as Laboratory Safety Officer.

13. It is the responsibility of all members of the supervisory and professional laboratory staffs of all sections, in cooperation with the Laboratory Safety Officer, to investigate and institute any and all practical safety measures or precautions.

14. Standards of blood bank operation must meet or exceed those specified by the current "Standards for Blood Banks and Transfusion Services", of the American Association of Blood Banks and shall conform to existing state and/or federal regulations. Blood Bank policies and procedures must be in writing and be reviewed annually by the chief of the Section of Blood Bank, or designee. These policies and procedures should also conform to standards for Blood Transfusion Services of TJC.

15. Particular attention is to be given the current American Association of Blood Banks’ recommendations and standards for choosing blood donors and blood products. Any deviation from donor standards as indicated by the American Association of Blood Banks must be approved by the section Chief of the Blood Bank. Any and all policy
changes will be in accord with prevailing standards of blood banking and the practice of medicine and must be approved in writing by the section chief of the Blood Bank.

16. Reference laboratories shall be recommended by the chairperson of the Department of Pathology, with concurrence of the Medical Staff Executive Committee.

DEPARTMENT OF PEDIATRICS
RULES AND REGULATIONS

1. Applications for Medical Staff membership in the Department of Pediatrics must be accompanied by a request for clinical privileges. The chairperson of the Department of Pediatrics and/or the directors of the divisions within the Department of Pediatrics will be responsible for determining procedure privileges for all individuals requesting clinical privileges in the Department of Pediatrics. Modification of privileges may be made by the chairperson of the Department of Pediatrics with approval of the Governing Body.

2. All patients who are admitted to the hospital with serious diseases or conditions or who require specialized tests in the following areas of subspecialties may require consultation by the subspecialty division director or designee. These include:
   - Pediatric Cardiology
   - Pediatric Neurology
   - Pediatric Gastroenterology
   - Pediatric Hematology/Oncology
   - Child Development
   - Pediatric Nephrology
   - Pediatric Endocrinology
   - Pediatric Allergy
   - Pediatric Pulmonology
   - Pediatric Infectious Diseases
   - Neonatology
   - Pediatric Intensive Care
   - Genetics
   - Pediatric Psychiatry/Psychology
   - Adolescent Care

Additions or deletions to this list may be made by the chairperson of the Department of Pediatrics with the approval of the Governing Body without the necessity of amending these Rules and Regulations.

3. The chairperson of the Department of Pediatrics or designee shall serve as director of the Pediatric In-Patient Services, including the Newborn Intensive Care Unit, Special Care Nursery, Routine Nursery, Pediatric Intensive Care Unit, and the Pediatric Ward Units.

4. Only members of the Active or Courtesy Medical Staff of the Pediatric Department may admit patients directly to the Pediatric Services. Others finding such admission necessary must first obtain permission from the chairperson of the Department of Pediatrics or the staff attending pediatrician on the appropriate in-patient service.

5. Members of the pediatric staff shall be expected to follow recognized and approved modalities of therapy. The use of any new or innovative therapy or procedure must be approved by the chairperson of the Department of Pediatrics prior to the institution of such procedure.

6. The chairperson of the Department of Pediatrics or designee may dismiss any patient at any time from any pediatric service if a more urgent need for the bed exists. However, such action must be with the concurrence of the pediatric director of the appropriate in-patient service or the pediatrician attending the service at that time.

7. A Quality Improvement Program will be maintained by the Department of Pediatrics.
DEPARTMENT OF PHYSICAL MEDICINE AND REHABILITATION
RULES AND REGULATIONS
1. The department chairperson or designee will maintain a list of clinical privileges for the Department of Physical Medicine and Rehabilitation.
2. A Quality Improvement Program will be maintained by the Department of Physical Medicine and Rehabilitation.

DEPARTMENT OF PSYCHIATRY
RULES AND REGULATIONS
1. The Department of Psychiatry’s Hospital Service is designated as the in-patient service. The activities of this service are under the immediate supervision of the Medical Director of Psychiatric In-Patient Services.
2. The Medical Director of Psychiatric In-patient Services shall be a member of the Active Medical Staff in the Department of Psychiatry appointed to the positions by the Chairperson of the Department of Psychiatry.
3. Only a physician member of the Active Medical Staff of the Department of Psychiatry may admit a patient directly to the psychiatric unit.
4. No patient may be admitted to the psychiatric unit without the approval of a member of the Active Medical Staff of the Department of Psychiatry.
5. All patients entering the Scott and White In-Patient Psychiatric Unit receive multi-disciplinary treatment plans supervised by their own personal psychiatrist.
6. All members of the department shall follow recognized and approved modalities of therapy. Any new or innovative therapy must be approved by the Medical Director of the In-Patient Psychiatric Service prior to institution of such therapy.
7. The In-Patient Milieu Therapy Program shall be under the direction of the director of the In-Patient Psychiatric Service.
8. Electroconvulsive therapy shall be administered only by the designated Electroconvulsive Therapy Team and according to procedures established for this treatment. The Medical Director of the In-Patient Psychiatric Service must approve any exceptions on a case-by-case basis.
9. The Medical Director of In-Patient Psychiatric Service or the Psychiatrist-on-call may dismiss any patient from the in-patient service at any time if, in his or her opinion, a more urgent need for the bed exists, provided proper notation is made on the patient’s medical record.
10. No member of the Department of Psychiatry shall perform a psychological or psychiatric evaluation on any member of the staff wherein such evaluation is necessary to function in a designated position, unless the Chairperson of the Credentials Committee and the Chairperson of the Department of Psychiatry are in agreement on the proposed evaluation. Special psychiatric treatment procedures requiring special justification:
   • Restraint or seclusion
     ▪ A time limit order from a psychiatrist is written within one (1) hour after the initial use of restraint or seclusion
     ▪ In critical situations when a patient presents a danger to self or others, the Charge Nurse may emergently initiate seclusion or restraint, but the primary psychiatrist or psychiatrist on-call will be immediately notified
     ▪ Nurses will document every fifteen (15) minutes that the needs of the patient are attended to, including meals, bathing, and requests for use of the toilet
   • Electroconvulsive therapy
     ▪ Prior to initiating electroconvulsive therapy in adults, informed written consent will be obtained from the patient. Risks and benefits of the procedure will be explained to the patient prior to obtaining informed consent and initiating

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electroconvulsive therapy

- Scott and White Memorial Hospital does not provide electroconvulsive therapy to children or adolescent patients under the age of sixteen (16) years

**Psychosurgery**

- Before initiating psychosurgery, two qualified psychiatrists (including one not directly involved in the treatment of the patient) will examine the patient and document in the patient's medical record, the failure of all reasonable therapeutic approaches tried previously
- Surgical consultation from a neurosurgeon experienced in psychosurgery will be obtained, and the surgery will not be undertaken without the unanimous consent of all three (3) examining physicians and with the patient's informed consent

**Behavior modification procedures that use aversive conditioning**

- Two (2) separate qualified psychiatrists (including one not directly involved in the care of the patient) will examine the patient and document in the patient's medical record, the failure of all reasonable, previously attempted therapeutic interventions, and record their concurrence in administration of such therapy
- Risks and benefits of the aversive therapy proposed will be explained and discussed with the patient, and informed written consent will be obtained prior to initiating aversive therapy

**DEPARTMENT OF RADIOLOGY**

**RULES AND REGULATIONS**

1. The Quality Improvement Program for each division shall be reviewed by the Quality Improvement Committee and reported semi-annually at department meetings.
2. Members of the Department of Radiology shall perform a majority of their consulting services as referrals from members of the Active Medical Staff of Scott and White Memorial Hospital.
3. Radiation protection procedures shall be in accordance with the adopted procedures of the Radiation Committee of Scott and White Memorial Hospital and Scott, Sherwood and Brindley Foundation as promulgated by the Texas Regulations for Control of Radiation and approved by the Texas Department of State Health Services, and as outlined in the Radiation Protection Procedures of Scott and White Memorial Hospital. The Radiation Safety Officer shall determine that these procedures are being adhered to as required by these documents.
4. All special diagnostic and/or treatment procedures shall be scheduled through the department chairperson or designee by department personnel so authorized, with priority for routine procedures given to Active, Courtesy, and Consulting Medical Staff, in that order.
5. Special preparation of the patient for any diagnostic or treatment procedure shall be as outlined in the various department and nursing directives.
6. Committees necessary to insure the best possible patient care and service available and dedicated to excellence in care of patients, in education of trainees, in stimulation of the Medical Staff, and in assimilating new procedures and improving presently used techniques shall be appointed by the department chairperson. These committees shall consist of:
   - Capital Equipment Committee
   - Education Committee
   - Research Committee
   - Quality Improvement Committee

   Additional committees may be appointed by the department chairperson, as necessary.
7. A duty roster shall be prepared by the division director, section chief, or designee, to
provide needed services during non-regular working hours.

8. The Infection Control Policy for the Department of Radiology shall be maintained with the Department Procedures Manual.

**DEPARTMENT OF SURGERY RULES AND REGULATIONS**

1. A list of surgical subspecialty privileges and procedures will be maintained for each individual with clinical privileges in the Department of Surgery. When indicated by the patient's condition, appropriate consultations should be obtained.

2. Only members of the professional staff and operating room employees will be allowed in the operating suite. All visitors must be cleared by the Director of Perioperative Services, Chairperson of the Department of Surgery, and the Chairperson of the Department of Anesthesiology, or designee.

3. No surgical procedure shall be performed in the operating room, except in an emergency, without the written consent of the patient or a legally authorized representative. It shall be the duty of the operating surgeon to ascertain that an informed consent recorded on the appropriate document has been properly obtained prior to beginning an operation.

4. When sterilization is requested by a patient or recommended by a physician, the same rules and regulations shall apply and be followed as for sterilization as outlined in the Department of Obstetrics and Gynecology Rules and Regulations.

5. Specimens removed at surgery shall be submitted for gross and microscopic examination, as appropriate, by a qualified pathologist except those specifically identified.

6. Specimens removed during surgical procedures not requiring a pathologist's evaluation have been identified by each subspecialty and a list has been provided to the Department of Pathology and is maintained in Perioperative Services.

7. The disposition of all specimens shall be recorded in the permanent medical record.

8. Members of the Department of Surgery utilizing sedation techniques will have read the approved policy on sedation and maintain privileges in the techniques.

9. A Quality Improvement Program will be maintained by the Department of Surgery.

**Departments, Divisions, and Sections**

Scott and White Memorial Hospital practitioners are assigned to a Department and/or Division and/or Section based on their designated practice specialty. Designated Departments maintain Rules and Regulations governing the practices of the practitioners assigned therein. Divisions and Sections are updated as needed and maintained by Medical Staff Services in the Medical Staff Organization Structure.
G L O S S A R Y

CLINICAL PRIVILEGES . . . permission to provide medical or other patient care services in the hospital, within well-defined limits, based on the individual's professional license and experience, competence, ability, and judgment

DENTIST . . . Individual who has received a doctor of dental surgery or doctor of dental medicine degree and is currently fully licensed to practice dentistry

MEDICAL STAFF MEMBERSHIP . . . Appointment to the Medical Staff of the hospital confers on the individual all the rights and responsibilities of Medical Staff membership; does not imply automatic granting of clinical privileges

MOONLIGHTING . . . Licensed independent practitioners in an area unaffiliated with the primary training program.

NON-PHYSICIAN PRACTITIONER . . . An individual who is licensed, registered, or certified to provide patient care independently and is not a physician

PHYSICIAN . . . An individual who has received a doctor of medicine or doctor of osteopathy degree and is currently fully licensed to practice medicine

PRACTITIONER . . . An individual who is licensed, registered, or certified to provide patient care independently or dependently

SUPPORT HEALTH CARE PRACTITIONERS . . . Individuals other than members of the Medical Staff who have responsibilities and provide patient care or services dependently within the scope of their licensure, registration, and certification