



CHRISTUS MOTHER FRANCES HOSPITAL - JACKSONVILLE

Medical Staff Amended & Restated Medical Staff Bylaws

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Definitions

1. The term Administrator means the individual appointed by the Governing Board to act on its behalf in the overall management of the Hospital.
2. Affected Member or Affected Practitioner means a member of the Medical Staff against whom a corrective action has been requested, recommended, or taken.
3. The term Allied Health Professional is defined as an individual, not a member of the Medical Staff, who is trained in some aspect of the evaluation or treatment of human illness and who is allowed, after approval by the Medical Executive Committee and appointment by the Governing Board of the Hospital, to perform specific services to patients under the responsibility and supervision of a Medical Staff member.
4. Bylaws or Medical Staff Bylaws means the Amended, Restated, and Adopted Medical Staff Bylaws of the Hospital.
5. The term Medical Executive Committee means the Executive Committee of the Medical Staff unless specific reference is made to the Executive Committee of the Governing Board.
6. The term Governing Board means the Governing Board of the Hospital.
7. Hospital shall mean CHRISTUS Mother Frances Hospital – Jacksonville.
8. The term Organized Medical Staff is defined as the group of healthcare professionals who have been granted appointment to the Medical Staff by the Governing Board and have the right to vote on adopting and amending these Bylaws, the Rules and Regulations, and the Hospital policies and procedures related to Medical Staff processes and patient care. The organized Medical Staff is a self-governing entity accountable to the Governing Board.
9. The term Professional Member or Licensed Independent Practitioner means an appropriately licensed medical physician, or an appropriately licensed dentist, or an appropriately licensed podiatrist with current licensure.

ARTICLE I: NAME

The name of this organization shall be the CHRISTUS Mother Frances Hospital – Jacksonville Medical Staff.

ARTICLE II: PURPOSES

The purposes of this organization are:

1. To provide oversight for a uniform quality of care, treatment and services provided by the practitioners who are credentialed and privileged through the medical staff process;
2. To set forth the process and criteria for the credentialing, privileging and evaluating the competency of all physicians, licensed independent practitioners and Allied Health Staff;
3. To provide leadership in performance improvement activities, to improve quality of care, treatment and patient safety;
4. To establish a framework for how the Medical Staff will organize and govern its affairs;
5. For the purpose of these Bylaws, the medical staff year commences on the first day of January each year.

Under no circumstances should these Bylaws and/or Rules and Regulations be interpreted as the standard of care or as any indicia of standards of care for the members of the Medical Staff in the care and treatment of patients.

ARTICLE III: MEDICAL STAFF MEMBERSHIP

SECTION 1. Nature of Medical Staff Membership

Membership on the Medical Staff of CHRISTUS Mother Frances Hospital - Jacksonville is a privilege, which shall be extended only to competent professionals who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated policies of the Medical Staff and Hospital.

SECTION 2. Qualifications for Membership

- a. Only professionals with a Doctor of Medicine or Doctor of Osteopathy degree, dentists, or podiatrists holding a license to practice in the state of Texas, and who have sufficient postgraduate training in a program accredited by the Accreditation Council on Graduate Medical Education, American Osteopathic Association Bureau of Professional Education, Council on Education of the American Podiatric Medical Association, American Dental Association, and, if applicable, holding a certificate by the Education Council of Foreign Medical Graduates, who can document evidence of three critical parameters; current licensure; education and relevant training; and professional experience, physical ability and current clinical competence to perform the requested privilege and to carry out patient activities.

Applicants for membership to the Medical Staff must meet at least one of the following criteria: a) Board certification granted in the specialty area in which primary clinical privileges are requested by a national board recognized by the Medical Executive Committee; or (b) participation in the process of becoming board certified in the specialty area in which primary clinical privileges are requested by a national board recognized by the Medical Executive Committee. Current members of the Medical Staff who fail to maintain their board certification are allowed two (2) years to renew from the date of expiration. Exceptions and/or waivers may be requested by the Section Chief in collaboration with the President of the Medical Staff and the Administrator and approved by the Governing Board.

This process will include an assessment for proficiency in the following six areas of General Competencies adapted from the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative: patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practitioner.

All applicants shall provide assurance to the Medical Staff and Governing Board that any patient treated by them will be given a high quality of medical care, shall be qualified for membership on the Medical Staff.

- b. Any applicant for staff membership shall provide current evidence of professional liability insurance and tail coverage. This policy must provide at a minimum an individual policy for the practitioner. The type, amount and duration of coverage shall be determined by the Governing Board upon recommendation of the Medical Executive Committee. If there is a disagreement, the difference shall be decided by a joint committee composed of an equal number of members from the Governing Board and the Medical Executive Committee.
- c. Any applicant for staff membership must have a current and unrestricted license to practice in the State of Texas and, when required by the practitioner's field of practice, unrestricted registration numbers from the U.S. Drug Enforcement Agency ("DEA") and Texas Department of Safety ("DPS").
- d. Applicants shall not be denied membership and/or clinical privileges on the basis of sex, race, creed, color or national origin, disability, or on the basis of any other criteria, lacking professional justification.
- e. Acceptance of membership on the Medical Staff shall constitute the staff member's agreement to abide by the Principles of Medical Ethics of the American Medical Association, or the American Osteopathic Association Bureau of Professional Education, or by the Code of Ethics of the American Dental Association, or the American Podiatric Medical Association, whichever is applicable, and the Ethical and Religious Directives for Catholic Health Care Services and the Medical Staff Bylaws, Rules and Regulations as well as any Hospital policies and procedures.

SECTION 3. Conditions and Duration of Appointment

- a. Initial appointments and reappointments to the medical staff shall be made by the Governing Board. The Governing Board shall act on appointments, reappointments, and 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 Board may act without such recommendation on the basis of documented evidence of the applicant's or staff member's professional and ethical qualifications obtained from reliable sources other than the medical staff.
- b. A Focused Professional Practice Evaluation (FPPE) shall be initiated for each initial applicant. Practitioners must comply with and actively participate in FPPE. The evaluation should be completed within 3-6 months of initiation of clinical activity (unless there is insufficient clinical data to access

competency). The department chair/section chief or appointed active staff member will review and approve the completed FPPE.

- c. Appointment to the medical staff shall confer on the appointee only such clinical privileges as have been granted by the Governing Board in accordance with these Bylaws.
- d. Appointment to the medical staff shall also confer a requirement for unassigned Emergency Room call coverage. Each member of the Active Category Medical Staff shall have an obligation to participate in the unassigned Emergency Room call according to the limitations of his/her clinical competence and privileges. Exemption from emergency room call coverage may be made at the discretion of the Medical Director, in conjunction with the Medical Executive Committee, or on the basis of illness as determined by the Medical Executive Committee, or at the age of sixty (60) with ten (10) years continuous Active Category Staff service. The on-call physician must be able to arrive at the hospital within thirty (30) minutes of being called, which requires residence within a reasonable distance from the Hospital. This requirement is designed to ensure that the hospital has physicians available to meet the needs of patients with emergency medical conditions as well as to meet the needs of patients without an established physician.
- e. Each applicant shall sign an application for staff appointment, and shall specifically acknowledge the obligation as a staff member to provide continuous care and supervision of patients, to abide by the Medical Staff Bylaws, Rules and Regulations
- f. Certifications and supporting documentation, which relate to the practitioner's specialty, must be provided at the time of reappointment. Failure to provide documentation and certification of continuing medical education upon request of the Medical Staff Office shall result in disciplinary action up to and including loss of staff membership and privileges.

SECTION 4: History and Physicals

Each practitioner with privileges shall prepare and complete in timely fashion, according to medical staff and Hospital policies, the medical and other required records for all patients to whom the practitioner provides care in the Hospital, or within its facilities, clinical services or departments.

- a. A medical history and physical examination shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, (an oral and maxillofacial surgeon, dentist, podiatrist), or other qualified licensed individual in accordance with State law and Hospital policy.
- b. An updated examination of the patient, including any changes in the patient's condition, be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, (an oral and maxillofacial surgeon, dentist, podiatrist), or other qualified licensed individual in accordance with State law and Hospital policy.
- c. The content of complete and focused history and physical examinations is delineated in the rules and regulations.

SECTION 5. Notice of Adverse Actions and Changes in Liability Insurance

Members must provide immediate notice to the President of the Medical Staff of the following: (a) change in or loss of professional liability insurance coverage; (b) an adverse license action in any jurisdiction; (c) adverse credentialing action at any hospital that is reportable to the National Practitioner Databank; (d) exclusion from the Medicare, Medicaid, TRICARE, or any government funded health care program; (e) conviction of a felony; (f) the filing or service of any professional liability demand letter or lawsuit; (g) the settlement of or judgment in any malpractice action, regardless of the amount; (h) voluntary surrender of privileges with any health care facility; (i) the entry into an order with any licensing board whether public, non-public, voluntary, agreed, disciplinary or non-disciplinary; (j) the initiation of formal action against the practitioner relating to the treatment of a patient, professional conduct, or professional competence of the practitioner by any professional licensing board, the DEA, the U.S. Food and Drug Administration, Medicare, Medicaid, TRICARE or any government funded health care program for matters relating to the practitioner's professional competence, professional conduct or billing practices.

SECTION 6: Leave of Absence

A leave of absence may be granted for not more than one (1) year with the staff member retaining current staff status. Leave of absence must be requested in writing with the staff member stating specific reason(s), the beginning date, and the requested duration. Prior to returning from an approved leave of absence it is the responsibility of the staff member to submit a letter confirming completion of the leave of absence. In case of leave of absence of more than one (1) year, the staff member must reapply for medical staff membership.

In circumstances when the leave of absence is due to illness, incapacity, or impairment or other causes that could affect the practitioner's ability to fully and competently exercise the scope of practice or scope of service granted, reinstatement is conditioned upon a showing that:

- (1) The practitioner has submitted to the Medical Executive Committee a written request for reinstatement at least 30 days prior to the expiration of the leave, and demonstrated that the reasons for the leave will no longer exist by the expiration of the leave or by the requested date for reinstatement;
- (2) In case of impairment, the practitioner must present a letter of release from the his/her personal physician, and, as may be required by the Medical Executive Committee, an agreement for ongoing treatment or therapy, a treatment plan from a treating physician, and the practitioner's agreement for random testing, if applicable;
- (3) The practitioner currently meets all of the qualifications for membership set forth in this Manual;
- (4) The practitioner has submitted such other information as requested by the MEC, or the Governing Board.

No reinstatement of a leave granted under (b) above shall be effective until approved by the Governing Board upon the recommendation of the MEC.

SECTION 7: Resignation

It is the responsibility of any Medical Staff member to submit a letter of resignation when resigning from the Medical Staff.

ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

SECTION 1. The Medical Staff

The Medical Staff shall be divided into Active and Courtesy Categories.

SECTION 2. The Active Category Medical Staff

The Active Category Medical Staff shall consist of practitioners who regularly admit patients, provide consultations, and/or use Hospital facilities to perform procedures and deliver patient care according to the limitations of his/her clinical competence and privileges. Additionally, all provider-based Trinity Clinic physicians shall belong to this category although they may choose to delegate in-patient responsibilities to the physician of their choice who has Active membership and appropriate privileges.

Members of the Active Category Medical Staff shall:

- Meet the qualifications of membership, in accordance with Article III, Section 2
- Be appointed to a specific department
- Be eligible to vote, to hold office and to serve on medical staff committees
- Assume responsibility for governance of the Medical Staff in accordance with these Bylaws
- Perform oversight activities of the organized medical staff
- Practice only within the scope of their privileges granted by the governing board
- Provide leadership in activities related to patient safety
- Provides oversight in the process of analyzing and improving patient satisfaction
- Participate in performance improvement activities, clinical programs, and Hospital operational projects and provide medical expertise and direction in such activities as appropriate
- Be required to participate in one (1) of their assigned Department meetings, at any CHRISTUS Mother Frances hospital (Jacksonville, Tyler, Winnsboro). Assignment and participation in a medical staff peer review committee shall be considered as meeting this requirement.
- Be required to participate in one (1) hour of risk management / Ethics CME. This one (1) hour of risk management CME may be through attendance at one of the risk management offerings by CHRISTUS Mother Frances Hospital – Jacksonville or through another formal risk management course approved/endorsed by a professional liability insurance carrier.

Active Category members must have at least ten (10) patient encounters at CHRISTUS Mother Frances Hospital – Jacksonville during each two-year reappointment period.

SECTION 3. The Courtesy Category Medical Staff

The Courtesy Category Medical Staff shall consist of those members who shall be privileged to admit and/or consult on a limited basis. Courtesy Category members must have no more than ten (10) patient encounters at CHRISTUS Mother Frances Hospital – Jacksonville in each two-year reappointment period. Examples of Courtesy Category Medical Staff are:

- a. Ten (10) years of continuous Active Category Medical Staff service
- b. Reasons of health
- c. Duty with the Armed Forces
- d. Extenuating circumstances acceptable to the Department and/or Medical Executive Committee.

Courtesy Category membership and privileges are defined as being:

- Time-limited as defined by the Medical Executive Committee
- Procedure specific to meet a specific patient care need with a defined limit on patient encounters
- Each procedure request shall be reviewed by the department and/or section and forwarded to the Medical Executive Committee for action
- Shall provide continuous coverage for the patient during their hospitalization; or in the alternative shall specify the name of the practitioner with comparable privileges who will cover call
- May not hold office
- May not vote
- Such limitations shall be considered non-reportable as recommended and approved by the Medical Executive Committee

The Courtesy Category Medical Staff will also include the following:

Locum Tenens Membership:

- Practitioner specifically designated and sponsored by a current staff member to attend a member's patients during the absence of the member.
- A practitioner brought in when there are insufficient physicians in an area of practice. Practitioner shall attend only the patients of the sponsoring staff member, and only during the absence of such member
- A practitioner brought in to perform a procedure no other practitioner(s) perform due to patient care need
- Practitioner shall have the obligation for emergency room call coverage for the current staff member they are covering according to the limitations of their clinical competence and privileges
- Membership and privileges are termed when the need no longer exists.
- Shall be reappointed annually.
- May not vote
- May not hold office

Honorary Medical Staff Membership:

- Status designed to provide recognition for practitioners who have made significant contributions to the practice of medicine, community health or to the field of healthcare
- Members in this category must be nominated by the Medical Executive Committee
- No privileges or call responsibility
- No reappointment requirement
- May not vote
- May not hold office
- Lifetime appointment unless removed by the Governing Board

SECTION 4. The Affiliated Category Medical Staff

The Affiliated Category Medical Staff shall consist of physicians, dentists, podiatrists, and advanced practice professionals who are not seeking privileges at CHRISTUS CHRISTUS Mother Frances Hospital – Jacksonville, but are seeking Membership only. The applicant for Affiliated Staff Category membership shall meet the qualifications and adhere to the conditions and duration for staff as defined in Article III, Section 2. Appointees to the Affiliated Category shall have not Hospital admitting privileges, staff committee responsibilities, may not vote, and may not hold office. They are encouraged to attend section meetings, but it is not required. Affiliated Category Medical Staff membership may be discontinued at any time, with prior notice by the Administrator

after consultation with the President of the Medical Staff or appropriate Department Chair. If this occurs, the affected practitioner will not be entitled to any hearing or appeal.

ARTICLE V: ALLIED HEALTH PROFESSIONALS

SECTION 1. Criteria

The Allied Health Professional Staff shall consist of health professionals other than physicians who may or may not be employed by the hospital or clinic and who hold a certificate, license or other legal credentials as required by state law.

Allied Health Professionals granted privileges within the CHRISTUS Mother Frances Jacksonville Hospital and Clinic shall function in collaboration with the health care team in the observation, assessment, diagnosis intervention, evaluation, care and counsel of patients under the direction or supervision of a physician or other appropriate supervisor and pursuant to any protocols or written authorization related to their administration of anesthesia.

CRNA members of the Allied Health Professional Staff shall function in a collaborative manner with the health care team. CRNAs may select, order, obtain and administer anesthesia and anesthesia-related medications and determine the appropriate medical devices necessary to accomplish this order and maintain the patient within a sound physiological status. The CRNA may carry out these functions pursuant to a physician's order for anesthesia or an anesthesia-related service that does not have to be drug specific, dose specific or administration-technique specific.

All other Allied Health Professionals granted privileges shall function as an aide to the physician in the area of specialty of their sponsoring physician member. They shall receive their medical authority from policies/protocols jointly developed by the Allied Health Professional and their sponsoring physician. They may perform duties which do not require the exercise of independent medical judgment.

Allied Health Professionals shall be eligible to provide specified services within the hospital in accordance with privileges granted by the Governing Board as recommended by the Medical Staff Department Chair and Medical Executive Committee.

Allied Health Professionals must document their experience, training, education and demonstrated ability in applying for membership. They must provide a needed service within the hospital and be able through documented references to demonstrate acceptable recognized professional ethics to include being able to work cooperatively with others.

Credentials and privileges requested of the Allied Health Professionals shall be reviewed by the Chairman of the Department annually. (Refer to G in Rules and Regulations).

Those Allied Health Professional Staff Members, not otherwise employed by the hospital or Trinity Clinic, shall be afforded fairness of process as described in Article VIII: Corrective Action and Article IX: Hearing and Appellate Review Procedure.

Physician assistants and advanced practice registered nurses shall participate in a minimum of one (1) midlevel peer review meeting per year. Failure to comply with this provision may result in disciplinary action up to and including loss of privileges.

ARTICLE VI: PROCEDURE FOR APPOINTMENT, PROMOTION AND REAPPOINTMENT

SECTION 1. Application for Appointment

- a. All applications for appointment to the Medical Staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Governing Board after appraisal by the department chair of the applicable service and recommendation by the Medical Executive Committee.
- b. All applications shall require the following detailed information concerning the applicant's professional qualifications:
 - 1. The name of at least three (3) peers in the same professional discipline as the applicant who have had extensive experience in observing and working with the applicant who can provide adequate references pertaining to the applicant's professional competence and ethical character;
 - 2. Evidence of current state license, DEA and DPS certificate (if applicable);
 - 3. Information as to whether the applicant's membership status and/or clinical privileges have ever been revoked, suspended, reduced or not renewed at any other hospital or institution, whether voluntarily or involuntarily; and whether any such action is currently pending;
 - 4. Information as to whether the applicant's membership in local, state or national medical societies, or license to practice in any profession in any jurisdiction, has ever been suspended or terminated, whether voluntarily or involuntarily; whether any such action is currently pending; including any Agreed Orders with state medical boards or medical societies;
 - 5. Information as to whether the applicant has ever been convicted of a felony and whether the applicant's narcotic license has ever been suspended or revoked, whether voluntarily or involuntarily; and, whether any such action is currently pending;
 - 6. Previously successful or currently pending challenges to any licensure or registration (Federal/CMS, State, Drug Enforcement Administration, and DPS);
 - 7. Relevant practitioner-specific data as compared to aggregate data, when available;
 - 8. Ongoing Professional Practice Evaluation (OPPE) data, when available;
 - 9. Evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgement against the applicant;
 - 10. Current evidence of adequate professional liability insurance in the type, amount and duration prescribed by the Governing Board. This policy must provide at a minimum an individual insurance policy for the physician.
 - 11. Confirmation of the absence of any physical or mental condition which could affect the applicant's ability to exercise the clinical privileges requested safely and competently

(regardless of how this is answered, the application will be processed in the usual manner). This documentation shall be confirmed.

12. Practitioners with inpatient privileges are required to take unassigned emergency room call and must reside within a reasonable distance (thirty minutes) of the Hospital or delegate in writing these responsibilities to another member of the medical staff.
13. A request for specific clinical privileges desired by the applicant.
14. A portion of continuing medical education hours should relate in part to the practitioner's specialty. Continuing medical education certifications and supporting documentation relating to the practitioner's specialty must be provided at the time of reappointment or annually as required by accreditation/certification programs or as specified on clinical privilege delineation forms as approved by the section or department. Failure to provide certifications and supporting documentation of continuing medical education shall result in disciplinary action up to and including loss of staff membership and privileges.
15. Evidence of completion of EHR training by TMFHS ConnectCARE trainer.
16. A statement indicating that he/she has received, read, and agrees to abide by these Bylaws, the Rules and Regulations, Hospital policies and procedures, and other governing documents of the Medical Staff and the Hospital, applicable to the Medical Staff members made available to him/her.
17. A grant of absolute immunity to and a release of the Hospital, the governing board, the Medical Staff, all peer review and medical committees, including, but not limited to the Credentialing Committee, and their members, the Hospital and Medical Staff officers and authorized representatives, and any third parties from any and all liability for any acts, communications, reports, records, statements, documents, recommendations or disclosures involving the practitioner that are performed, made, requested, or received by such persons without malice related to the following:
 - a. Applications for appointment, reappointment, or clinical privileges, including temporary clinical privileges;
 - b. Periodic reappraisals undertaken for reappointment or for an increase or decrease in clinical privileges;
 - c. Proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, or any other disciplinary sanction;
 - d. Summary suspension;
 - e. Hearings and appellate reviews;
 - f. Medical Care evaluations;
 - g. Utilization reviews;
 - h. Any other Hospital, Medical Staff, Department, Division, or committee activities;
 - i. Matters or inquiries concerning the practitioner's professional qualifications, credentials, clinical competence, character, ethics, behavior, or ability to perform fully the essential functions of the professional services and clinical privileges requested; and
 - j. Any other matter that might directly or indirectly have an effect on the practitioner's competence, patient care, or the orderly operation of the Hospital or any other hospital or health care facility.

The practitioner acknowledges that all proceedings or information relating to the above shall be privileged to the fullest extent permitted by law and that the privilege extends to the Hospital, the

governing board, the Medical Staff, all peer review committees, including, but not limited to the Credentialing Committee, and their members, the Hospital and Medical Staff officers and their authorized representatives, and any third parties who provided information or participated in the proceedings.

- d. The completed application shall be submitted to the CHRISTUS Mother Frances Medical Staff Central Credentialing Office. Once the Central Credentialing Medical Staff Office has collected and verified the references and other materials deemed pertinent, the completed application and all supporting materials shall be forwarded to the CHRISTUS Mother Frances Hospital – Jacksonville Medical Staff Office to initiate the credentialing and privileging process. The completed application shall then be submitted to the Department Chair of the applicable service for evaluation. Primary source verifications are listed below, but may not be inclusive:
1. Current licensure, registration and/or certification. Document and verify from primary sources the Practitioner's current licensure, registration and/or certification status.
 2. Relevant education, training and experience. Document and verify from primary sources whenever feasible the veracity of the Practitioner's disclosures regarding relevant education, training and experience; and query the National Practitioner Data Bank.
 3. Continuing professional competence. Review of at least three (3) written references from individuals in the same or similar professional discipline as the Practitioner and who are knowledgeable about the Practitioner's professional performance within the past two (2) years to attest to and confirm the Practitioner's continuing professional competence and ability to perform the privileges requested. Additional references may include peers who are neither related to nor associated in practice with the Practitioner, but who are personally acquainted with the Practitioner's professional qualifications and current professional competence.
 4. Health status. Confirm absence of any substance abuse or health conditions that may adversely affect the Practitioner's ability to perform the privileges or scope of service requested from the chief of service or staff at another hospital where the Practitioner has privileges or scope of service, or by a currently licensed physician designated by the Medical Executive Committee. Such confirmation may include a physical and/or mental health examination conducted by a health care professional of the Medical Executive Committee's choosing.
 5. Litigation history. Explanation of the existence of any prior or current lawsuits, settlements, or judgments, including malpractice claims.
 6. Exclusions. Confirm absence of exclusions from participation in Medicare, Medicaid, Tricare.
- e. By applying for appointment to the Medical Staff, each applicant thereby signifies a willingness to appear for interviews in regard to the application, pledges to provide for continuous care of said applicant's patients, pledges to inform the hospital (this is a continuous requirement) of any changes in membership or privileges at other hospitals whether voluntarily or involuntary; sanctions or investigative proceedings by third party payors, state medical board orders, loss of medical license, DEA certificate, DPS certificate or professional liability insurance, 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, character and ethical qualifications, consents to the hospital's inspection of all records and documents that may be material to an evaluation of the applicants professional qualifications and competence to carry out the clinical privileges requested as well as of the applicant's moral and ethical qualifications for staff membership, releases from any liability all representatives of the hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluation of the applicant and the applicant's credentials, and releases from any liability all individuals and organizations who provide information to the hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.

- f. The application form shall include a statement that the physician has received and been reviewed the Medical Staff Bylaws, Rules and Regulations and policies and procedures, and that the applicant agrees to abide by these; and, that the applicant agrees to be bound by the terms thereof without regard to whether or not membership and/or clinical privileges is granted in all matters relating to consideration of the application.
- g. Each applicant for appointment or reappointment to the Medical Staff or for clinical privileges shall be obligated to supplement his/her responses to questions, or requests for information on the application form after the application has been submitted, if a response or information given was incorrect or incomplete, or is no longer correct or complete due to a change in circumstances. The applicant for appointment, reappointment, and/or the grant of clinical privileges has the burden to produce evidence necessary for appropriate evaluation of the application and failure to provide any requested information will result in a finding of incomplete application.

SECTION 2. Appointment Process

- a. Within ninety (90) days after receipt of the application for membership and privileges and once all information has been verified and required supporting documentation has been obtained inclusive of querying the National Practitioner's Data Bank, the Medical Executive Committee, through its chairperson, shall make a written report of its investigation to the Governing Board. Prior to making this report, the Department Chair shall examine the evidence of character, professional competence, qualifications and ethical standing of the practitioner and shall determine, through information contained in references given by the practitioner and from other sources available to the committee, including an appraisal from the department chair in the service which privileges are sought, whether the practitioner has established and meets all of the necessary qualifications for the category of staff membership and the clinical privileges requested by the applicant. The Department Chair in which the practitioner seeks clinical privileges shall provide the Medical Executive Committee with specific, written recommendations for delineating the practitioner's clinical privileges, and these recommendations shall be made a part of the report. Together with its report, the Department Chair shall transmit to the Medical Executive Committee the completed application and a recommendation that the practitioner be appointed to the Medical Staff with the requested clinical privileges or rejected for Medical Staff membership and privileges, or that the application be deferred for further consideration.
- b. At its next regular meeting, or within thirty (30) days after receipt of the completed application, the Medical Executive Committee shall determine whether to recommend to the Governing Board that the practitioner be appointed to the Medical Staff, that the practitioner be rejected for Medical Staff membership, or that the application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by probationary conditions relating to such clinical privileges.

The Governing Board shall take final action on a completed application within sixty (60) days after a completed application is received with report and recommendation of the Medical Executive Committee.

The applicant shall be notified in writing of the final action taken by the Governing Board, including a reason for denial or restriction of privileges requested, not later than twenty (20) days after the date on which the final action is taken.

- c. When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed up within ninety (90) days with a subsequent recommendation for appointment with specified clinical privileges, or for rejection for staff membership.

- d. When the recommendation of the Medical Executive Committee is favorable to the practitioner, the application shall be promptly forwarded, together with all supporting documentation, to the Governing Board.
- e. When the recommendation of the Medical Executive Committee is adverse to the practitioner either in respect to appointment or clinical privileges, the practitioner shall promptly be notified by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the Governing Board until after the practitioner has exercised or has been deemed to have waived the right to a hearing as provided in Article X of these Bylaws.
- f. If, after the Medical Executive Committee has considered the report and recommendations of the Hearing Committee and the hearing record, the Medical Executive Committee's reconsideration and recommendation is favorable to the practitioner, it shall be processed in accordance with subparagraph d. of this Section 2. If such recommendation continues to be adverse, the applicant shall be promptly notified by certified mail, return receipt requested. Such recommendation and documentation shall be forwarded to the Governing Board, but the Governing Board shall not take any action thereon until after the practitioner has exercised or has been deemed to have waived the rights to an appellate review as provided in Article X of these Bylaws.
- g. At its next regular meeting, but not later than sixty (60) days, after receipt of a favorable recommendation, the Governing Board or its Executive Committee shall act in the matter. If the Governing Board's decision is adverse to the practitioner in respect to either appointment or clinical privileges, the applicant shall be promptly notified of such adverse decision, within twenty (20) days, along with the reason for denial or restriction of privileges, by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the practitioner has exercised or has been deemed to have waived the rights under Article X of these Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.
- h. At its next regular meeting, but not later than sixty (60) days, after all of the practitioner's rights under Article X have been exhausted or waived, the Governing Board or its duly authorized committee shall act in the matter. The Governing Board's decision shall be conclusive, except that the Governing Board may defer final determination by referring the matter for further reconsideration. Any such referral shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Governing Board shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation and new evidence in the matter, if any, the Governing Board shall make a decision either to appoint the practitioner to the staff or to reject the practitioner for staff membership. All decisions to appoint shall include a delineation of the clinical privileges, which the practitioner may exercise.
- i. Whenever the Governing Board's decision will be contrary to the recommendation of the Medical Staff Executive Committee, the Governing Board shall submit the matter to a joint committee composed of an equal number of members from the Governing Board and Medical Executive Committee for review and recommendation and shall consider such recommendation before making its decision final.
- j. When the Governing Board's decision is final, it shall send notice promptly of such decision through the administrator or the secretary of the medical staff, to the chairperson of the Executive Committee, and of the department concerned, and by certified mail, return receipt requested, to the practitioner.

SECTION 3. Reappointment Process

An application for reappointment to the Medical Staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Governing Board.

- a. The Department Chairman of the applicable service shall review the information form and other available information pertinent to the reappointment of the staff member inclusive of querying the National Practitioner's Data Bank and shall recommend to the Medical Executive Committee reappointment and renewal of clinical privileges, or change in staff status or clinical privileges. The reason for any change in staff status or clinical privileges shall be documented.
- b. Each recommendation concerning the reappointment of a medical staff member and the clinical privileges to be granted upon reappointment shall be based upon the individual's current licensure, DEA & DPS number (if applicable), professional liability insurance renewal, verification of hospital affiliations, changes in membership or privileges at other hospitals whether voluntarily or involuntary; challenges to any licensure or registration; voluntary or involuntary relinquishment of any license or registration; voluntary and involuntary limitation, reduction or loss of clinical privileges; Agreed Orders with state medical boards or medical societies, any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgement against the applicant for reappointment; sanctions or investigative proceedings by third party payors, loss of professional liability insurance, documentation of the practitioner's health status, character, professional performance / competence, judgment, and clinical technical skills, as indicated through results of performance improvement activities inclusive of morbidity and mortality data when available and relevant practitioner data as compared to aggregate data when available. Additionally, evidence of required participation in medical staff review, receipt of continuing medical education inclusive of one (1) CME hour of risk management education, an appraisal by the chairperson of the department of the applicable service, compliance with Medical Staff Bylaws and Rules and Regulations and policies and procedures of the Medical Staff, use of the hospital's facilities for patients, relations with other practitioners and general attitude toward patients, the hospital and the public. Maintenance of board certification is not required for reappointment.
- c. The Medical Executive Committee shall review the hospital personnel information form and other relevant information available to the reappointment of the staff member, and recommend to the Governing Board that appointment be renewed, renewed with modified staff category, department affiliation and/or clinical privileges, or terminated. The reason for change in staff status or clinical privileges shall be documented.
- d. The staff member seeking reappointment shall, if requested by the Medical Executive Committee as part of the reappointment appraisal, be willing to undergo physical or psychiatric examination. Refusal by the staff member to undergo such examination shall be cause to initiate the termination of staff membership.
- e. Thereafter, the procedure provided in Section 2 of this Article VI, relating to recommendations on applications for initial appointment shall be followed.

ARTICLE VII: EXPEDITED PROCESS FOR GRANTING PRIVILEGES

(Board Credentials Sub-Committee)

SECTION 1. Expedited Governing Body (Board Sub-Committee)

- a. Composition: This committee shall consist of at least two voting members of the Governing Body.
- b. Duties: The Board Subcommittee shall receive and act on behalf of the Board regarding positive recommendations from the Medical Executive Committee concerning appointments, reappointments or renewal or modification of clinical privileges.
- c. Meetings: This meeting shall meet as soon after every Medical Executive Committee as possible.
- d. Eligibility:
 1. If any of the following has occurred, the applicant will be ineligible for the expedited process:
 - The applicant submits an incomplete application,
 - The Medical Executive Committee makes a final recommendation that is adverse or has limitations.
 2. If any of the following has occurred, the applicant will be evaluated on a case-by-case basis and usually results in ineligibility for this process:
 - There is a current challenge or a previously successful challenge to licensure or registration.
 - The applicant has received an involuntary termination of medical staff membership at another hospital
 - The applicant has received involuntary limitation, reduction, denial or loss of clinical privileges
 - The Hospital determines that there has been either an unusual pattern of or an excessive number of professional liability actions resulting in a final judgment against the applicant.
- e. Ratification: The Governing Body shall ratify the decision(s) made by this Board Sub-Committee.

ARTICLE VIII: CLINICAL PRIVILEGES

SECTION 1. Clinical Privileges Restricted

- a. Every practitioner by virtue of medical staff membership or otherwise, shall, in connection with such membership, be entitled to exercise only those privileges specifically granted by the Governing Board, except as provided in Sections 2 and 3 of Article VIII.
- b. Confirm the absence of any physical or mental condition, which could affect the member's ability to exercise the clinical privileges requested safely and competently.
- c. Privileges granted to applicants for the Medical Staff shall be recommended to the Medical Executive Committee of the Medical Staff by the Department Chairman.

- d. Periodic redetermination of clinical privileges and the increase or curtailment of same shall be based upon the quality of care and professional competency and proficiency of the practitioner.
- e. Applications for additional clinical privileges must be in writing. To assure uniformity, they should be submitted on a prescribed form, on which the type of clinical privileges desired and the applicant's relevant recent training and/or experience must be stated. For clinical privileges for which there are no applicable criteria, the resources necessary to support each new requested privilege must be determined.

Such applications should be processed in the same manner as applications for initial appointment.

- f. Privileges granted to dentists/oral and maxillofacial surgeons and podiatrists shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists/oral surgeons and podiatrists shall be under the supervision of the chairperson of the department of surgery.
- g. All podiatric and dental/oral maxillofacial patients shall receive the same basic medical appraisal as patients admitted for other services. A physician member of the Medical Staff shall be responsible for the care of medical problems that may be present upon admission or that may arise during hospitalization. Dental/oral maxillofacial surgeons and podiatrists are responsible for their part of their patient's history and physical examination. See Article III Section 4 regarding History and Physicals.

SECTION 2. Emergency Privileges

In the case of an emergency, any practitioner member of the Medical Staff, to the degree permitted by his license and regardless of department or staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or the practitioner does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff. For the purpose of this Section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

SECTION 3. Reserved.

SECTION 4. Educational Privileges

Educational privilege requests shall be in keeping with the requirements of the Texas Medical Board. Educational privileges require adequate notice to permit primary source verification of licensure; and, review and approval by the Department Chairman and President of the Medical Staff. The applicant must have and provide: a copy of current and unrestricted license to practice medicine, a current copy of their professional liability coverage; a copy of the practitioner's privilege list from the practitioner's primary hospital affiliation indicating approval of the specific procedure the physician is to proctor. The Medical Staff member requesting the educational consultation shall submit a letter of request specifically delineating the request, as well as the specific timeframe for such request. The sponsoring physician shall have the responsibility of obtaining written consent from the patient.

SECTION 5. Disaster Privileges

Disaster privileges shall be granted on a case by case basis to a licensed independent practitioner (LIP) when the organization's emergency management plan has been formally activated or the organization is unable to meet immediate patient needs, i.e. community disaster/national disaster. Any licensed physician shall be permitted and assisted to do everything possible in the care of the patients within the scope of their license. The granting of disaster privileges shall be authorized by the President of the Medical Staff, the Medical Director, or an authorized designee. The specific practitioner shall present to the Medical Staff Office or Command Center and present to the chief administrative officer or president of the medical staff or their designee(s) a current license to practice medicine or a valid government issued photo identification issued by a state or federal agency (e.g. driver's license or passport). In addition, the volunteer LIP must provide at least one of the following: a current hospital picture identification card that clearly identifies the individual's professional designation; a current license to practice; identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organization or group(s); identification indicating that the individual has been granted authority to render patient care, treatment, or services in disaster circumstances (such as authority having been granted by a federal, state, or municipal entity); identification by a current member of the organization or medical staff who possesses personal knowledge regarding the individual's ability to act as a LIP during a disaster. Upon approval, a volunteer identification badge will be issued. A list of volunteer practitioners with disaster privileges will be posted in the patient care areas. Volunteer LIPs shall be assigned to work with another LIP within the scope of their license for organization oversight. Once the immediate situation is under control, the medical staff office shall obtain primary source verification of the volunteer practitioner's license. Once the immediate situation is under control, the medical staff office shall obtain primary source verification of the volunteer LIP's license. Primary source verification shall be completed within 72 hours from the time the volunteer LIP presented to the organization. In extraordinary circumstances (e.g. no means of communication or a lack of resources), verification may exceed 72 hours, but shall be completed as soon as possible. The Hospital's Active Medical Staff will oversee the professional practice of the LIP with disaster clinical privileges and will decide within 72 hours whether or not to continue to the disaster clinical privileges initially granted.

Proof of professional liability insurance coverage shall also be provided or verified as soon as practically possible. Disaster privileges shall be terminated once the disaster no longer exists.

SECTION 6. Telemedicine Privileges

Telemedicine is the provision of clinical services to patients by practitioners from a distance via electronic communications. Practitioners providing only telemedicine services to the Hospital from a distant site will not be appointed to the medical staff, but must be granted privileges at this Hospital. The medical staff may recommend privileges to the governing body through one of the following mechanisms:

- a. The Hospital uses the credentialing and privileging decision made by the distant-site to make a final privileging decision. For the medical staff to rely upon the credentialing and privileging decisions made by the distant-site hospital when making recommendation on privileges for the individual distant-site physicians and practitioners providing such services, the Hospital's governing body ensures, through its written agreement with the distant-site hospital, that all of the following provisions are met:
 1. The distant-site providing the telemedicine services is a Medicare participating and Joint Commission-accredited hospital or ambulatory care organization,
 2. The individual distant-site physician or practitioner is privileged at the distant-site providing the telemedicine services for those services to be provided at the originating site, and the distant

site provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or ambulatory care organization,

3. The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the Hospital whose patients are receiving the telemedicine services is located,
 4. Provide proof of malpractice insurance in the type, amount and duration required by the Hospital,
 5. With respect to a distant-site physician or practitioner, who holds current privileges at the hospital whose patients are receiving the telemedicine services (originating site), the hospital has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site hospital such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided by the distant-site physician or practitioner to the hospital's patients; and all complaints the hospital has received about the distant-site physician or practitioner.
- b. The originating site privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission-accredited organization. Once the medical staff makes its recommendation regarding the privileging of the telemedicine provider, it then must go through the remainder of the credentialing process for a decision regarding approval by the Board.
 - c. The Hospital fully privileges and credentials the practitioner.
 - d. The Distant Site will attest that it has privileged the practitioner and the practitioner is licensed in Texas.
 - e. The services of the Distant Site practitioners shall be subject to Focused and Ongoing Professional Practice Evaluations, these Bylaws, Rules and Regulations and Hospital policies.

Once there is approval of a recommendation for privileges from the medical staff, the governing body shall decide whether to grant privileges through the usual credentialing process.

SECTION 7. Temporary Privileges

There are two circumstances in which Temporary Privileges may be granted. Each circumstance has different criteria for granting privileges. The circumstances are:

- To fulfill an important patient care, treatment and service need. An example would be if a specific physician has the necessary skills to provide care to a patient that no physician currently privileged possesses. These Temporary Privileges may be granted on a case-by-case basis when an important patient care need mandates an immediate authorization to practice.
 - Privileges may be granted for a limited period of time or for a patient specific case.
 - When temporary privileges are granted to meet an important care need, the organized medical staff verifies current licensure and current competence.
- When an applicant for new privileges with a complete application that raises no concerns is awaiting review and approval by the Medical Executive Committee and the Governing Board. Examples

would include an individual applying for privileges at the hospital for the first time; an individual currently holding clinical privileges who is requesting an additional privilege(s); and an individual who is in the reappointment/recredentialing process and is requesting one or more additional privileges.

- Privileges may be granted for a period of up to 120 days. ○ Temporary privileges under this category may be granted by the organized medical staff upon verification of the following:
 - Current Licensure
 - Relevant training or experience
 - Current competence
 - Ability to perform the privileges requested
 - Other criteria required by the Medical Staff Bylaws
 - A query and evaluation of the NPDB information
 - A complete application
 - No current or previously successful challenge to licensure or registration
 - No subjection to involuntary termination of medical staff membership at another organization
 - No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges.
 - Documentation of current immunizations as required pursuant to the Hospital or health system Immunization Policy
 - Evidence of current professional liability insurance with coverage satisfactory to the Hospital

The Department Chairperson responsible for supervision may impose special requirements of consultation and reporting. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the bylaws, policies, procedures, rules, regulations, manuals, guidelines and requirements of the Hospital and its Medical Staff in all matters relating to his temporary privileges. Whether or not such written agreement is obtained, this Manual and the bylaws, policies, procedures, rules, regulation, manuals, guidelines and requirements of the Hospital and/or its Medical Staff control all matters relating to the exercise of clinical privileges.

Temporary Privileges are recommended by the Department Chair, Chairman of the Medical Executive Committee and approved by the Administrator/CEO or designee.

(a) Termination. The Chief of Staff or the Chief Executive Officer, after consultation with the appropriate Department Chairman, may on the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's professional qualifications or ability to exercise any or all of the temporary privileges granted, and may at any other time terminate any or all of a practitioner's temporary privileges, provided that where the life or well-being of a patient is determined to be endangered, the termination may be effected by any person entitled to impose summary suspension as outlined in this Manual. In the event of any such termination, the Department Chairperson responsible for supervision shall assign the practitioner's patients then in the Hospital to another practitioner. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

(b) Rights of the Practitioner. A practitioner is not entitled to the procedural rights outlined in Article X of this Manual because his request for temporary privileges is refused or because all or any part of his temporary privileges are terminated, limited or suspended.

ARTICLE IX: CORRECTIVE ACTION

Corrective action against any member of the Medical Staff, including the appeal of any adverse action by any properly constituted professional review body, shall be conducted pursuant to these Bylaws.

SECTION 1. Procedure

- a. Whenever the activities, professional conduct, or clinical practice of any member with clinical privileges are considered to be lower than the standards or aims of the Medical Staff or to be disruptive to the operations of the Hospital or contrary to these Bylaws, the Rules and Regulations or Hospital Policies and Procedures, corrective action against such member may be requested by any officer of the Medical Staff, by the Chairperson of any Clinical Department, by the Chairperson of any standing committee of the Medical Staff, by the Administrator or by the Governing Board. All requests for corrective action shall be in writing, shall be made to the Medical Executive Committee, and shall be supported by reference to the specific activities or conduct, which constitute the grounds for the request.
- b. Whenever the corrective action could be a reduction or suspension of clinical privileges, the Executive Committee shall forward such request to the Chairperson of the Department wherein the member has such privileges. Upon receipt of such request, the Chairperson of the Department shall immediately appoint an Ad Hoc Committee to investigate the matter.
- c. Within fifteen (15) days after the Department's receipt of the request for corrective action, the Departmental Ad Hoc Committee shall make a report of its investigation to the Medical Executive Committee. Prior to the making of such report, the member against whom corrective action has been requested shall have an opportunity for an interview with the Departmental Ad Hoc Investigating Committee. At such interview, the member shall be informed of the general nature of the charges and shall be invited to discuss, explain or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of such interview shall be made by the Department and included with its report to the Medical Executive Committee. The Ad Hoc Committee may determine in its report that a claim has no merit.
- d. Within seven (7) days following receipt of a report from a Department following the Department's investigation of a request for corrective action involving reduction or suspension of clinical privileges, the Medical Executive Committee shall take action upon the request. If the corrective action should involve a reduction or suspension of clinical privileges, or a suspension or expulsion from the Medical Staff, the affected member shall be permitted to make an appearance before the Medical Executive Committee prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. The Medical Executive Committee shall make a record of such appearance.
- e. The action of the Medical Executive Committee on a request for corrective action may be to reject or modify the request for corrective action, to issue a warning, a letter of admonition, or a letter of reprimand, to impose terms of probation or a requirement for consultation, to recommend reduction, suspension or revocation of clinical privileges, to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained, or to recommend that the member's staff membership be suspended or revoked.
- f. Any recommendation by the Medical Executive Committee for reduction, suspension or revocation of clinical privileges or for suspension or expulsion from the Medical Staff shall entitle the affected member

to the procedural rights provided in Article X of these Bylaws, as well as to any right(s) to alternative dispute resolution expressly contemplated by the Texas Health and Safety Code.

- g. The President of the Medical Executive Committee shall promptly notify the Administrator or his designee in writing of all requests for corrective action received by the Medical Executive Committee and shall continue to keep the Administrator fully informed of all action taken in correction therewith. After the Medical Executive Committee has made its recommendation in the matter, the procedure to be followed shall be as provided in Article VI, Section 2, and Article X if applicable, of these Bylaws.

SECTION 2. Summary Suspension

- a. Any one of the following - the President of the Medical Staff, the Chairperson of a Clinical Department, the Medical Executive Committee of the Governing Board, or the Administrator or Acting Administrator with the concurrence of any of the aforementioned - shall each have the authority, whenever action must be taken immediately in the best interest of patient care in the hospital, to suspend summarily all or any portion of the clinical privileges of the practitioner, and such summary suspension shall become effective immediately upon imposition.
- b. A practitioner whose clinical privileges have been summarily suspended shall be entitled to request that the Medical Executive Committee of the Medical Staff hold a hearing on the matter within such reasonable time period thereafter as the Medical Executive Committee may be convened in accordance with Article X of these Bylaws.
- c. The Medical Executive Committee may recommend modification, continuance or termination of the terms of the summary suspension. If, as a result of such hearing, the Medical Executive Committee does not recommend immediate termination of the summary suspension, the Affected Member shall, also in accordance with Article X, be entitled to request an appellate review by the Governing Board, but the terms of the summary suspension as sustained or as modified by the Medical Executive Committee shall remain in effect pending a final decision thereon by the Governing Board.
- d. Immediately upon the imposition of a summary suspension, the President of the Medical Executive Committee or responsible Departmental Chairperson shall have authority to provide for alternative medical coverage for the patients of the suspended practitioner still in the hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative practitioner.

SECTION 3. Administrative Suspension

- a. An administrative suspension of the Member's clinical privileges may be made by the Medical Executive Committee based on a Member's conduct as described in this Section 3(c). Unless otherwise stated, such administrative suspension shall be effective immediately upon imposition, and the Medical Staff Office shall deliver written notice to the Affected Practitioner and the Chair of the Medical Executive Committee. The administrative suspension shall be limited in duration and shall remain in effect for the period stated or, if not stated, until resolved as set forth herein.
- b. Administrative suspension may be applied by failure to abide by continuing duties after appointment as described in section 1.12.
- c. Automatic Suspension will occur under the following circumstances:

- (1.) Licensure. If a Practitioner's license, certification or registration to practice in Texas lapses, the Practitioner's clinical privileges shall be suspended until the deficiency is corrected. If, within 90 days following the lapse, the Practitioner does not demonstrate the license, certification, or registration has been renewed, the Practitioner's clinical privileges shall be automatically revoked.
- (2.) DEA Certificate and DPS Registration. If a Practitioner's DEA certificate or DPS registration lapses, that Practitioner shall be immediately and automatically divested, of his or her clinical privileges to prescribe controlled substances. If said certificate or registration lapses and is required for medical practice, the Practitioner's clinical privileges will be suspended unless the Practitioner provides documentation from the DEA or DPS demonstrating that the expiration date of the DEA certificate or DPS registration has been extended. If, within 90 days following the lapse, the Practitioner does not demonstrate the DEA certificate or DPS registration has been renewed, the Practitioner's clinical privileges shall be automatically revoked.
- (3.) Professional Liability Insurance. If a Practitioner fails to maintain professional liability insurance as set forth in these Bylaws, the Practitioner's clinical privileges will be suspended until the deficiency is corrected. If within 90 days following the deficiency the Practitioner does not provide evidence of required professional liability insurance, the Practitioner's clinical privileges may be automatically revoked.
- (4.) Repetitious Infractions. If a Practitioner has been subject to at least three (3) administrative suspensions under this Section 3 within any consecutive twenty-four (24) month period, the Practitioner's clinical privileges may be revoked by the Medical Executive Committee.
- (5.) Reappointment. If a practitioner fails to return his/her reappointment packet prior to deadline, the practitioner's clinical privileges will be suspended until the reappointment is approved by the Governing Board. If within 90 days following reappointment expiration date, the practitioner has not complied, the Practitioner's clinical privileges may be automatically revoked.
- (6.) Electronic Health Record (EHR) Training. If a practitioner fails to successfully complete ConnectCARE training his/her clinical privileges shall be suspended until such time as training is complete and documentation of completion is received in the Medical Staff Office.
- (7.) A temporary suspension in the form of withdrawal of a practitioner's admitting and clinical privileges, effective until medical records are completed, shall be imposed automatically after warning of delinquency for failure to complete medical records within the time specified in Rules and Regulations.
- (8.) Action by the State Board of Medical Examiners revoking or suspending a practitioner's license, or placing said practitioner on probation, shall automatically suspend all of the practitioner's privileges. If placed on probation, the Medical Executive Committee of the Medical Staff shall evaluate the practitioner's hospital standing and appropriate action shall be taken.
- (9.) Exclusions. Any practitioner excluded from participation in Medicare/Medicaid/Tricare or any government funded healthcare program will be suspended immediately.
- (10.) Felony. If a Practitioner is convicted of a felony, the Practitioner's scope of practice or scope of service shall be automatically revoked upon the Hospital receiving actual notice of the conviction.

It shall be the duty of the President of the Medical Staff to cooperate with the Administrator in enforcing all automatic suspensions.

ARTICLE X: HEARING AND APPELLATE REVIEW PROCEDURE

SECTION 1. Right to Hearing and to Appellate Review

- a. When any practitioner receives notice of a recommendation of the Medical Executive Committee that, if ratified by decision of the Governing Board, will adversely affect the practitioner's exercise of clinical privileges or appointment to or status as a member of the Medical Staff or Allied Health Professional Staff who are not otherwise employed by the hospital, the practitioner shall be entitled to a hearing before an Ad Hoc Committee of the Medical Staff. If the recommendation of the Medical Executive Committee following such hearing is still adverse to the Affected Practitioner, the practitioner shall be entitled to an appellate review by the Governing Board before the Governing Board makes a final decision on the matter.
- b. When any practitioner receives notice of a decision by the Governing Board that will affect the practitioner's exercise of clinical privileges or appointment to or status as a member of the Medical Staff or Allied Health Professional Staff who are not otherwise employed by the hospital, and such decision is not based on a prior adverse recommendation by the Medical Executive Committee of the Medical Staff with respect to which the practitioner was entitled to a hearing and appellate review, the practitioner shall be entitled to a hearing by a committee appointed by the Governing Board, and if such hearing does not result in a favorable recommendation, to an appellate review by the Governing Board before the Governing Board makes a final decision on the matter.
- c. All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article X to assure that the Affected Practitioner is accorded all rights to which the practitioner is entitled.

SECTION 2. Request for Hearing

- a. The Administrator or his designee shall be responsible for giving prompt written notice of an adverse recommendation or decision to any Affected Practitioner who is entitled to a hearing or to an appellate review, by certified mail, return receipt requested.
- b. The failure of a practitioner to request a hearing to which the practitioner is entitled by these Bylaws within thirty (30) days and in the manner herein provided shall be deemed a waiver of the practitioner's right to such hearing and to any appellate review the practitioner might otherwise have been entitled on the matter. The failure of a practitioner to request an appellate review to which the practitioner is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of the practitioner's right to such appellate review on the matter.
- c. When the waived hearing or appellate review relates to an adverse recommendation of the Medical Executive Committee of the Medical Staff or of a Hearing Committee appointed by the Governing Board, the same shall thereupon become and remain effective against the practitioner pending the Governing Board's decision on the matter.
- d. When the waived hearing or appellate review relates to adverse decision by the Governing Board, the same shall thereupon become and remain effective against the practitioner in the same manner as a

final decision of the Governing Board provided for in Section 7 of this Article X. In either of such events, the Administrator or his designee shall promptly notify the Affected Practitioner of the practitioner's status by certified mail, return receipt requested.

SECTION 3. Notice of Hearing

- a. Within ten (10) days after receipt of a request for hearing from a practitioner entitled to the same, the Medical Executive Committee or the Governing Board, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the Administrator or his designee, notify the practitioner of the time, place and date so scheduled, by certified mail, return receipt requested. The hearing date shall not be less than thirty (30) days from the date of receipt of the request for hearing; provided, however, that a hearing for a practitioner who is under suspension which is then in effect shall be held as soon as arrangements therefore may reasonably be made.
- b. The notice of hearing shall state in concise language the acts or omissions with which the practitioner is charged, a list of specific or representative charts being questioned and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision, a list of the witnesses, and a summary of the rights of the practitioner.

SECTION 4. Composition of Hearing Committee

- a. When a hearing relates to an adverse recommendation of the Medical Executive Committee, such hearing shall be conducted by an Ad Hoc Hearing Committee of not less than five (5) members of the Medical Staff appointed by the President of the Medical Staff in consultation with the Medical Executive Committee and one of the members so appointed shall be designated as Chairperson. Appointees shall not be in direct competition with the physician involved. No staff member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this Hearing Committee unless it is otherwise impossible to select a representative group due to the size of the Medical Staff.
- b. When a hearing relates to an adverse decision of the Governing Board that is contrary to the recommendation of the Medical Executive Committee, the Governing Board shall appoint a Hearing Committee to conduct such hearing and shall designate one of the members of this Committee as Chairperson. The appointed Chairperson shall not be in direct competition with the physician involved. At least one representative from the Medical Staff, not in direct competition with the physician involved, shall be included on this Committee when feasible.

SECTION 5. Conduct of Hearing

- a. There shall be at least a majority of the members of the Hearing Committee present when the hearing takes place, and no member may vote by proxy.
- b. An accurate record of the hearing must be kept. The mechanism shall be established by the Ad Hoc Hearing Committee, and may be accomplished by the use of a court reporter, electric recording unit, detailed transcription, or by the taking of adequate minutes.
- c. The personal presence of the practitioner for whom the hearing has been scheduled shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived rights in the same as provided in Section 2 of this Article X and to have accepted the

adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in said Section 2.

- d. Postponement of hearings beyond the time set forth in these Bylaws shall be made only with the approval of the Ad Hoc Hearing Committee. Granting of such postponements shall only be for good cause shown and in the sole discretion of the Hearing Committee.
- e. The Affected Practitioner shall be entitled to be accompanied and/or represented at the hearing by an attorney or other person of the practitioner's choice.
- f. 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, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.
- g. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of existence of any common law or statutory rule, which make evidence inadmissible over objection in civil or criminal actions. The practitioner for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record.
- h. The Medical Executive Committee, when its action has prompted the hearing, shall appoint one of its members, some other Medical Staff member or its' attorney to represent it at the hearing, to present the facts in support of its adverse recommendation, and to examine witnesses. The Governing Board, when its action has prompted the hearing, shall appoint one of its members to represent it at the hearing, to present the facts in support of its adverse decision and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision, but the affected practitioner shall thereafter be responsible for supporting the practitioner's challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious.
- i. The Affected Practitioner and Hearing Committee shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witness on any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence. If the practitioner does not testify in the practitioner's own behalf, the practitioner may be called and examined as if under cross-examination. The practitioner may submit a written statement at the close of the hearing.
- j. 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.
- k. Within twenty (20) days after final adjournment of the hearing, the Hearing Committee shall make a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the Medical Executive Committee or to the Governing Board, whichever appointed it and the Affected Practitioner. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Medical Executive Committee or decision of the Governing Board. Thereafter, the procedure to be followed shall be as provided in Section 2 of Article

VI of these Bylaws. The Affected Practitioner has the right to the record of the proceedings, copies of which may be obtained by the practitioner upon payment of reasonable charges associated with the preparation thereof.

SECTION 6. Appeal to the Governing Board

- a. Within ten (10) days after receipt of a notice by an Affected Practitioner of an adverse recommendation or decision made or adhered to after a hearing as above provided, the practitioner may, by written notice to the Governing Board delivered through the Administrator or his designee by certified mail, return receipt requested, request an appellate review by the Governing Board. Such notice may request that the appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the practitioner's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.
- b. If such appellate review is not requested within ten (10) days, the Affected Practitioner shall be deemed to have waived the right to the same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in Section 2 of this Article X.
- c. Within thirty (30) days after receipt of such notice of request for appellate review, the Governing Board shall schedule a date for such review, including a time and place for oral argument if such has been requested, and shall, through the Administrator or his designee, by written notice sent by certified mail, return receipt requested, notify the Affected Practitioner of the same. The date of the appellate review shall not be less than thirty (30) days, nor more than forty-five (45) days, from the date of the receipt of the notice of request for appellate review, except that when the practitioner requesting the review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than fifteen (15) days from the date of receipt of such notice.
- d. The appellate review shall be conducted by the Governing Board or by a duly appointed appellate review committee of the Governing Board of not less than three (3) members. To the extent possible based on the availability of Board Members, no member of the appellate review committee will have been a member of the Ad Hoc Hearing Committee or a member of the Medical Executive Committee making an adverse determination that is subject to the appeal.
- e. The Affected Practitioner shall have access to the report and record and transcription, (if any) of the Ad Hoc Hearing Committee and all other material favorable or unfavorable, that was considered in making the adverse recommendation or decision against the practitioner. The Affected Practitioner shall have fifteen (15) days to submit a written statement in the practitioner's own behalf, in which those factual and procedural matters with which the Affected Practitioner disagrees, and subsequent reasons for such disagreement, shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Governing Board through the Administrator his designee by certified mail, return receipt requested, at least fifteen (15) days prior to the scheduled date for the appellate review. A similar statement may be submitted by the Medical Executive Committee of the Medical Staff or by the Chairperson of the Hearing Committee appointed by the Governing Board and if submitted, the Administrator or his designee shall provide a copy thereof to the practitioner at least seven (7) days prior to the date of such appellate review by certified mail, return receipt requested.
- f. The Governing Board or its appointed review committee shall act as an appellate body. The Chairperson of the appellate review body shall be the Presiding Officer. The Chairperson will determine the order of procedure during the review, make all required rulings, and maintain decorum. It shall

review the record created in the proceedings, and shall consider the written statements submitted pursuant to subparagraph e. of this Section 6, for the purpose of determining whether the adverse recommendation or decision against the Affected Practitioner was justified and was not arbitrary or capricious. If an oral argument is requested as part of the review procedure, the Affected Practitioner shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to the practitioner by any member of the appellate review body. The Medical Executive Committee or the Governing Board, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to said practitioner by any member of the appellate review body.

- g. New or additional matters not raised during the original hearing or in the Hearing Committee Report, nor otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances, and the Governing Board or the committee thereof appointed to conduct the appellate review shall in its sole discretion determine whether such new matters shall be accepted.
- h. If the appellate review is conducted by the Governing Board, it may affirm, modify or reverse its prior decision, or in its discretion, refer the matter to the Medical Executive Committee of the Medical Staff for further review and recommendation within thirty (30) days. Such referral may include a request that the Medical Executive Committee of the Medical Staff arrange for a further hearing to resolve specified disputed issues.
- i. If the appellate review is conducted by a committee of the Governing Board, such committee shall, within seven (7) days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Governing Board affirm, modify or reverse its prior decision, or refer the matter to the Executive Committee for further review and recommendation within thirty (30) days. Such referral may include a request that the Medical Executive Committee of the Medical Staff arrange for a further hearing to resolve disputed issues. Within seven (7) days after receipt of such recommendation after referral, the committee shall make its recommendation to the Governing Board as above provided.
- j. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 6 have been completed or waived. Where permitted by the Hospital Bylaws, all action required of the Governing Board may be taken by a committee of the Governing Board duly authorized to act.

SECTION 7. Final Decision by Governing Board

- a. Within seven (7) days after the conclusion of the appellate review, the Governing Board shall make its final decision in the matter and shall send notice thereof to the Executive Committee and, through the Administrator or his designee, to the Affected Practitioner, by certified mail, return receipt requested. If this decision is in accordance with the Medical Executive Committee's last recommendation in the matter, it shall be immediately effective and final, and shall not be subject to further hearing or appellate review. If this decision is contrary to the Medical Executive Committee's last such recommendation, the Governing Board shall refer the matter to a joint committee composed of an equal number of members from the Governing Board and Medical Executive Committee for further review and recommendation within fifteen (15) days, and shall include in such notice of its decision a statement that a final decision will not be made until the Committee's recommendation has been received.
- b. Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action

by the Medical Executive Committee of the Medical Staff, or by the Governing Board, or by duly authorized committee of the Governing Board, or by both.

- c. If at any time after receipt of special notice of an adverse recommendation, action or result, a practitioner fails to make a required request or appearance or otherwise fails to comply or to proceed with the matter, the practitioner shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights to which he might otherwise have been entitled under the Medical Staff Bylaws then in effect with respect to the matter involved.

SECTION 8. Reporting

- a. In accordance with Texas Occupations Code Section 160.003, if a determination is made that a practitioner in Texas poses a continuing threat to the public welfare through the practice of medicine, the person or committee must report relevant information in writing to the Texas Medical Board, or appropriate Board. This report must include:
1. The name of the practitioner;
 2. A description of the acts or omissions or other reasons for the action or, if know, for the surrender; and
 3. Such other information respecting the circumstances of the action or surrender, as the Secretary deems appropriate.
- b. In accordance with 42 U.S.C. Sections 11133, 11134, 11131, and Texas Occupations Code Section 160.002, to prevent loss of immunity from civil damages afforded by statute, the following professional review actions must be reported by the Hospital's authorized representative to the National Practitioners Data Bank and to the Texas Medical Board or appropriate Board:
1. Action that adversely affects the clinical privileges of a practitioner for a period longer that 30 days; or
 2. Acceptance of the surrender of clinical privileges of a practitioner (while the practitioner is under an investigation by the entity relating to possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding).

This duty may not be nullified through contract.

- c. To avoid being subject to a civil monetary penalty, the Hospital must also report payments made for the benefit of a physician, dentist, or other practitioner in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action against the practitioner. A payment resulting from a claim that is solely against an entity (e.g. Hospital, clinic, group practice) and that does not name an individual practitioner is not reportable. The information required to be reported shall be reported regularly (but not less often than monthly) to the NPDB and to the Texas Medical Board and or other appropriate Board and must include:
1. The name of the practitioner for whose benefit the payment is made;
 2. The amount of the payment;
 3. The name (if known) of any hospital with which the practitioner is affiliated or associated;
 4. A description of the acts or omissions and injuries or illnesses upon which the action or claim was based; and
 5. Such other information as the Secretary determines is required for appropriate interpretation of information reported under this 42 U.S.C Section 11131.

To the extent the aforementioned state and federal laws change, this section shall conform to such changes without regard to whether an amendment has yet been adopted in accordance with these bylaws.

ARTICLE XI: OFFICERS

SECTION 1. Officers of the Medical Staff

The officers of the Medical Staff shall be:

- 1) President
- 2) President-Elect/Secretary

SECTION 2. Qualification of Officers

Officers must have been members of the Active Staff for not less than three (3) years at the time of nomination and election, and must remain members in good standing during their term of office. Failure of an officer to maintain good standing shall immediately vacate the practitioner from office.

SECTION 3. Election of Officers

- a. Officers shall be elected at the annual meeting of the Medical Staff or by written ballot at the direction of the Medical Executive Committee. Only members of the Active Medical Staff shall be eligible to vote.

When there are three (3) or more candidates and no candidate receives a majority vote, the process of successive balloting shall apply, such that the name of the candidate receiving the fewest votes is omitted from each successive slate until one candidate obtains a majority vote.

- b. The Nominating Committee shall consist of three (3) members of the Active Medical Staff, one of them the President Elect, appointed by the President of the Medical Staff at least one (1) month before the annual meeting. This committee shall offer one nominee for each office and the list of nominees shall be mailed to each member of the Active Medical Staff prior to the annual meeting.
- c. Nominations may also be made from the floor at the time of the annual meeting. The Governing Board shall approve all nominees before taking office.

SECTION 4. Term of Office

Officers shall serve their term of office as follows:

President: The President of the Medical Staff shall serve for a two (2) year period.

President-Elect/Secretary: The President-Elect /Secretary shall serve for a two (2) year period.

Officers shall serve their term from their election date or until a successor is elected.

SECTION 5. Vacancies in Office

Vacancies in office during the Medical Staff year, except for the Presidency, shall be filled by the Executive Committee of the Medical Staff and approved by the Governing Board. If there is a vacancy in the office of the President, the President-Elect/Secretary shall serve out the remaining term.

SECTION 6. Duties of Officers

- a. President: The President shall serve as the Chief Administrative Officer of the Medical Staff to:
1. Act in coordination and cooperation with the Administration in all matters of mutual concern within the hospital;
 2. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
 3. Preside on the Medical Staff Executive Committee with full voting privileges at all meetings of the Medical Executive Staff;
 4. Serve as ex-officio member of all other Medical Staff committees without vote;
 5. Be responsible for the annual review and enforcement of Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;
 6. Appoint Committee members to all standing, special and multi-disciplinary Medical Staff Committees except the Executive Committee;
 7. Represent the views, policies, needs and grievances of the Medical Staff to the Governing Board and to the Administrator or his designee;
 8. Receive and interpret the policies of the Governing Board to the Medical Staff and report to the Governing Board on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;
 9. Be responsible for the educational activities of the Medical Staff;
 10. Be the spokesperson for the Medical Staff in its external professional and public relations.
- b. President-Elect/Secretary: In the absence of the President, the President-Elect/Secretary shall assume all the duties and have the authority of the President.
- c. The President-Elect/Secretary shall be a member of the Medical Executive Committee of the Medical Staff. The President-Elect/Secretary shall automatically succeed the president when the latter fails to serve for any reason. The President-Elect/Secretary shall keep accurate and complete minutes of all Medical Staff meetings, call Medical Staff meetings on order of the President, attend to all correspondence, and perform such other duties as ordinarily pertain to the office. Where there are funds to be accounted for, the Secretary also shall act as Treasurer.

SECTION 7. Removal of Officers

Any officer may be removed by any of the following:

- a. The Governing Board;
- b. A two-thirds vote of the Active Medical Staff present at a special meeting if the Governing Board ratifies such vote of the Active Medical Staff.
- c. Grounds for removal may include any of the following:
 1. Failure to perform the duties of office in a timely and appropriate manner; or
 2. Failure to satisfy continuously the qualifications of office; or
 3. Physical or mental infirmity that renders the officer incapable of fulfilling the duties of office.

ARTICLE XII: CLINICAL DEPARTMENTS

SECTION 1: Organization of Clinical Departments and Services

The Medical Staff shall be organized into three (3) departments, Medicine, Emergency Medicine, and Surgery, and shall have a chairperson who shall be responsible for the overall supervision of the clinical work within the department. The three (3) departments shall be comprised of various clinical sections. Each department shall have a Chairperson appointed by the Medical Executive Committee. Medical Staff peer review shall be accomplished within the three (3) organized departments. Any physicians within the clinical departments or sections may organize themselves to discuss a particular issue, hold educational functions, or for whatever reason they deem necessary. Any clinical section, if organized, shall not be required to hold regular meetings. Only when sections are making formal recommendations to a department or are conducting medical peer review will a documented record be required from the chief.

The clinical sections of the Medical Staff which shall be assigned to the Department of Surgery, are as follows: General Surgery, Anesthesiology, Oral & Maxillofacial Surgery / Dentistry, Neurosurgery, Gynecology, Ophthalmology, Otolaryngology, Orthopedics, Pain Management, Pathology, Podiatry, and Urology.

The clinical sections of the Medical Staff which shall be assigned to the Department of Medicine, are as follows: Family Practice, Internal Medicine, Neurology, Pediatrics, Psychiatry and Radiology.

The clinical section of the Medical Staff which shall be assigned to the Department of Emergency Medicine is as follows: Emergency Medicine and Trauma.

SECTION 2. Selection and Tenure of Department Chairperson

- a. Each department chairperson shall be a member of the Active Category staff best qualified by training, experience and demonstrated ability for the position and shall be certified by their specialty board.
- b. Each department chairperson shall be appointed by the Governing Board upon recommendation of the Medical Executive Committee and shall continue to serve until a successor has been appointed.

- c. Removal of a department chairperson during a term of office may be initiated by any of the following:
1. The Governing Board; or
 2. The Medical Executive Committee if ratified by the Governing Board; or
 3. A two-thirds majority vote of all Active Category Medical Staff members of the department if ratified by the Medical Executive Committee and the Governing Board.

Grounds for removal may include any of the following:

1. Failure to perform the responsibilities of the department chairperson in a timely and appropriate manner; or
2. Failure to satisfy continuously the qualification of department chairperson; or
3. Physical infirmity that renders the department chairperson incapable of fulfilling the responsibilities of office;

SECTION 3. Qualifications and Responsibility of Department Chairperson

Each department chairperson shall be a member of the Active Medical Staff, willing and able to discharge the functions of the office and shall be either board certified or shall have been determined to possess equivalent qualifications by the Medical Executive Committee. Department Chairpersons shall continue to function until new chairpersons are assigned and approved by the Governing Board. Each department chairperson is responsible for the following:

1. Clinically related activities of the department;
2. All administratively related activities of the department, unless otherwise provided for by the hospital;
3. Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department;
4. Recommending clinical privileges for each member of the department;
5. Assessing and recommending to the relevant hospital authority off-site sources for needed patient care services not provided by the department or organization;
6. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges including Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE);

Each department chairperson is responsible for and shall collaborate with the administrative designee of each Department with:

- a. The integration of the department or service into the primary functions of the organizations;
- b. The coordination and integration of interdepartmental and intradepartmental services;

- c. The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;
- d. The continuous assessment and improvement of the quality of care, treatment and services provided;
- e. The recommendations for a sufficient number of qualified and competent persons to provide care treatment and services;
- f. The determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services;
- g. The maintenance of quality control programs, as appropriate;
- h. The orientation and continuing education of all persons in the department or service;
- i. The recommendations for space and other resources needed by the department or service.

Allied Health Professionals whose patient care duties are of a nature that must be quality controlled by direct Medical Staff evaluation shall be initially evaluated and periodically reevaluated as necessary by their sponsoring physician and the department chairperson. Evaluation shall focus upon the Allied Health Professionals' qualifications, status, clinical duties, FPPE & OPPE and job responsibilities with respect to risk to the patient in performance of those responsibilities. Department chairpersons shall continue to function until new chairpersons are assigned and approved by the Governing Board.

SECTION 4. Functions of Departments

- a. Each clinical section may establish its own criteria consistent with the policies of the Medical Staff and of the Governing Board, for the granting of clinical privileges. The section may make recommendations to the Medical Executive Committee as to section chief.

Clinical privileges that cross section, specialty and/or department lines will be reviewed and recommended for approval by affected sections, specialties and/or departments.

- b. Each section may establish a method to determine the appropriateness of patient care.
- c. Each clinical section and service shall determine the number of meetings it will hold each year, unless otherwise approved by the Medical Executive Committee, to consider the findings, conclusions, recommendations and actions taken by the ongoing monitoring and evaluation of section activities conducted by its members. Clinical sections may elect to meet together as a service to facilitate communication between sections and conduct business, such as peer review, that may benefit from interaction between sections.
- d. Only when sections or services are making formal recommendations to a department or are conducting medical peer review will a documented record be required from the chief.

SECTION 5. Assignment to Departments and Medical Staff Categories

The Medical Executive Committee recommends initial departmental assignments and medical staff categories for all medical staff members and for all other approved practitioners with clinical privileges.

ARTICLE XIII: MEDICAL STAFF PEER REVIEW COMMITTEES

SECTION 1. Medical Executive Committee

The Organized Medical Staff has delegated to the Medical Executive Committee the authority to carry out responsibilities of the Medical Staff, including the Medical Staff's responsibility to be accountable to the governing board for the quality of medical care provided to patients. Therefore, the Medical Executive Committee shall act on the authority of the Board of Trustees on matters of a medical nature, and shall perform any other duties that the governing board may require in order to promote quality of care. The Medical Executive Committee has the right to, but is not required to, create a Credentialing Committee and delegate responsibility for certain credentialing processes for health care providers to such Credentialing Committee.

- a. Composition: The Medical Executive Committee shall be a standing committee whose members shall have at least three (3) years membership on the Active Category Medical Staff at time of elections. The Executive Committee shall consist of the officers of the Medical Staff, and not less than three (3) and no more than five (5) other members elected for two (2) year terms. Three members will be elected on alternate years from the other two (2) members. The majority of voting Medical Staff Executive Members shall be doctors of medicine or osteopathy.

The administrator of the Hospital or designee shall attend each Medical Executive Committee meeting on an ex officio basis without vote. The primary function of the Medical Executive Committee is to approve and amend medical staff bylaws and to provide oversight for the quality of care, treatment, and services provided by practitioners with privileges. Adoption or amendment of the Medical Staff Bylaws, rules and regulations, and policies cannot be delegated by the organized medical staff and governing body.

The Medical Executive Committee makes recommendations directly to the governing body on at least the following:

1. Initiating and developing the Medical Staff Bylaws, Rules and Regulations;
2. Recommending approval and disapproval of amendments to the Medical Staff Bylaws to the Medical Staff and Governing Board;
3. The organized medical staff's structure;
4. Selecting and removing Medical Staff officers;
5. Medical staff membership and termination of membership;
6. Medical staff membership and termination of membership;
7. The process used to review credentials and delineate privileges;

8. Delineation of privileges for each practitioner privileged through the medical staff process, and
 9. The Medical Executive Committee's review of and actions on reports of all medical staff committees and departments.
- b. Duties: The duties of the Medical Executive Committee shall be:
1. To represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;
 2. To work with the Governing Body to define their shared and unique responsibilities;
 3. To work with the Governing Body and senior leaders to identify skills required of individual leaders within management;
 4. To work with the Governing Body and senior leaders to create the hospital's mission, vision and goals;
 5. To work with the Hospital's Governing Body and senior leaders to define what constitutes a conflict of interest that could affect safety and quality;
 6. To work with the hospital's governing body and senior leaders in developing an ongoing process that defines how conflict of interest will be addressed;
 7. To work with the Hospital's Governing Body and senior leaders in developing processes that support efficient patient flow;
 8. To act on behalf of the Medical Staff between meetings;
 9. To coordinate the activities and general policies of the Medical Staff departments;
 10. To receive and act upon reports and recommendations from Medical Staff committees, clinical departments and any ad hoc committees;
 11. To implement policies of the Medical Staff not otherwise the responsibility of the departments;
 13. To provide liaison between the Medical Staff and the administrator and the governing board;
 14. To make recommendations on hospital management matters (for example, long range planning) to the governing board through the chief executive officer;
 15. To fulfill the Medical Staff's accountability to the Governing Board for promoting patient safety and the quality of medical care, treatment, and services;
 16. To ensure that the Medical Staff is educated in all new or changed regulatory standards affecting the Medical Staff, and informed of the accreditation/regulatory status of the Hospital;

17. To provide for the preparation of all meeting programs, either directly or through delegation to a Program Committee or other suitable agent;
 18. To review the credentials of all applicants and to make recommendations for staff membership, assignment to department and delineation of clinical privileges;
 19. To review on an ongoing basis all information inclusive of FPPE and OPPE reports, regarding the performance and clinical competence of staff members and other practitioners with clinical privileges and as a result of such reviews to make recommendations for reappointments and renewal or changes in clinical privileges;
 20. To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;
 21. To recommend appointment of the department chairpersons, section chiefs and committee members in accordance with these Bylaws, Rules and Regulations;
 22. To be responsible for the organization of the performance improvement activities of the Medical Staff as well as the mechanism used to conduct, analyze/evaluate and revise such activities on an ongoing basis;
 23. To, at a minimum, review the following: Operative or other procedures that place patients at risk of disability or death, all significant discrepancies between preoperative and postoperative diagnoses (including pathologic diagnoses), adverse events related to using moderate or deep sedation or anesthesia, the use of blood and blood components, all reported and confirmed transfusion reactions, the use of restraints and/or seclusion, resuscitation results, significant medication errors and significant adverse drug reactions, the effectiveness of all fall reduction activities, data on the effectiveness of responding to change or deterioration in a patient's condition, mortality, readmissions and length of stay review, infection surveillance, the review and analysis of actual infections, the promotion of a preventative and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the hospital's activities, prevention and control, near misses, adverse outcomes and sentinel/never events, and significant departures from established patterns of clinical practice.
 24. To provide oversight in the process of analyzing and improving the patient's perception of the safety and quality of care and treatment and services.
 25. To keep regular minutes of their proceedings and report any relevant information at each general staff meeting or to the Governing Board, as appropriate.
- c. Meetings: The Medical Executive Committee shall meet at least on a monthly basis.
- d. The revocation or resignation of a committee member's Medical Staff membership and/or appointment will serve as a resignation from the Medical Executive Committee.

SECTION 2. Pharmacy and Therapeutics Committee

- a. Composition: Membership shall consist of at least five (5) representatives of the Medical Staff, the Hospital director of pharmacy, pharmacy personnel and Hospital administrative personnel as required.
- b. Duties: This committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the hospital in order to assure optimum clinical results and a minimum potential for hazard. The committee will review any adverse drug reactions.
- c. The committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the Hospital.
- d. Meetings: This committee shall meet at least quarterly. The committee shall maintain a permanent record of its proceedings and transmit reports and/or recommendations to the Medical Executive Committee.

SECTION 3. Special Committees / Ad Hoc Committees

Special committees shall be appointed from time-to-time as may be required to carry out properly the duties of the medical staff. Such committees shall confine their work to the purpose for which they were appointed and shall report to the Medical Executive Committee. They shall not have power of action unless such is specifically granted by the motion which created the committee.

SECTION 4. Each Committee

Each committee, in addition to its specific reporting requirements shall report its activities and decisions to the Chief Medical Officer of CHRISTUS Mother Frances Hospital - Jacksonville.

ARTICLE XIV: MEDICAL STAFF MEETINGS

SECTION 1. Meetings

- a. Regular Meetings: Meetings of the General Medical Staff shall be held once per year. Department meetings of the staff shall be held no less than two (2) times a year. In addition to matters of organization, these meetings may include a report of the Executive Committee and various committee chairpersons, these meetings shall include the findings, conclusions, recommendations and actions taken by the ongoing monitoring and evaluation of department activities conducted by its members.
- b. Officers for the ensuing year shall be elected at the annual meeting; or, may be elected via written ballot to eligible voters at the direction of the Medical Executive Committee following a mail out of the list of nominees to each member of the Active Medical Staff.

SECTION 2. Special Meetings

- a. The President may call a special meeting of the Medical Staff at any time. The President shall call a special meeting within ten (10) days after receipt of a written request stating the purpose of such meeting. The President shall designate the time and place of any special meeting.
- b. Written or printed notice stating the place, day and hour of any special meeting of the Medical Staff shall be posted on the bulletin board in the physician's lounge not less than four days before the time and date of such meeting, by or at the direction of the President. 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. Quorum

A quorum consists of those members present.

SECTION 4. Attendance Requirements

Members of the Active Medical Staff Category shall be required to participate in one (1) of their assigned Department meetings per year. Participation in medical staff peer review shall also be considered as meeting this requirement. Participation in medical staff peer review may be met through attendance at one of the following meetings: a medical staff department meeting or assignment to a medical staff peer review committee. Failure to comply with this provision may result in disciplinary action up to and including loss of medical staff membership and privileges.

Members of the Medical Executive Committee and Pharmacy & Therapeutics Committee are expected to attend at least fifty percent (50%) of the meetings held.

SECTION 5. Notice of Meetings

Written or oral notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the committee or department not less than five days before the time of such meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at the proper address as it appears on the records of the hospital with postage thereon prepaid. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

SECTION 6. Manner of Action

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee or department. Action may be taken without a meeting by unanimous consent in writing (setting forth the action so taken) signed by each member entitled to vote thereat.

SECTION 7. Rights of Ex Officio Members

Persons serving under these Bylaws as ex officio members of a committee shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum nor shall they be permitted to vote.

SECTION 8. Minutes

Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer and forwarded to the Medical Executive Committee. Each committee and department shall maintain a permanent file of the minutes of each meeting.

ARTICLE XV: PRACTITIONER RIGHTS

SECTION 1.

Each physician on the Medical Staff has the right to an audience with the Medical Executive Committee. In the event a practitioner is unable to resolve a difficulty working with his/her respective department chair, that physician may, upon presentation of a written notice, meet with the Medical Executive Committee to discuss the issue.

SECTION 2.

Any practitioner has the right to initiate a recall election of a medical staff officer and/or appointment of a department chair. A petition for such recall must be presented, signed by at least 25% of the members of the Active Staff. Upon presentation of such valid petitioner, the Medical Executive Committee will schedule a special general staff meeting for the purposes of discussing the issue and (if appropriate) entertain a no-confidence vote.

SECTION 3.

Any practitioner may call a general staff meeting. Upon presentation of a petition signed by 30% of the members of the active staff, the Medical Executive Committee will schedule a general staff meeting for the specific purpose addressed by the petitioners. No business other than that in the petition may be transacted.

SECTION 4.

Any practitioner may raise a challenge to any rule or policy established by the Medical Executive Committee. In the event a rule, regulation or policy is felt to be inappropriate, any physician may submit a petition signed by 30% members of the active staff. When the Medical Executive Committee has received such petition, it will either: (1) provide the petitioners with information clarifying the intent of such rule, regulation or policy and/or (2) schedule a meeting with the petitioners to discuss the issue.

SECTION 5.

Any department/subspecialty group may request a department meeting when a majority of the department/subspecialists believes that the department has not acted appropriately.

SECTION 6.

This section is common to Section 1 through 5 above. This section does not pertain to issues involving disciplinary action, denial of request for appointment or clinical privileges, or any other matter relating to individual credentialing actions. Section 7 and the Fair Hearing Plan provide recourse in these matters.

SECTION 7.

Any physician has a right to a hearing/appeal to the institution's Fair Hearing Plan in the event any of the following actions are taken or recommended:

1. Denial of initial staff appointment;
2. Denial of reappointment;
3. Revocation of staff appointment;
4. Denial or restriction of requested clinical privileges;
5. Reduction in clinical privileges;
6. Revocation of clinical privileges;
7. Individual application of, or individual changes in, mandatory consultation requirements; and
8. Suspension of staff appointment or clinical privileges if such suspension is for more than 14 days.

ARTICLE XVI: CONFLICT RESOLUTION MECHANISM

Process for Managing Conflict between the Medical Executive Committee (MEC) and the Organized Medical Staff:

For the purposes of these bylaws, the process for conflict management outlined below applies only to conflict between the MEC and the organized Medical Staff regarding adoption or amendment of medical rules and regulations, and/or policy.

Should there be disagreement between the MEC and the organized medical staff over the adoption or amendment of medical staff rules and regulations, and/or policy, the following shall occur:

- The MEC will inform the governing body that either they or the organized medical staff has adopted or amended medical staff rules and regulation, and/or policies, and that there is disagreement between the two bodies.

- The governing body shall appoint a special committee consisting of five individuals – one each from the MEC and the organized medical staff, and three members of the governing body – who are neither members of the MEC or of the organized medical staff – one of whom shall serve as Chair.
- The special committee shall review the adoption or amendment as well as the MEC’s reason for disagreement. By majority decision, the special committee will make a recommendation to the governing body to either allow the adoption or amendment to be proposed, or to decline receiving said proposal.
- Based on the recommendation from the special committee, the governing body shall decide whether or not to receive the proposed adoption or amendment. The decision by the governing body is final. Both the MEC and the organized medical staff shall be notified in writing of the governing body’s decision.

Nothing in this process is to be construed as preventing the organized medical staff from communicating directly with the governing body. The governing body will determine the method of communication in such matters.

ARTICLE XVII: PHYSICIAN RESPONSIBILITIES

SECTION 1. Patient Safety

It is the responsibility of each physician holding medical staff membership and privileges to report issues or occurrences impacting patient safety. This is inclusive of any suspected or actual unsafe practice. Any such communication shall be referred to the Medical Executive Committee. Any such communication or report with respect to any practitioner made in good faith and without malice shall be privileged and confidential and as such work product of a medical staff peer review committee.

SECTION 2. Anesthesia, Surgical and Medical Informed Consent

In keeping with the requirements of the Texas Medical Disclosure Panel it is the responsibility of each physician holding medical staff membership and privileges to provide the patient with information with which to make an informed decision regarding medical treatment or surgical intervention. This is inclusive of risks, benefits and alternatives to the medical treatment or surgical intervention. Additionally, in keeping with the requirements of CMS and the Joint Commission, this process should include a discussion about potential benefits, risks and side effects of the proposed care, treatment and services, the likelihood of the patient achieving his or her goals and the potential problems that may occur during recuperation. The informed consent process should also include a discussion about reasonable alternatives to the proposed care, treatment or services. It also includes risks, benefits and side effects related to the alternatives and the risks related to not receiving the care, treatment or services. The process should also include a discussion about circumstances under which information must be disclosed. This entry must also be dated and times. This information should be patient specific and in language and terms the patient can understand. The date and time informed consent is given to the patient must be documented in the medical record of the patient by the physician.

ARTICLE XVIII: IMMUNITY FROM LIABILITY

The following shall be express conditions to any practitioner’s application for, or exercise of, clinical privileges at this Hospital:

First, any act, communication, report, recommendation, or disclosure, with respect to any such practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged and confidential.

Second, such privilege shall extend to all persons, organizations and committees under applicable law including, without limitation, Governing Board, officers and administrative staff, and to third parties who provide information to any of the foregoing authorized to receive, release or act upon the same. Third parties' means both individuals and organizations from which information has been requested by an authorized representative of the Governing Board or Medical Staff.

Third, there shall be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

Fourth, such immunity shall apply to all acts, communications, reports, recommendation, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to: (1) applications for appointment or clinical privileges, (2) periodic reappraisals for reappointment or clinical privileges (3) corrective action, including summary suspension, (4) hearings and appellate reviews, (5) medical care evaluations, (6) utilization reviews, and (7) other hospital, departmental, service or committee activities related to quality patient care and unprofessional conduct.

Fifth, the acts, communications, reports, recommendations and disclosures referred to in this Article XVIII 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 have an effect on patient care.

Sixth, each practitioner shall upon request of the hospital execute releases in accordance with the tenor and import of the Article XVIII in favor of the individuals and organizations specified in paragraph second, subject to such requirements as may be applicable under the laws of Texas.

Seventh, the consents, authorizations, releases, rights, privileges and immunities provided by section 1 and 2 of Article VI of these Bylaws in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this article XVIII.

ARTICLE XIX: RULES AND REGULATIONS

The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Board. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the hospital. Such Rules and Regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present and without previous notice or at any special meeting on notice, or they may be voted upon via written ballots to eligible voters at the direction of the Medical Executive Committee. To be adopted, the Rules and Regulations shall require a simple majority vote of eligible voters present at the time of such vote or a majority of the signed returned ballots. Such changes shall become effective when approved by the Governing Board.

ARTICLE XX: AMENDMENTS

All proposed amendments to these Bylaws shall be referred to the Medical Executive Committee of the Medical Staff by the Bylaws Committee. The Medical Executive Committee shall report on them either favorably or unfavorably at the next regular meeting of the Medical Staff or at a special meeting called for such purpose with the vote adopting the same taken at the next succeeding meeting where a quorum is present; or, a copy of the proposed amendment(s) shall be mailed to each staff member at least fourteen days (14) prior to the meeting at which time proposed amendments will be presented for vote; or, they may be voted on via written ballots to

eligible voters at the direction of the Medical Executive Committee following discussion at one (1) Medical Staff meeting or following a mail out of proposed amendments at least fourteen (14) days prior to the mail out of the written ballot. To be adopted, the amendment(s) shall require a simple majority vote of eligible voters present at time of such vote or a majority of the signed returned ballots. Amendments so made shall be effective when approved by the Governing Board.

RULES AND REGULATIONS

A. ADMISSION AND DISCHARGE OF PATIENTS

1. The Hospital shall accept patients for care and treatment.
2. A patient may be admitted to the Hospital as an Inpatient or placed in observation only by a member of the Active or Courtesy Medical Staff. All practitioners shall be governed by the official admitting policy of the Hospital.
3. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical records.
4. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency such statement shall be recorded as soon as possible.
5. In any emergency case in which it appears the patient will have to be admitted to the Hospital, the practitioner shall when possible first contact the Admitting Department to ascertain whether there is an available bed.
6. Practitioners admitting emergency cases shall be prepared to justify to the Executive Committee of the Medical Staff and the Administration of the Hospital that such said emergency admission was a bona fide emergency. 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 chart as soon as possible after admission.
7. A patient who is admitted on an emergency basis who does not have a private practitioner may select any consenting practitioner in the applicable department or service to attend to him. Where no such selection is made, the member of the Active or Courtesy Staff on call in the Department will be assigned to the patient, on a rotation basis, where possible. The Chairman of each Department and/or service shall provide a schedule for such on-call assignments.
8. CHRISTUS Mother Frances Hospital - Jacksonville Admissions will admit patients on the basis of the following orders of priorities and placement determined by Bed Control:

A. Emergency Admissions

Within 24 hours following an emergency admission, the attending practitioner shall document the need for this admission on patient's medical records.

History and Physical shall suffice. Failure to furnish this documentation, or evidence of willful or continued misuse of this category of admission, will be brought to the attention of the Medical Executive Committee for appropriate action.

B. Pre-Operative Admissions

This includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the Department Chairman of Surgery may decide the urgency of any specific admission.

C. Routine Admissions

Shall be accepted from an Active or Courtesy Category Medical Staff member.

Day Surgery patients must be admitted at least two (2) hours prior to their surgical procedure.

9. Patient Transfers – Transfer priorities shall be as follows:

A. Emergency Room to appropriate patient bed.

No patient will be transferred without such transfer being approved by the responsible practitioner.

10. The admitting practitioner shall be expected to give such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his patients might be a source of danger from any cause whatever.

11. For the protection of patients, medical and nursing staffs, and the hospital, certain principles are to be met in the care of the potentially suicidal patient:

- 1) If a patient remains suicidal or has suicidal inclinations, the patient should be transferred to an appropriate facility.
- 2) If the patient is not suicidal or does not demonstrate suicidal inclinations, the patient may be transferred to an appropriate facility or routine nursing unit.

12. Patients shall be discharged only on a written order of the attending practitioner. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

13. In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his designee within a reasonable time. Suicides, known or suspected, and accidental deaths, shall be reported to the local law enforcement authorities. Policies with respect to release of dead bodies shall conform to local law.

14. It shall be the duty of all staff members to secure autopsies whenever possible in keeping with Policy D-76.0, approved by the Medical Staff. An autopsy may be performed only with a written consent, signed in accordance with state law. The complete autopsy report should be made a part of the medical record within 30 days.
15. The use of restraints shall be limited to only those situations in which alternatives have failed or there is imminent danger to self and others. Any use of restraints requires appropriate clinical justification. A written time limited order is necessary from the physician for each use of restraints. PRN orders shall not be accepted. (Refer to Policy D-117 approved by the Medical Staff.)

B. MEDICAL RECORDS

1. The attending practitioner shall be responsible for the preparation of a complete, timely and legible medical record for each patient. Its contents shall be pertinent and current. This record shall include identification data; 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 or discharge note; clinical resume; and autopsy report, when performed.
2. All qualified practitioners must complete a medical history and physical no more than thirty (30) days prior to, or within twenty-four (24) hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. For a medical history and physical examination that was completed within thirty (30) days prior to registration or inpatient admission, an update documenting any changes in the patient's conditions completed within twenty-four (24) hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. An Inpatient History and Physical shall at a minimum include an Admitting or Provisional Diagnosis; History of Present Illness; Medications; Allergies; Past Medical and Surgical History; Family History; Review of Systems; Physical Exam; and, Plan of Care. The Outpatient History and Physical shall at a minimum include a Chief Complaint; Diagnosis; Allergies, Medications, Physical Exam; and, Plan of Care. A durable, typed copy of complete history and physical done before the patient is admitted may be used in the Hospital record, providing the history and physical was done by a member of this Hospital staff, and was completed within thirty (30) days of the admit date. When so used, the history and physical must be updated within twenty-four (24) hours of admission and must be in the admission note, which includes all additional history changes or additional physical findings. The only exceptions to the typed format are the Abbreviated H&P (Form #2103-8720,11/02) that may be utilized in those situations where transcription is not practical; and, the Physician Pre-Sedation Assessment History and Physical (Form #2100-8720,10/02). In elective surgery the History and Physical must be completed and on the medical record prior to surgery. **Before operative or other high risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered, a pre-sedation or pre-anesthesia patient assessment must be completed.**
3. Prior to emergency surgery the admitting physician should enter in the Progress Notes an admitting note to include indications for surgery and pertinent physical findings. In elective surgery, the history and physical must be dictated and on the medical record prior to surgery.
4. All patients requiring moderate or deep sedation/analgesia shall have a documented History and Physical or Emergency Department Physician Assessment, which meets the applicable requirements of B. Medical Records #2 by the healthcare provider at the time of moderate or deep sedation/analgesia.

The Physician Pre-Sedation Assessment History & Physical (form #2100-8720, 10/02) or the Abbreviated H&P (Form #21038720, 11/02) may be used for sedation.

5. Patients converted from outpatient status to inpatient status must have a History and Physical which meets the applicable inpatient History & Physical requirements within 24 hours of change status.
6. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least daily on critically ill patients, and those where there is difficulty in diagnosis or management of the clinical problem.
7. Operative reports and/or any interventional procedures (i.e., cardiology reports, GI procedures, pain management procedures, radiology interventions) shall include a detailed account of the findings at surgery as well as the details of the surgical and/or interventional technique. These reports shall be dictated and include the following: the name of the practitioner who performed the procedure and his/her assistant(s), the name of the procedure performed, a description of the procedure, findings of the procedure, estimated blood loss, any specimen removed, and post-operative diagnosis. If a full operative report cannot be dictated prior to the patient being transferred to the next level of care, a hand-written post-procedure note may be entered on the Progress Note indicating the name of the surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimen removed, and post-operative.
 - It shall be the responsibility of the physician to document that he has provided the patient with informed consent in medical, surgical and anesthesia procedures requiring informed consent. This process includes a discussion about potential benefits, risks and side effects of the proposed care, treatment and services, the likelihood of the patient achieving his or her goals, and any potential problems that may occur during recuperation. The informed consent process also includes a discussion about reasonable alternatives to the proposed care, treatment or services. It also includes risks, benefits and side effects related to the alternatives and the risks related to not receiving the care, treatment or services. The process should also include a discussion about circumstances under which information must be disclosed. This entry must also be dated and timed. This may be documented in the Physician Progress Note, in the Operative Report, or on the Physician Pre-Sedation Assessment History and Physical, or by signing the Anesthesia, Surgical and medical Informed Consent signed by your patient.
 - It is the responsibility of the physician writing a "Do Not Resuscitate" order to document in the Progress Notes that the patient or patient's surrogate was involved in the decision.
 - Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation/procedure.
 - All clinical entries in the patient's medical record shall be legible, accurately dated, timed and authenticated in either written or electronic form by the author.
 - Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved abbreviations should be kept on file in the record room.

- The use of Unacceptable/Do-Not Use/Dangerous Abbreviations shall result in a clarification call to the practitioner in the interest of patient safety. The use of Unacceptable/Do-Not Use/Dangerous Abbreviations applies to all orders and all medication-related documents.
- Final diagnosis shall be recorded in full, without the use of symbols or abbreviations by the responsible practitioner at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order.
- A discharge clinical summary shall be dictated on all medical records of patients hospitalized over 48 hours. All summaries shall be authenticated by the responsible practitioner and shall include instructions for post-hospital care.
- Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.
- Original records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or state law. Unauthorized removal of charts from the Hospital is grounds for suspension of the practitioner for a period to be determined by the Executive Committee of the Medical Staff.
- Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. The Executive Committee of the Medical Staff shall approve all such projects before records can be studied. Subject to the discretion of the Administrator or his designee, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.
- A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Executive Committee.
- A practitioner's preprinted order, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated and signed by the practitioner.
- All orders (except verbal orders) must be dated, timed, and authenticated by the next time the prescriber or another practitioner who is responsible for the care of the patient and has been credentialed by the Medical Staff and granted privileges which are consistent with the written orders, provides care to the patient, assesses the patient, or documents information in the patient's medical record.
- All verbal orders must be dated, timed and authenticated within forty-eight (48) hours by the prescriber or another practitioner who is responsible for the care of the patient.

Medical records shall be completed within thirty (30) calendar days following discharge:

- a. In order to manage the record completion process, the Health Information Management Department will send a notification letter once monthly advising practitioners of the need to complete all delinquent records within 14 days of receipt of the notification.
- b. Failure to complete records within the designated time frame will result in temporary suspension of admitting and/or clinical privileges until such time as all delinquent records are completed.

- c. Suspension letter informs the physician in writing that the attached summary medical records report must be completed by a specific date and time; and if the medical records remain incomplete that his/her admitting and/or clinical privileges shall be denied until all delinquent medical records have been completed. This is inclusive of physician signatures / electronic signatures on transcription.
- d. Suspension letters for failure to complete medical records will be included in the provider's credentialing file.
- e. Physicians may access the electronic medical record system to obtain detailed information regarding their incomplete and delinquent medical records at any time.
- f. When a private patient of the suspended physician desires admission to this Hospital, the patient shall name another physician of his choice or otherwise be admitted to the applicable Department of the physician on emergency call.
- g. Three such suspensions of admitting and clinical privileges within any 12-month period shall be sufficient cause for referral to the Medical Executive Committee for action.
- h. Recommendation not to renew staff privileges shall be made to the Governing Board by the Executive Committee for any physician with three suspensions within any 12-month period.

C. GENERAL CONDUCT OF CARE

1. A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. The admitting officer should notify the attending practitioner whenever the patient has refused such consent. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is admitted to the Hospital.
2. The Medical Staff shall recognize the rights of patients to self-determination including:
 - A. The right to accept or refuse medical or surgical treatment;
 - B. The right to formulate advance directives such as through the appointment of an agent to make decisions on his/her behalf (Medical Power of Attorney) or written instructions about health care (Directive to Physicians which includes the Out-of-Hospital DNR).
3. In situations wherein the physician and family or patient disagree on resuscitative measures, the physician, utilizing sound medical judgement, will counsel with the family and patient, document the conversation thoroughly in the medical record and will then respect the patient and/or family's wishes for that care. (See Patient Self-Determination Policy, A-24.0)
 - a. If an attending physician disagrees with and refuses to honor a treatment decision chosen by a patient or the patient's representative, the conflict shall be reviewed by the Ethics Committee. The patient shall be given life-sustaining treatment at a minimum during the review. The attending physician shall not be a member of that committee.

- b. If the physician, patient or patient's representative responsible for the healthcare decisions of the patient is requesting life-sustaining treatment that the Ethics Committee decides is inappropriate, the patient shall be given life-sustaining treatment pending transfer. The physician and the facility will work together to transfer the patient to a willing provider.
 - c. If within ten (10) days a willing provider cannot be found, life sustaining treatment may be stopped unless a court order has granted an extension of time within which life-sustaining treatment must be given. (See Ethics Committee Policy, A-23.0)
4. All orders for treatment shall be in writing. A verbal order shall be considered to be in writing if dictated to a registered nurse, licensed vocational nurse, social worker, pharmacist, dietitian, technologist, physical therapist, or respiratory therapist when functioning within his/her sphere of competence and signed by the responsible practitioner. Practitioners giving verbal and telephone orders shall permit the receiver of the order time to write the complete order, read it back to the practitioner and receive confirmation from the practitioner. All orders dictated by telephone shall be signed over the name of the practitioner by the registered nurse, licensed vocational nurse, pharmacist, social worker, dietitian, technologist, physical therapist, or respiratory therapist to whom dictated. All verbal orders must be dated, timed and authenticated within forty-eight (48) hours by the prescriber or another practitioner who is responsible for the care of the patient. Authentication of verbal orders must include the date and time of authentication.
 5. The practitioner's orders must be written clearly, legibly and completely and all entries dated and timed. Orders, which are illegible or improperly written, will not be carried out until rewritten and understood by the nurse.
 6. All previous orders are canceled when patients go to surgery.
 7. All drugs and medications administered shall be those approved by the Food and Drug Administration. Drugs for approved clinical investigations may be exceptions. Investigational drug protocols will be approved by the TMFHS Investigational Review Board. These shall be conducted in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals, and all regulations of the Food and Drug Administration.
 8. Any medication that the patient brings with him for continued use in the hospital should be duly recorded by the physician and placed in the custody of the Charge Nurse.
 9. Medication shall be administered to patients only by registered nurses or licensed vocational nurses properly oriented and according to Nursing Service policies and procedures; or by physicians; or Allied Health Professionals, with prescriptive authority or by the following licensed persons: respiratory therapists; radiology technicians; nuclear medication technicians; physical therapists; pharmacists, when done so within the scope of their responsibilities and consistent with laws and regulations, and policies of their department. All such administrations of medication shall be pursuant to the order of a prescriber with clinical privileges granted by the medical staff. The pharmacist shall dispense medication only for use under such circumstances.
 10. There shall be an effective automatic stop order for all medications, which shall apply unless the prescribing physician specifies a period of time or number of doses to be administered. The automatic stop order shall be thirty (30) days from the date of the physician order. A notice of renewal shall be posted with the Progress Notes, or on the Physician Order form twenty-four

(24) before the automatic stop date takes effect. The order will be stopped automatically at 2400 hours on the date specified.

- a. The stop order procedures shall include a system to notify the practitioner of the impending expiration and to assure that affected medications shall not be stopped until physician is notified.
 - b. There shall be effective procedures for the safe control, prescription, administering, use and disposition of cancer chemotherapy agents.
11. The Pharmacy cannot fill take-home prescriptions nor can the nurse copy a take-home prescription order from the chart onto a prescription blank and sign the physician's name as a telephone or verbal order.
 12. Generically equivalent drugs will be dispensed by the pharmacy.
 13. Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within his area of expertise. If usual methods of obtaining a consult are unsuccessful and the attending physician believes patient care will be compromised without appropriate consultation, the Department Chairperson, President or President-Elect of the Medical Staff may require a consultation based on the appropriate unassigned Emergency Department call schedule. Such a required consultation will be mandatory and performed in an expeditious manner by the on-call member of the Medical Staff.
 14. Consultation is encouraged in the following situations:
 - a. When the patient is not a good risk for operation or treatment;
 - b. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;
 - c. Where there is doubt as to the choice of therapeutic measures to be utilized;
 - d. In unusually complicated situations where specific skills of other practitioners may be needed;
 - e. In instances in which the patient exhibits severe psychiatric symptoms;
 - f. When requested by the patient or his family.
 15. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant.
 16. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained he/she shall call this to the attention of his/her supervisor who in turn may refer the matter to the Chief Nursing Officer or her designee, and/or the Medical Director. If warranted, the Chief Nursing Officer or her designee may bring the matter to the attention of the Chairman of the Department. Where circumstances are such as to justify such action, the Chairman of the Department may himself request a consultation.

17. All Allied Health Professional personnel who are either in the employ of a private Medical Staff Member or whom he/she brings in for either teaching or assisting purposes are the direct responsibility of that individual physician. Failure by the Allied Health Practitioner to comply with Bylaws, Regulations, or hospital policy may result in the suspension of Allied Health Practitioner supervision privileges for the Medical Staff Member. All Allied Health Professional personnel shall be credentialed according to the current medical staff bylaws.
18. All clinical laboratory procedures ordered by the physician shall be performed in the Hospital Laboratory if such procedures are available. Laboratory procedures not available in the Hospital Laboratory may be referred only to laboratories recommended and approved by the Medical Executive Committee.
19. Diagnostic and therapeutic radiology services shall be maintained and directed by one or more qualified radiologists. Performance and interpretation of radiological examinations shall be made by a qualified radiologist whose name shall be specified in the written order for the examination by the referring physician. Privileges to perform specific limited interpretative diagnostic and monitoring radiologic studies which have been granted to staff physicians who are not radiologists should be of a highly specialized nature, the performance of which requires special qualifications or training and/or experience in the use of the equipment and in the interpretation of results, as well as practice in a field of related diagnostic/therapeutic activities. Credentials files of all physicians thus engaged shall reflect the training, experience and current competence required for the aspects of radiological services for which they are engaged. All off-site therapeutic radiology shall be referred to an appropriately accredited facility that has been recommended by the Department Chairman and approved by the Governing Board, when not available in-house.
20. Laboratory, x-ray and other reports of diagnostic procedures performed outside the Hospital but related to a patient's current admission shall be placed on the patient's record to substantiate the diagnoses and treatment.
21. In the interest of patient safety, critical lab values called to the physician shall be read back so as to confirm accurate transmittal to the physician.
22. The legal code of the State of Texas, regulating adoptions and child placements, shall be observed and enforced at all times.
23. To facilitate the care of the patient, timely care is required and all patients admitted through the Emergency Department shall be seen by the attending physician of record no later than 12:00 noon on the day following their admission. Orders written by the Emergency Department physician and shall expire at the time the patient is seen by the attending physician of record, or no later than 12:00 noon the day following their admission. The attending physician shall be notified via telephone at 7:00 a.m. and reminded of the patient's admission and expiration of orders at 12:00 noon. Patients shall be seen daily by the attending physician or consultant who may have assumed care of the patient.
24. All patients admitted to the hospital or placed in observation will be evaluated by a member of the Active or Courtesy Medical Staff. Allied Health Professionals may not independently admit patients.
25. Medication reconciliation is a prescribing activity and as such the execution of medication reconciliation is seen as a responsibility of the physician. Medication reconciliation shall be

completed upon admission, at the time of patient transfer to a different level of care, and at the time of the patient's discharge.

D. GENERAL RULES REGARDING SURGICAL CARE

1. Written, signed, informed surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or an unconscious patient in which consent for surgery cannot be immediately obtained from patients, guardian or next of kin, these circumstances should be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits. It shall be the physician's obligation to have the required informed consent form completed prior to surgery or any other medical procedure requiring consent.
2. In keeping with the requirements of the Texas Medical and Disclosure Panel it shall be the responsibility of the physician to document that he has provided the patient with the risks, benefits, and alternatives in medical and surgical procedures requiring informed consent. The physician must also document the date and time informed consent is given. This may be documented in the Physician Progress Notes, in the Operative Report or on the Physician Pre-Sedation Assessment History & Physical or by signing the Anesthesia, Surgical & Medical Informed Consent form signed by the patient.
3. Except in severe emergencies, the perioperative diagnosis and pertinent laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. In any emergency the practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery. In elective surgery the history and physical must be completed and on the medical record prior to surgery.
4. All patients shall be assessed preoperatively according to medical staff approved policies. This assessment shall be documented by the practitioner prior to conducting emergent and non-emergency operative and other procedures.
5. A patient admitted for dental or podiatric care is a dual responsibility involving the dentist or podiatrist and a qualified practitioner who is also a member of the medical staff with the appropriate clinical privileges.

Dentists' or Podiatrists' responsibilities:

- A detailed dental or podiatric history justifying hospital admission;
- A detailed description of the examination of the oral cavity or podiatric issue and a preoperative diagnosis;
- A complete operative report, describing the finding and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed;
- Progress notes as are pertinent to the oral or podiatric condition;
- Clinical resume (or summary statement);
- Pertinent instructions to patient and/or family at time of discharge.

Physician's responsibilities:

- Medical history pertinent to the patient's general health;
 - A physical examination to determine the patient's condition prior to anesthesia and surgery;
 - Management and coordination of the patient's general health status while hospitalized.
6. The discharge of the patient shall be on written order of the dental or podiatric member of the Medical Staff and he will be responsible for post-operative instructions.
 7. Patients admitted to the Hospital for oral maxillofacial/dental surgery shall receive the same basic medical appraisal as patients admitted for other services whether the appraisals are performed by a physician member of the medical staff or an Oral and Maxillofacial Surgeon qualified to complete an admission history and physical examination and assess medical risks of the procedure to the patient. A physician member of the medical staff shall be responsible for the care of medical problems that may be present upon admission or that may arise during hospitalization of the Oral Surgery patient.
 8. Patients admitted for Podiatric care shall receive the same basic medical appraisal as patients admitted for other services. A qualified practitioner shall be responsible to complete the history and physical exam and assess the medical risks concerning the procedure as it pertains to the patient prior to surgical intervention. The Podiatrist shall be responsible for the portion of the history and physical examination related to Podiatry prior to surgical intervention.
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 11. Patients admitted for Podiatric care shall receive the same basic medical appraisal as patients admitted for other services. A qualified practitioner shall be responsible to complete the history and physical exam and assess the medical risks concerning the procedure as it pertains to the patient prior to surgical intervention. The Podiatrist shall be responsible for the portion of the history and physical examination related to Podiatry prior to surgical intervention.
 12. When Podiatric surgery or oral maxillofacial surgery is being done under general anesthesia, an Anesthesiologist or CRNA will be responsible for the anesthesia and for any resuscitative efforts should they be needed.

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16. Contraceptive sterilization is prohibited. All cases involving a procedure that induces sterility as an unintended but foreseeable secondary outcome must be referred to the Ethics Committee.
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19. Anesthesiologists and CRNAs shall maintain a complete anesthesia record to include evidence of pre-anesthetic or pre-sedation evaluation, immediately prior to induction or moderate-deep sedation/analgesia; and, post-anesthetic or post-sedation/analgesia follow-up of the patient's condition.
20. All tissues removed at operation, with the exception of those exempted by the Pathologist and Medical Staff, shall be sent to the Hospital Pathologist who shall make such examination as he may consider necessary to arrive at a tissue diagnosis. His authenticated report shall be made a part of the patient's medical record.
21. Surgeons must be in the operating room and ready to commence operation at the time scheduled and in no case will the operating room be held longer than fifteen minutes after the time scheduled.
22. Planning, marking and making a surgical incision or administering a pain block is the responsibility of physicians or CRNAs who have been involved in a formal training and who hold privileges for the specific procedure being performed. Non-physician providers privileged to do so may perform a subsequent incision when directly supervised by the sponsoring physician.
23. All general Dentists and Podiatrists will have a physician anesthesiologist or CRNA in attendance for all anesthesia administered in the Hospital and Outpatient Services.

E. EMERGENCY SERVICES

1. Emergency Room services, other than those provided by the Emergency Department Physician, shall be provided by the physician on-call on a rotation basis. Patients who are admitted on an emergency basis and who do not have a private practitioner may request any consenting practitioner in the applicable department or section to attend to him. Where no such selection is made, the Medical Staff member on call in the department or section will be assigned to the patient. Physicians on call must be able to respond in person within thirty (30) minutes. The chairman of each department and/or section or his designee shall provide a schedule for such assignments. The monthly on-call calendar shall be the responsibility of the Department Chairmen. When there are insufficient Active Category physicians in a department or section to provide full call coverage, each physician in the department or section shall assume a reasonable response obligation at the discretion of the Medical Executive Committee.
2. The patient presenting with a private physician on the Staff shall be the responsibility of that physician and his/her designee will be notified, if requested. The medical staff shall provide an appropriate medical screening within the capability of the Emergency Care Center consistent with the symptom(s) for individuals presenting in the Emergency Care Center to include all ancillary services routinely available to the ECC before discharge or transfer.
3. The duties and responsibilities of all personnel serving patients within the Emergency area shall be defined in policy and procedure. The contents of such policy and procedure shall be developed by the Department of Emergency Medicine.
4. Allied Health Professionals may not substitute for an Active member of the medical staff in providing call responsibility for the hospital. If an Allied Health Professional is assisting in the call responsibility of their supervising physician, the Emergency Department Physician has the authority to speak directly with the physician on call and request their presence within 30 minutes.
5. Consultation done in the Emergency Department by an Allied Health Practitioner must be seen and evaluated by their supervising Physician prior to discharge from home from the Emergency Department.
6. The medical staff member on-call may not refuse an appropriate transfer of an individual if the hospital has the specialized capabilities, available personnel and space for appropriately treating the needs of an individual requiring a higher level of care.
7. The medical staff member on-call shall provide an appropriate medical screening consistent with the symptom(s) when: individuals arrive at the hospital who may or may not be under the immediate supervision of a personal attending physician; has one or more diagnosed or undiagnosed medical conditions; and, within reasonable medical probability, requires immediate or continuing hospital services and medical care; or, requests medical treatment. This screening shall be conducted within the capability of the ECC and shall include ancillary services routinely available to the ECC before transfer. The medical screening exam will be conducted by a physician or AHP who has received training in emergency medical services and can render immediate life-saving treatment.
8. The Medical Staff shall inform each patient or the person acting on his/her behalf of the risks and benefits to the individual of examination and treatment and/or transfer and take all

reasonable steps to secure the individual's written consent or refusal of such examination and treatment and/or transfer.

9. The transferring Medical Staff member shall determine and order life support measures which are medically appropriate to stabilize the patient prior to transfer and sustain the patient during transfer. He/she shall also determine and order the appropriate medical personnel and equipment for the transfer.
10. Prior to each individual transfer the transferring medical staff member who authorizes the transfer shall personally examine and evaluate the patient to determine the patient's medical needs and to assure that appropriate transfer procedures are utilized unless the time required would unnecessarily delay the transfer to the detriment of the patient.
11. An appropriate medical record shall be kept for every patient receiving emergency service in accordance with current standards of the Joint Commission. This information shall be incorporated in the patient's hospital record if patient is admitted to the Hospital.
12. Each patient's medical record shall be signed by the practitioner in attendance that is responsible for its clinical accuracy.
13. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. The Medical Staff shall approve the plan.

F. RULES REGARDING ALLIED HEALTH PROFESSIONAL PERSONNEL

1. The purpose of these Rules and Regulations is to encourage more effective utilization of skills of physicians by enabling them to delegate certain health care tasks to qualified health care professionals where such delegation is consistent with the patient's health and welfare. The review and appointment of each Allied Health Professional shall be the direct responsibility of each Department Chairman in accordance with Article XI, Section 3 of these Bylaws.
2. Allied Health Professionals shall be identified as, Physician's Assistants, Advanced Nurse Practitioners, Psychologists, Nurses and/or other healthcare professionals identified by the Department to which assigned as meeting the criteria established in these guidelines. Each Allied Health Professional shall be individually assigned to an appropriate clinical service and shall carry out his activities subject to Hospital policies and procedures and in conformity with applicable provisions of the Medical Staff Bylaws, Rules and Regulations.
3. Advanced Nurse Practitioners and Physician's Assistants granted Allied Health Professional Staff privileges within the CHRISTUS Mother Frances Jacksonville Hospital and Clinic shall function in collaboration with the health care team in the observation, assessment, diagnosis, intervention, evaluation, care and counsel of patients.
4. CRNAs may select, obtain and administer anesthesia and anesthesia-related medications and apply appropriate medical devices necessary to accomplish this order and maintain the patient within a sound physiological status. The CRNA may carry out these functions pursuant to a physician's order for anesthesia or an anesthesia-related service that does not have to be drug specific, dose specific or administration-technique specific.

5. Other Allied Health Professional Physician's Assistants and Advanced Nurse Practitioners granted privileges shall function as a physician extender in the area of specialty of their supervising physician member. They shall receive their medical authority from policies/protocols jointly developed by the Allied Health Professional and their supervising physician. They may perform only those functions for which they have been granted privileges.
6. Registered Nurses or Licensed Vocational Nurses granted Allied Health Professional Staff privileges within the CHRISTUS Mother Frances Hospital – Jacksonville may only function in a dependent manner under the direction or supervision of a physician in the area of specialty of the supervising physician. They may only perform those tasks for which they have been granted privileges.
7. Each Allied Health Professional individually employed by members of the Medical Staff may function within the guidelines of the Medical Staff Bylaws, Rules and Regulations and hospital policies. They may function only as an aide to a practitioner only in the area of specialty of the supervising member. They may not serve as a substitute for the practitioner under any circumstances. They may perform duties that do not require the exercise of independent medical judgment as assigned by the supervising practitioner who is responsible for the performance of such tasks and who retains direct control and supervision over them.
8. The procedure for evaluating Allied Health Professionals shall be:
 - a. Application shall be made to the appropriate Department in which he/she is requesting privileges through the Medical Staff Office and shall be approved by the Medical Executive Committee and the Governing Board.
 - b. The completed application shall include verification of qualifications regarding training, experience, scope of service, competence and current licensure.
 - c. Clinical privileges and responsibilities shall be reviewed and established by the Department and shall be based on training and experience. The supervising/sponsoring physician member of the Medical Staff shall retain ultimate patient care responsibility. The candidate shall be approved by the Chairman or Chief of the appropriate Department. This recommendation shall be forwarded to the Executive Committee and Governing Board for approval.
 - d. The right to participate directly in the management of patients while under the sponsorship/direction of a member in good standing of the Medical Staff shall be granted in accordance with these guidelines.
 - e. These Allied Health Professionals shall function within the limits established by the Department, which shall be consistent with State practice acts. Allied Health Professionals shall be reappointed every two (2) years.
 - f. Allied Health Professionals shall be evaluated annually utilizing the prescribed format adopted by the Executive Committee and approved by the Governing Board. The Allied Health Professional's sponsoring physician shall complete this evaluation, with feedback from administrative and hospital staff.
 - g. It shall be the responsibility of the Allied Health Staff member to ensure authentication of any History & Physical, Discharge Summary, Progress Notes or Orders written.

Authentication by their supervising physician must occur by the next visit of the supervising physician.

h. Prescriptive Practice

- (1) All prescriptive practice shall be delegated by a supervising physician, registered with the Texas State Board of Medical Examiners. Supervision shall not require the physical presence of the supervising physician. All medication orders must be signed by the supervising physician by the next visit.
- (2) Only PAs and APNs who have received approval from the Texas State Board of Medical Examiners/Board of Nurse Examiners for the State of Texas shall be given approval to carry out or sign prescriptions in accordance with protocol developed with the supervising physician.

i. Physician Assistants and Advanced Practice Nurses in rural health clinics shall function in accordance to laws in the State of Texas.