

**St. David's North Austin Medical Center**

# **MEDICAL STAFF BYLAWS**

**Approved December 19, 2016**

**MEDICAL STAFF BYLAWS  
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**ARTICLE 1**  
**NAME, PURPOSES AND RESPONSIBILITIES**

**1.A. NAME**

The name of the Medical Staff shall be the “Medical Staff of St. David’s North Austin Medical Center.”

**1.B. PURPOSES AND RESPONSIBILITIES**

The purposes and responsibilities of the Medical Staff are:

- (1) To provide a formal organizational structure through which the Medical Staff shall carry out its responsibilities and govern the professional activities of its Members and other Practitioners and to provide mechanisms for accountability of the Medical Staff to the Board of Trustees. These Bylaws, the Credentials Policy, and the Organization Manual shall reflect the current organization and functions of the Medical Staff;<sup>1</sup>
- (2) To provide patients with the quality of care that is commensurate with acceptable standards and available community resources;
- (3) To collaborate with the Hospital in providing for the uniform performance of patient care processes throughout the Hospital;<sup>2</sup>
- (4) To service as a primary means for accountability to the Board of Trustees concerning professional performance of practitioners and others with Clinical Privileges authorized to practice at the Hospital with regard to the quality and appropriateness of health care. This shall be provided through leadership and participation in the quality assessment, performance improvement, risk management, case management, utilization review and resource management, and other Hospital initiatives to measure and improve performance;<sup>3</sup>
- (5) To provide mechanisms for recommending to the Board of Trustees the grant of initial and renewed Medical Staff Membership to qualified practitioners, and making recommendations regarding Clinical Privileges for qualified and competent practitioners;
- (6) To provide education that will assist in maintaining patient care standards and encourage continuous advancement in professional knowledge and skills;
- (7) To adopt Rules and Regulations for the proper functioning of the Medical Staff, and the integration and coordination of the Medical Staff with the functions of the Hospital;

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<sup>1</sup> MS.01.01.01; LD.01.05.01; 42 C.F.R. 482.22(b)(1); 42 C.F.R. 482.22(c)(3); 42 C.F.R. 482.12(a)(3)

<sup>2</sup> LD.04.03.07

<sup>3</sup> MS.01.01.01; LD.01.05.01; 42 C.F.R. 482.22(b)(1); 42 C.F.R. 482.22(c)(3)

- (8) To provide a means for communication with regard to issues of mutual concern to the Medical Staff, Administration and Board of Trustees;<sup>4</sup>
- (9) To participate in identifying community health needs and establishing appropriate institutional goals;<sup>5</sup>
- (10) To assist the Board of Trustees by serving as a professional review body in conducting professional review activities, which include, without limitation, focused professional practice evaluations, ongoing professional practice evaluations, quality assessment, performance improvement, and peer review;<sup>6</sup>
- (11) To pursue corrective actions with respect to Practitioners, when warranted;
- (12) To monitor and enforce compliance with these Bylaws, the Credentials Policy, the Organization Manual, the Medical Staff Rules and Regulations, other Medical Staff policies, and Hospital policies; and
- (13) To maintain compliance of the Medical Staff with regard to applicable accreditation requirements and applicable Federal, State, and local laws and regulations.<sup>7</sup>

#### **1.C. POWERS AND RESPONSIBILITIES OF THE BOARD OF TRUSTEES**

- (1) The Hospital is owned by St. David's Healthcare Partnership. The Partnership retains all authority and control over the business, policies, operations, and assets of the Hospital via the Board of Governors. The Board of Governors is elected by the shareholders of the Partnership. The Board of Governors retains ultimate responsibility for the Hospital's compliance with all applicable Federal, State, and local laws and regulations.<sup>8</sup> The Board of Governors has delegated certain duties to the Managing Partner's officers and to the Board of Trustees. The rights and duties delegated to the Board of Trustees, acting in its capacity as the authorized agent of the Partnership and as the governing body of the Hospital, are described in these Bylaws, the Credentials Policy, the Organization Manual, the Medical Staff Rules and Regulations, and other Medical Staff policies.<sup>9</sup>
- (2) The Board of Governors has appointed the Board of Trustees to assist and advise the Chief Executive Officer, the Partnership, the Board of Governors, and the Medical Staff. The primary function of the Board of Trustees shall be to assure that the Hospital and its Medical Staff provide quality medical care that meets the needs of the community. For this purpose, the Board of Governors has delegated to the Board of Trustees the authority to receive and evaluate periodic reports from the Medical Staff and its officers, to make decisions in compliance with the Partnership's policies regarding Medical Staff Membership and granting of Clinical Privileges, to oversee performance improvement,

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<sup>4</sup> MS.01.01.01; Id.03.01.01

<sup>5</sup> LD.02.01.01; LD.04.03.01

<sup>6</sup> 42 C.F.R. 482.12 (a)(5); MS.05.01.01; MS.08.01.01; MS.08.01.03; MS.09.01.01

<sup>7</sup> LD.04.01.01

<sup>8</sup> 42 C.F.R. 482.11; 42 C.F.R. 482.12; LD.04.01.01

<sup>9</sup> LD.01.01.01

utilization review, risk management, and similar matters regarding the provision of quality patient care at the Hospital, and to establish policies regarding such matters.<sup>10</sup> All officers, Medical Staff Members, Advanced Practice Professionals, Hospital employees, non-employees who provide patient care under an approved scope of practice, and other agents of the Hospital are subject to the control and direction of, and removal by, the Board of Trustees. All Practitioners are subject to termination or modification of their Medical Staff Membership and/or Clinical Privileges by the Board of Trustees, based on factors deemed relevant by the Board of Trustees. Actions taken by the Board of Trustees may, but need not, follow the procedures outlined in the Medical Staff Bylaws, Credentials Policy, Organization Manual, Rules and Regulations, and other Medical Staff policies.

- (3) In a manner mutually agreeable to the Partnership and the Board of Trustees, the Board of Trustees shall report any matters of concern to the Partnership. Any such matters that are within the scope of duties of the Board of Trustees, but exceed the scope of their authority, such as issues related to financial management, can be referred back to the Partnership and the Board of Governors.
- (4) The Board of Governors, through its officers and the CEO, retains authority for the Hospital's business decisions, adherence to HCA Ethics and Compliance Policies, and financial management, including long-range and short-range planning and budgeting, but may request the advice of the Board of Trustees on such matters. The Board of Governors expressly reserves the right to amend, modify, rescind, clarify, or terminate at any time and without Notice any delegation of authority given to the Board of Trustees and, if deemed necessary by the Board of Governors, to overrule decisions made by the Board of Trustees.

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<sup>10</sup> LD.01.03.01; 42 C.F.R. 482.12(a)

**ARTICLE 2**  
**GENERAL**

**2.A. DEFINITIONS**

The definitions that apply to the capitalized terms used in the Medical Staff Bylaws, the Credentials Policy, the Organization Manual, and the Medical Staff Rules and Regulations are set forth in the Credentials Policy.

**2.B. TIME LIMITS**

Time limits referred to in these Bylaws, the Credentials Policy, and the Organization Manual are advisory only and are not mandatory, unless it is expressly stated. Medical Staff Leaders will strive to be fair under the circumstances.

**2.C. DELEGATION OF FUNCTIONS**

- (1) When a function is to be carried out by a member of Hospital administration, by a Medical Staff Member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.
- (2) When a Medical Staff Member is unavailable or unable to perform an assigned function, one or more Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

**2.E. ORGANIZED HEALTH CARE ARRANGEMENT**

The Hospital and all Members of the Medical Staff shall be considered members of, and shall participate in, the Hospital's Organized Health Care Arrangement ("OHCA") formed for the purpose of implementing and complying with the Standards for Privacy of Individually Identifiable Health Information promulgated by the U.S. Department of Health and Human Services pursuant to the Administrative Simplification provisions of HIPAA. An OHCA is a clinically integrated care setting in which individuals typically receive health care from more than one health care provider. An OHCA allows the Hospital to share information with the Practitioners and the Practitioners' offices for purposes of payment and practice operations. The patient will receive one Notice of Privacy Practices during the Hospital's registration or admissions process, which shall include information about the Organized Health Care Arrangement with the Medical Staff, Practitioners and others, including non-employees who provide patient care under an approved scope of practice. All Practitioners and non-employees with an approved scope of practice agree to comply with the Hospital's policies as adopted from time to time regarding the use of disclosure of individually identifiable health information ("IIHI") and protected health information ("PHI"), as those terms are defined by HIPAA or as any similar terms are defined by more stringent state law (collectively, "IIHI/PHI").<sup>11</sup>

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<sup>11</sup> 45 C.F.R. 164.50

**ARTICLE 3**  
**CATEGORIES OF THE MEDICAL STAFF**

Only those Physicians, Dentists, and Podiatrists who satisfy the qualifications and conditions for Medical Staff Membership, as set forth in these Bylaws and the Credentials Policy, are eligible to apply for Membership in one of the categories listed below. Requests for waivers related to the categories set forth in this Article will be processed in the same manner as requests for waivers of threshold eligibility criteria, as set forth in the Credentials Policy.

**3.A. ACTIVE STAFF**

**3.A.1. Qualifications:**

The Active Staff will consist of Members of the Medical Staff who demonstrate a commitment to fulfilling Medical Staff functions by completing at least two of the following types of activities during the previous term for continuing Medical Staff Membership:

- (1) Serving as a Medical Staff officer, department chairperson or section chief;
- (2) Membership on the Board of Trustees;
- (3) Medical Staff committee chairperson;
- (4) Medical Staff committee member;
- (5) Serving as a proctor to a practitioner under focused professional practice evaluation;
- (6) Serving as a Member advisor or peer reviewer;
- (7) Serving on a Hospital committee or team/task group
- (8) Supervisory duties, e.g., serving as the medical director of a Hospital department or Supervision of another practitioner;
- (9) Providing education to fellow Medical Staff Members, e.g., grand rounds, formal educational presentation, author of a Medical Staff newsletter article;
- (10) Supervising participants in a Hospital-sponsored professional graduate education program; or
- (11) Timely completion of medical records (e.g., Member had patient contacts and had no delinquencies in completion of their records during term of appointment); or
- (12) Conducting oneself in a professional manner consistent with the Medical Staff Code of Conduct;
- (13) Attendance at one or more meetings of the General Medical Staff annually.

### **3.A.2. Prerogatives:**

Active Staff Members may:

- (1) Vote in general and special meetings of the Medical Staff and applicable department, section, and committee meetings; and
- (2) Hold office, serve on Medical Staff committees, and serve as department chairperson, section chief, and committee chairperson if they meet the qualifications of the office or position.

### **3.A.3. Responsibilities:**

Active Staff Members must assume all the responsibilities of the Active Staff, including:

- (1) Serving on committees, as requested;
- (2) Participating in the professional practice evaluation and performance improvement processes; and
- (3) Accepting inpatient consultations, when requested; and
- (4) Participate in Emergency coverage as required by the Department of section and as delineated in the Medical Staff Rules and Regulations.

## **3.B. COURTESY STAFF**

### **3.B.1. Qualifications:**

The Courtesy Staff shall consist of Members of the Medical Staff who:

- (1) Are not actively involved in Medical Staff affairs and not major contributors to the fulfillment of Medical Staff functions due to practicing primarily at another hospital or being in a specialty that has an office-based practice; and
- (2) Wish to remain affiliated with the Hospital for consultation, call coverage, referral of patients or other patient care purposes.

### **3.B.2. Prerogatives and Responsibilities:**

Courtesy Staff Members:

- (1) May attend meetings of the Medical Staff and applicable department and section meetings (without vote) and committee meetings for which they are members (with vote);
- (2) May not hold office or serve as a department chairperson, section chief, or committee chairperson, unless waived by the Medical Executive Committee and Board;

- (3) Must cooperate in the professional practice evaluation and performance improvement process; and
- (4) May request advancement to the Active Staff category if the Medical Staff activities required for Active Staff status are completed at any time with a term of Medical Staff Membership.

### **3.C. AMBULATORY STAFF**

#### **3.C.1. Qualifications:**

The Ambulatory Staff will consist of Members of the Medical Staff who:

- (1) Desire to have Medical Staff Membership to satisfy a criterion for participation in a managed care panel or to pursue professional and educational opportunities, including continuing medical education, available at the Hospital;
- (2) Do not intend to establish a clinical practice at this Hospital, are not seeking and will not be granted Clinical Privileges, and are not subject to focused professional practice evaluation and ongoing professional practice evaluations; and
- (3) Satisfy the qualifications for Medical Staff Membership set forth in the Credentials Policy, but are exempt from the qualifications pertaining to Clinical Privileges, such as response time requirements, coverage, emergency call, clinical activity, DEA registration, state controlled substance licenses, and professional liability insurance.

#### **3.C.2. Prerogatives and Responsibilities:**

Ambulatory Staff Members:

- (1) May attend meetings of the Medical Staff and applicable departments and sections (without vote);
- (2) May not hold office or serve as department chairperson or section chief;
- (3) May serve on Hospital committees (with vote), including as committee chairperson, but not Medical Staff committees;
- (4) May attend educational activities sponsored by the Medical Staff and the Hospital;
- (5) May refer patients to Members of the Medical Staff for admission and care;
- (6) Are encouraged to communicate directly with Active Staff Members about the care of any patients referred, as well as to visit any such patients and provide relevant information from the patient's outpatient care;

- (7) May review the medical records and test results (via paper or electronic access) for any patients who are referred;
- (8) May perform preoperative history and physical examinations in the office have those reports entered into the Hospital's medical record;
- (9) Are not granted inpatient or outpatient Clinical Privileges and, therefore, may not admit patients, attend patients, write orders for inpatients, perform consultations, assist in surgery, or otherwise participate in the management of clinical care to patients at the Hospital; and
- (10) May refer patients to the Hospital's diagnostic facilities and order such tests.

### **3.D. HONORARY RECOGNITION**

#### **3.D.1. Qualifications:**

- (1) Honorary Recognition may be granted to former Members of the Medical Staff who:
  - (a) Have a record of previous long-standing service to the Hospital and have retired from the active practice of medicine; or
  - (b) Are recognized for outstanding or noteworthy contributions to the medical sciences.

Individuals who have been granted Honorary Recognition are not Members of the Medical Staff and are not granted Clinical Privileges, and, therefore, do not need to satisfy any of the threshold eligibility criteria associated with Membership and Privileges and will not be subject to focused professional practice evaluation or ongoing professional practice evaluation.

- (2) Once an individual is granted Honorary Recognition, that status is ongoing. Honorary Recognition may be terminated by the Board, with no right to a hearing or appeal.

#### **3.D.2. Prerogatives and Responsibilities:**

Individuals who are granted Honorary Recognition may attend educational and social functions of the Hospital and its Medical Staff.

### **3.E. ADVANCED PRACTICE PROFESSIONALS**

#### **3.E.1. Qualifications:**

Advanced Practice Professionals are those Practitioners who are listed in Appendix A to the Credentials Policy. Advanced Practice Professionals are not Medical Staff Members, but are granted Clinical Privileges and permission to practice at the Hospital, generally under a defined degree of delegation, direction or supervision by or collaboration with from a Supervising/Collaborating Physician, Dentist, Oral Maxillofacial Surgeon or Podiatrist.

### **3.E.2. Prerogatives and Responsibilities:**

Advanced Practice Professionals:

- (1) May attend and participate in Medical Staff, department and section meetings (without vote);
- (2) May not hold office or serve as department chairperson, section chief, or committee chairperson;
- (3) May be invited to serve on Hospital or Medical Staff committees (with or without vote); and
- (4) Must cooperate in the professional practice evaluation and performance improvement processes.

**ARTICLE 4**  
**OFFICERS**

**4.A. DESIGNATION**

The Medical Staff will have the following officers:

- (1) Chief of Staff;
- (2) Vice Chief of Staff;
- (3) Secretary; and
- (4) Immediate Past Chief of Staff.

**4.B. ELIGIBILITY CRITERIA**

Only those Members of the Medical Staff who satisfy the following criteria initially and continuously will be eligible to serve as an officer of the Medical Staff (unless an exception is recommended by the Medical Executive Committee and approved by the Board).<sup>12</sup> They must:

- (1) Have served on the Active Staff for at least five years;
- (2) Have no pending adverse recommendations concerning Medical Staff Membership or Clinical Privileges and be a Member in Good Standing;
- (3) Not be under investigation by any state or federal agency regarding clinical competence or professional conduct;
- (4) Not presently be serving as a Medical Staff Officer, Board member, or department chairperson at any other hospital and will not so serve during their terms of office;
- (5) Be willing to faithfully discharge the duties and responsibilities of the position;
- (6) Have experience in a leadership position or other involvement in performance improvement functions;
- (7) Participate in Medical Staff Leadership training as determined by the Medical Executive Committee;
- (8) Have demonstrated an ability to work well with others; and
- (9) Not have a financial relationship (i.e., an ownership or investment interest) with an entity, other than an Affiliated Entity, that competes with the Hospital. This does not apply to services provided within a Practitioner's office and billed under the same provider number used by the Practitioner. If a potential conflict exists or develops prior

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<sup>12</sup> MS.01.01.01; 482.22(b)(3)

to election or during the tenure, disclosure of the conflict should be made and will be reviewed on a case-by-case basis by the Board of Trustees.

Additionally, the Member serving as Chief of Staff must be a Physician.<sup>13</sup>

#### **4.C. DUTIES<sup>14</sup>**

##### **4.C.1. Chief of Staff:**

The Chief of Staff will:

- (1) Act in coordination and cooperation with the Chief Medical Officer, the Chief Executive Officer, and the Board in matters of mutual concern involving the care of patients in the Hospital;
- (2) Represent and communicate the views, policies and needs, and report on the activities, of the Medical Staff to the Chief Executive Officer, Chief Medical Officer, and the Board;
- (3) Call, preside at, and be responsible for the agenda of the meetings of the Medical Staff and the Medical Executive Committee;
- (4) Promote adherence to the Bylaws, policies, manuals, and Rules and Regulations of the Medical Staff and to the policies and procedures of the Hospital;
- (5) Appoint ad hoc committees to: (1) assist in the development of Hospital and Medical Staff policies and procedures; and (2) to provide a forum for consideration of plans of future growth or change in the Hospital organization, and for discussion of problems that arise in the operation of the Hospital. Ensure preparation of a written record of the proceedings and recommendations of the ad hoc committees and communicate it to the Board of Trustees and to the Medical Staff;
- (6) Perform functions authorized in these Bylaws and other applicable policies, manuals, and the Rules and Regulations, including collegial intervention in the Credentials Policy, and as may be assigned by the Medical Executive Committee or Board of Trustees;
- (7) Act as a representative of the Medical Staff to the public as well as to other healthcare providers, other organizations, and regulatory or accrediting agencies in external, professional and public relations;
- (8) Serve as an ex-officio member of the Board of Trustees, with vote, and
- (9) Ensures ongoing surveillance of the professional performance of all Practitioners in accordance with the Hospital's performance improvement plan.<sup>15</sup>

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<sup>13</sup> 22 Tex. Admin. Code Sec. 133.41(k)(2)(D)

<sup>14</sup> MS.01.01.01

<sup>15</sup> MS.06.01.07; MS.08.01.03

#### **4.C.2. Vice Chief of Staff:**

The Vice Chief of Staff will:

- (1) Assume the duties of the Chief of Staff and act with full authority as Chief of Staff in his/her absence;
- (2) Perform other duties as are assigned by the Chief of Staff or the Medical Executive Committee; and
- (3) Automatically succeed the Chief of Staff at the conclusion of the Chief of Staff's term (unless the Chief of Staff is reelected) or sooner should the office become vacated for any reason during the Chief of Staff's term of office.

#### **4.C.3. Secretary:**

The Secretary will

- (1) Cause to be kept accurate and complete minutes of meetings of the Medical Executive Committee and Medical Staff;
- (2) Give proper Notice of Medical Staff meetings;
- (3) Perform other duties as are assigned by the Chief of Staff or the Medical Executive Committee; and
- (4) In the temporary or permanent absence of the Chief of Staff and the Vice Chief of Staff, assume all duties and responsibilities and have the authority of the Chief of Staff until such time as a new Chief of Staff and/or Vice Chief of Staff are elected.

#### **4.C.4. Immediate Past Chief of Staff:**

The Immediate Past Chief of Staff will:

- (1) Serve as an advisor to other Medical Staff Leaders; and
- (2) Perform other duties as are assigned by the Chief of Staff or the Medical Executive Committee.

### **4.D. NOMINATION AND ELECTION PROCESS**

#### **4.D.1. Nominating Process:**

- (1) Not less than 90 Days prior to the end of the Medical Staff Year, the Medical Staff Nominating Committee will prepare a slate of nominees for each Medical Staff office that will be vacant. Notice of the nominees will be provided to the Medical Staff at least 30 Days prior to the end of the Medical Staff Year.

- (2) Additional nominations may be submitted to the Medical Executive Committee, in writing, by a petition signed by at least 10% of the voting Members of the Medical Staff in writing, along with receipt of a signed statement of willingness to serve by the nominee and satisfy the qualifications of Section 4.B of these Bylaws. The petition must be presented to the Chairperson of the Nominating Committee at least 15 Days prior to the end of the Medical Staff Year.

#### **4.D.2. Election:**

Only members of the Active Medical Staff shall be eligible to vote. A nominee shall be elected upon receiving a majority of the valid votes cast at the meeting of the General Medical staff where the election is held. If no candidate for an office receives a majority vote, a runoff election between the two candidates receiving the highest number of votes shall be held. For a runoff election, voting shall be by mail or electronic voting, using the procedures in Section 7.B.3. If a tie results, another vote shall be conducted by electronic voting until one candidate receives a majority of the votes. The election shall become effective upon approval of the Board of Trustees. Officers shall take office on the first date of the Medical Staff year.

#### **4.E.1. TERM OF OFFICE, VACANCIES AND REMOVAL**

##### **4.E.1. Term of Office:**

- (1) Officers will assume office on the first day of the Medical Staff Year.
- (2) Medical Staff Officers will serve an initial two-year term and may be reelected for up to one additional two-year term.

##### **4.E.2. Vacancies:**

- (1) If there is a vacancy in the office of Chief of Staff, the Vice Chief of Staff will serve until the end of the unexpired term of the Chief of Staff.
- (2) If there is a vacancy in the office of Vice Chief of Staff or Secretary, the Medical Executive Committee will appoint an individual, who satisfies the qualifications set forth in Section 4.B of these Bylaws, to the office until a special election can be held using the procedures in Section 4.D, modified as necessary to conduct the election within 60 days. The appointment will be effective upon approval by the Board of Trustees.
- (3) In the temporary or permanent absence of both the Chief of Staff and the Vice Chief of Staff, the Secretary shall assume all the duties and responsibilities and have the authority of the Chief of Staff until such time as a new Chief of Staff and Vice Chief of Staff are elected using the procedures in Section 4.D, modified as necessary to conduct the election within 60 days.
- (4) In the temporary or permanent absence of all officers, the Board of Trustees shall appoint interim officers to fill these positions and an election shall be conducted using the procedures in Section 4.D, modified as necessary to conduct the election within 90 days.

- (5) Special meetings of the Medical Staff may be used for initial voting.

**4.E.3. Removal:**

- (1) Removal of an elected officer may be effectuated by a two-thirds vote of the Medical Staff, a majority vote of the Medical Executive Committee or by a majority vote of the Board of Trustees for:<sup>16</sup>
  - (a) Failure to comply with or enforce applicable Hospital policies, these Bylaws, the Credentials Policy, the Organization Manual, other Medical Staff policies, or the Rules and Regulations;
  - (b) Failure to perform the duties of the position held;
  - (c) Conduct detrimental to the interests of the Medical Staff or the Hospital;
  - (d) An infirmity that renders the individual incapable of fulfilling the duties of that office; or
  - (e) Failure to continue to satisfy any of the criteria in section 4.B of these Bylaws.
- (2) Prior to scheduling a meeting to consider removal, a representative from the Medical Staff, Medical Executive Committee or the Board will meet with and inform the individual of the reasons for the proposed removal proceedings.
- (3) The individual will be given at least ten Days' Special Notice of the date of the meeting at which removal is to be considered. The individual will be afforded an opportunity to address the Medical Executive Committee, the Active Staff, or the Board, as applicable prior to a vote on removal.
- (4) Removal will be effective when approved by the Board of Trustees.
- (5) Failure to maintain Active Staff status in Good Standing will result in automatic removal without the need to compliance with the procedures above.

**4.E.4. Resignation:**

Any Medical Staff officer may resign at any time by giving written Notice to the Medical Executive Committee and the acceptance of such resignation shall not be necessary to make it effective.

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<sup>16</sup> MS.01.01.01

**ARTICLE 5**  
**CLINICAL DEPARTMENTS**

**5.A. ORGANIZATION**

**5.A.1. Organization of Departments and Sections:**

- (1) The Medical Staff may be organized into the clinical departments, sections, and service lines as listed and described in the Medical Staff Organization Manual.<sup>17</sup>
- (2) Subject to the approval of the Board, the Medical Executive Committee may create or eliminate departments, create or eliminate sections within departments, or otherwise reorganize the department structure, including but not limited to the creation of service lines.

**5.A.2. Assignment to Departments:**

- (1) At the time of initial Medical Staff Membership or the granting of initial Clinical Privileges, each Practitioner will be assigned to a clinical department and may be assigned to a section. Assignment to a particular department or section does not preclude a Practitioner from seeking and being granted Clinical Privileges typically associated with another department or section.
- (2) A Practitioner may request a change in department or section assignment to reflect a change in the Practitioner's clinical practice.

**5.A.3. Functions of Departments:**

The departments shall perform the following functions:

- (1) Serve as a forum for the exchange of clinical information regarding services provided by department members;
- (2) Provide recommendations to the department chairperson and/or the Medical Executive Committee with regard to the development of clinical practice guidelines related to care and services provided by department members;
- (3) Provide recommendations to the department chairperson regarding professional criteria for Clinical Privileges designed to assure the Medical Staff and Board of Trustees that patients shall receive quality care.<sup>18</sup> The recommendations shall include:
  - (a) Criteria for granting, withdrawing and modifying Clinical Privileges;<sup>19</sup> and

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<sup>17</sup> MS.01.01.01; LD.04.01.05

<sup>18</sup> MS.01.01.01

<sup>19</sup> 42 C.F.R. 482.22(c)(6)

- (b) A procedure for applying these criteria to individuals requesting Clinical Privileges;<sup>20</sup>
- (4) Ensure that Practitioners provide appropriate and medically necessary care to patients of the Hospital;<sup>21</sup>
- (5) Ensure that the same level of quality of patient care is provided by all Practitioners within the department and across departments:<sup>22</sup>
  - (a) By establishing uniform patient care process;<sup>23</sup>
  - (b) By establishing similar clinical privileging criteria for similar Clinical Privileges;<sup>24</sup> and
  - (c) By using similar indicators in performance improvement activities;<sup>25</sup>
- (6) Provide recommendations to the department chairperson and/or the Medical Executive Committee with regard to issues related to standards of practice and/or clinical competence;
- (7) Ensure effective mechanisms for the Supervision of Advanced Practice Professionals and other Practitioners, as required;
- (8) Provide information and/or recommendations to the department chairperson with regard to the criteria for granting Clinical Privileges within the department;
- (9) Ensure that Practitioners within the department who admit patients have Clinical Privileges to do so;<sup>26</sup> and that all Practitioners within the department only provide services with the scope of the Clinical Privileges granted;<sup>27</sup>
- (10) Provide information and/or recommendations to the department chairperson and/or the Medical Executive Committee with regard to Medical Staff policies;
- (11) Provide recommendations to the department chairperson and/or the Medical Executive Committee with regard to ensuring appropriate call coverage by department members;
- (12) Perform Medical Peer Review, including without limitation, ongoing professional practice evaluation, initial focused professional practice evaluation, for-cause focused professional practice evaluation, peer review and other quality assessment activities

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<sup>20</sup> 42 C.F.R. 482.22(c)(6)

<sup>21</sup> MS.03.01.01

<sup>22</sup> MS.01.01.01

<sup>23</sup> LD.04.03.07

<sup>24</sup> MS.01.01.01

<sup>25</sup> MS.01.01.01

<sup>26</sup> MS.03.01.01

<sup>27</sup> MS.08.01.03

relative to the performance of Practitioners in the department and report such activities to the Medical Executive Committee on a regular basis;

- (13) Provide leadership for activities related to patient safety, including proactive risk assessments, root cause analysis in response to an unanticipated adverse event, addressing patient safety alerts, and implementing procedures to comply with patient safety goals;<sup>28</sup>
- (14) Receive reports regarding Hospital performance improvement results that are applicable to the performance of the department and its members, and integrate the department's performance improvement activities with that of the Hospital by taking a leadership and participatory role in such activities, as outlined in the Hospital Performance Improvement Plan; and
- (15) Recommend medical educational programs to meet the needs of department members, based on the scope of services provided by the department, changes in medical practice or technology, and the results of departmental performance improvement activities.<sup>29</sup>

## **5.B DEPARTMENT CHAIRPERSONS AND VICE CHAIRPERSONS**

### **5.B.1. Qualifications:**

Each department chairperson, vice chairperson and section chief will:

- (1) Be an Active Staff Member in Good Standing;
- (2) Be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process; and
- (3) Satisfy the eligibility criteria in Section 4.B.

### **5.B.2. Selection and Term of Department Chairpersons and Vice Chairpersons:<sup>30</sup>**

- (1) Except as otherwise provided by contract, when there is a vacancy in a department chairperson position, or a new department is created, the Medical Executive Committee will recommend the name(s) of individual(s) eligible to serve as department chairperson. The recommendation of the Medical Executive Committee will be presented to the department for vote. The election of a chairperson by the department will be forwarded to the Board of Trustees for final action.
- (2) Except as may otherwise be provided by contract, a department chairperson will serve a term of two years and may succeed himself or herself for two additional terms.

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<sup>28</sup> MS.03.01.01; 42 C.F.R. 482.22

<sup>29</sup> MS.12.01.01

<sup>30</sup> MS.01.01.01

- (3) Each department chairperson may recommend the appointment of a vice chairperson. These recommendations will be reviewed by the Medical Executive Committee and will be forwarded to the Board of Trustees for final action.

**5.B.3. Duties of Department Chairperson:**<sup>31</sup>

Each department chairperson is responsible for the following functions, either individually or in collaboration with Hospital personnel:

- (1) All clinically-related activities of the department;<sup>32</sup>
- (2) All administratively-related activities of the department, unless otherwise provided for by the Hospital;<sup>33</sup>
- (3) Continuing surveillance of the professional performance of Practitioners in the department, including performing ongoing and focused professional practice evaluations;<sup>34</sup>
- (4) Recommending criteria for Clinical Privileges that are relevant to the care provided in the department;<sup>35</sup>
- (5) Evaluating requests for initial and renewal of Clinical Privileges in the department;<sup>36</sup>
- (6) Assessing and recommending off-site sources for needed patient care, treatment, and services not provided by the department or the Hospital;<sup>37</sup>
- (7) The integration of the department into the primary functions of the Hospital;<sup>38</sup>
- (8) The coordination and integration of interdepartment and intradepartment services;<sup>39</sup>
- (9) The development and implementation of policies and procedures that advance quality and that guide and support the provision of care, treatment, and services;<sup>40</sup>
- (10) Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;<sup>41</sup>

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<sup>31</sup> MS.01.01.01; LD.04.01.05

<sup>32</sup> MS.01.01.01; MS.06.01.07; LD.04.01.05

<sup>33</sup> MS.01.01.01; LD.04.01.05

<sup>34</sup> MS.01.01.01; LD.04.01.05

<sup>35</sup> MS.01.01.01; MS06.01.07; LD.04.01.05

<sup>36</sup> MS.01.01.01; MS06.01.07; LD.04.01.05

<sup>37</sup> MS.01.01.01; LD.04.03.01; LD.04.03.09

<sup>38</sup> MS.01.01.01; LD.04.01.05; LD.03.06.01

<sup>39</sup> MS.01.01.01; LD.04.01.05; LD.03.06.01

<sup>40</sup> MS.01.01.01; LD.04.01.05; LD.03.06.01; LD.04.01.07

<sup>41</sup> MS.01.01.01; LD.04.01.05; LD03.06.01

- (11) Determination of the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;<sup>42</sup>
- (12) Continuous assessment and improvement of the quality of care, treatment and services provided;<sup>43</sup>
- (13) Maintenance of quality monitoring programs, as appropriate;<sup>44</sup>
- (14) Ensure proper orientation and continuing education of persons in the department;<sup>45</sup>
- (15) Recommendations for space and other resources needed by the department;<sup>46</sup>
- (16) Performing functions authorized in the Credentials Policy, including collegial intervention efforts;
- (17) Presiding at all department meetings;
- (18) Serving as an ex officio member of all departmental committees, if any, without vote, unless specifically stated otherwise in these Bylaws or the Rules and Regulations;
- (19) Serving as a member of the Medical Executive Committee and being accountable to the Medical Executive Committee with regard to the activities and functioning of the department; and
- (20) Appointing and removing one or more department vice chairpersons as deemed necessary, appointing section chiefs, subject to approval of the Medical Executive Committee, and appointing members to service on department committees, if any.

**5.B.4. Duties of Department Vice Chairpersons:**

The Vice Chairperson shall assist the department chairperson in the performance of the department chairperson's duties, and shall assume the duties of the department chairperson in his/her absence.

**5.B.5. Removal of Department Chairpersons and Vice Chairpersons:<sup>47</sup>**

- (1) Removal of a department chairperson or vice chairperson may be effectuated by a two-thirds vote of the department, as applicable, or a majority vote of the Medical Executive Committee, or by the Board of Trustees for:

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<sup>42</sup> MS.01.01.01; LD.04.01.05; LD.03.06.01; LD.04.01.07

<sup>43</sup> MS.01.01.01; LD.04.01.05; LD.03.06.01

<sup>44</sup> MS.01.01.01; LD.04.01.05; LD.03.06.01

<sup>45</sup> MS.01.01.01; LD.03.06.01

<sup>46</sup> MS.01.01.01; LD.04.01.05; LD.03.06.01; LD.4.01.11

<sup>47</sup> MS..01.01.01

- (a) Failure to comply with the Bylaws or applicable policies, manuals, or the Rules and Regulations;
  - (b) Failure to perform the duties of the position held;
  - (c) Conduct detrimental to the interests of the Medical Staff or the Hospital;
  - (d) An infirmity that renders the individual incapable of fulfilling the duties of that office;
  - (e) Failure to continue to satisfy any of the criteria in Section 4.B of these Bylaws;
  - (f) Failure to adhere to professional ethics; or
  - (g) Failure to support the compliance of the Hospital and the Medical Staff with applicable federal and state laws and regulations, and the standards or other requirements of any regulatory or accrediting agency having jurisdiction over the Hospital or any of its services.
- (2) Prior to scheduling a meeting to consider removal, a representative from the department, Medical Executive Committee, or Board of Trustees will meet with and inform the individual of the reasons for the proposed removal proceedings.
  - (3) The individual will be given at least ten Days' Special Notice of the date of the meeting at which removal is to be considered. The individual will be afforded an opportunity to address the department or section, as applicable, the Medical Executive Committee, or the Board of Trustees, as applicable, prior to a vote on removal.
  - (4) Removal will be effective when approved by the Board of Trustees.
  - (5) Failure to maintain Active Staff status in Good Standing will result in automatic removal without the need for compliance with the procedures above.

## **5.C. SECTIONS**

### **5.C.1. Qualifications, Selection and Removal of Section Chiefs:<sup>48</sup>**

- (1) The relevant department chairperson may appoint qualified individuals to serve as chief of each section, subject to the approval of the Medical Executive Committee and the Chief Executive Officer.
- (2) Section Chiefs must meet the same qualifications as department chairpersons.
- (3) If requested by two-thirds of the Members assigned to a section, the department chairperson will evaluate the performance of a section chief to determine whether the section chief should be removed from office. The department chairperson's decision to

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<sup>48</sup> MS.01.01.01

remove a section chief from office is subject to the approval of the Medical Executive Committee and the Chief Executive Officer. Failure to maintain Active Staff status in Good Standing will result in automatic removal from the position of section chief.

**5.C.2. Duties of Section Chief:**

The section chief will carry out the duties requested by the department chairperson. These duties may include:

- (1) Review and reporting on Applications for initial Medical Staff Membership and Clinical Privileges; including interviewing Applicants;
- (2) Review and reporting on Applications for renewal of Medical Staff Membership and Clinical Privileges;
- (3) Evaluation of Practitioners in order to confirm competence;
- (4) Participation in the development of criteria for Clinical Privileges within the section;
- (5) Review and reporting on the professional performance of Practitioners practicing within the section; and
- (6) Support the department chairperson in making recommendations regarding the coordination of section activities, as well as the Hospital resources necessary for the section to function effectively.

**5.C.3. Functions of Sections:**

- (1) Sections may perform any of the following activities:
  - (a) Continuing education;
  - (b) Discussion of policy;
  - (c) Discussion of equipment needs;
  - (d) Development of recommendations to the department chairperson or the Medical Executive Committee;
  - (e) Participation in the development of criteria for Clinical Privileges (when requested by the department chairperson); and
  - (f) Discussion of a specific issue (related to credentialing, professional practice evaluation, and/or performance improvement), at the special request of a department chairperson or the Medical Executive Committee.
- (2) Minutes or reports will be required reflecting the activities of a section.

- (3) Sections are not required to hold regularly scheduled meetings.

## **5.D. SERVICE LINES**

### **5.D.1. Organization of Service Lines**

Service lines shall be comprised of administrative personnel and a multidisciplinary team of Practitioners who devote a significant portion of their practice to treating the medical condition, procedure, clinical service or patient population upon which the patients were classified and the service line defined.

### **5.D.2. Functions of Service Lines**

Each service line shall:

- (1) Provide or coordinate complete, comprehensive care related to the medical condition, procedure, clinical service or patient population upon which the patients were classified and the service line is defined, including but not limited to inpatient and outpatient care, rehabilitation services and social services;
- (2) Provide patient and family education and follow-up;
- (3) Measure outcomes, costs and processes using a common measurement platform;
- (4) Meet monthly, or more often as needed, to discuss patients, processes and results to assure that care is coordinated and evidence-based protocols are followed; and
- (5) Make recommendations to the Medical Executive Committee and the Chief Executive Officer regarding:
  - (a) Budget, equipment, personnel and facility needs;
  - (b) Clinical guidelines for the care of patients within the defined classification;
  - (c) Mechanisms to assess outcomes and costs;
  - (d) Clinical indicators for review; and
  - (e) Quality improvement activities.

### **5.E. Creation of Service Lines and Service Line Medical Directors**

Creation of service lines will be at the discretion of the Medical Executive Committee and the Board of Trustees. Service lines may require the direction of a medical director and an administrative leader both of whom are selected by and serve at the discretion of the Chief Executive Officer and the Board of Trustees after consultation with the Medical Executive Committee.

**ARTICLE 6**  
**MEDICAL STAFF COMMITTEES**

**6.A. GENERAL**

**6.A.1. Appointment:**

- (1) This Article and the Medical Staff Organization Manual outlines the committees of the Medical Staff that carry out ongoing and focused professional practice evaluations and other Medical Peer Review functions that are delegated to the Medical Staff by the Board of Trustees and contain a description of the committees' composition, duties and reporting requirements.
- (2) Except as otherwise provided by these Bylaws or the Medical Staff Organization Manual, within three months prior to the end of the each Medical Staff Year, the Chief of Staff, in consultation with the Medical Executive Committee, will appoint the members and the chairperson of each Medical Staff committee when such positions are due to be vacated at the start of the next Medical Staff Year. Committee chairpersons must satisfy the criteria in Section 4.B of these Bylaws. The Chief of Staff, in consultation with the Medical Executive Committee, may appoint Physicians and other health care professionals who are not Members of the Medical Staff to be members of a standing committee of the Medical Staff upon determination that the committee's functions and operations necessitate the expertise. The Chief of Staff will also recommend Medical Staff representatives to Hospital committees.
- (3) The Chief Executive Officer will make appointment so f administrative staff to Medical Staff committees. Administrative staff will serve on Medical Staff committees without the right to vote unless otherwise provided herein or in the Organization Manual.
- (4) Chairpersons and members of standing committees will be appointed for an initial term of two years, but may be reappointed for additional terms.
- (5) Chairpersons and members of standing committees may be removed and vacancies filled at the discretion of the individual currently in the office or position that initially appointed them.
- (6) The Chief of Staff will be an ex officio member, with vote, on all Medical Staff committees.
- (7) The Chief Medical Officer and Chief Executive Officer will be ex officio<sup>49</sup> members, without vote, on all Medical Staff committees.
- (8) Any Board member may attend and informally participate in, without vote, any meeting (including any executive or closed session) of the Medical Staff or its committees, departments, or sections.

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<sup>49</sup> MS.02.01.01

### **6.A.2. Meetings, Reports and Recommendations:**

Except as otherwise provided, committees will meet, as necessary, to accomplish their functions, and will maintain a permanent record of their findings, proceedings, and actions. Committees will make timely written reports to the Medical Executive Committee.

### **6.B. MEDICAL EXECUTIVE COMMITTEE**

#### **6.B.1. Composition:**

- (1) The Medical Executive Committee will include the following individuals, the majority of whom shall be Physicians actively practicing at the Hospital.<sup>50</sup>
  - (a) The Chief of Staff;
  - (b) The Vice Chief of Staff;
  - (c) The Secretary;
  - (d) The Immediate Past Chief of Staff;
  - (e) The department chairpersons; and
  - (f) Representation from hospital-based physician groups as deemed necessary and appropriate by the Medical Executive Committee; and
  - (g) The Chief Executive Officer<sup>51</sup> and the Chief Medical Officer, ex officio, without vote.
- (2) No Active Staff Member is ineligible for membership on the Medical Executive Committee solely because of his/her professional discipline, specialty, employment by an Affiliated Entity, or practice as a Hospital-based Physician.<sup>52</sup>
- (3) The Chief of Staff will serve as chairperson of the Medical Executive Committee, with vote.
- (4) Other individuals may be invited to Medical Executive Committee meetings as guests, without vote, subject to agreement to maintain the confidentiality of the proceedings.

#### **6.B.2. Duties:**

The Medical Executive Committee is delegated the primary authority over activities related to the Medical Staff and Medical Peer Review activities. The authority may be removed or modified by amending these Bylaws, the Credentials Policy, the Organization Manual, the Rules

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<sup>50</sup> MS.01.01.01; C.F.R. 482.22(b)(2); MS.02.01.01; 22 Tex. Admin. Code Sec. 133.41(d)(2)(B)

<sup>51</sup> MS.02.01.01, EP 2 requires the CEO to attend all meetings of the Medical Executive Committee

<sup>52</sup> MS.02.01.01

and Regulations, and other Medical Staff policies, as applicable. The Medical Executive Committee is responsible for the following:

- (1) Acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between Medical Executive Committee meetings);<sup>53</sup>
- (2) Recommending directly to the Board on at least the following:<sup>54</sup>
  - (a) The Medical Staff's structure;
  - (b) The mechanism used to review credentials and to delineate individual Clinical Privileges;
  - (c) Applicants for initial and renewed Medical Staff Membership;
  - (d) Delineation of Clinical Privileges for each eligible individual;
  - (e) Participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;
  - (f) The mechanism by which Medical Staff Membership may be terminated;
  - (g) Hearing and appeal procedures; and
  - (h) Reports and recommendations from Medical Staff committees, departments, and other groups, as appropriate;
- (3) Consulting with Administration on quality-related aspects of contracts for patient care services;
- (4) Providing oversight and guidance with respect to continuing medical education activities;
- (5) Reviewing or delegating the review of quality indicators to facilitate uniformity regarding patient care services;
- (6) Providing leadership in activities related to patient safety;
- (7) Providing oversight in the process of analyzing and improving patient satisfaction, patient engagement and patient-centered care;
- (8) Ensuring that, at least every three years, the Bylaws and applicable policies are reviewed and, if necessary, updated;

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<sup>53</sup> MS.02.01.01

<sup>54</sup> MS.02.01.01

- (9) Providing and promoting effective liaison among the Medical Staff, Administration, and the Board;
- (10) Recommending clinical services, if any, to be provided by telemedicine;
- (11) Reviewing and approving all standing orders and clinical protocols for consistency with nationally recognized standards, evidence-based guidelines and clinical appropriateness criteria;
- (12) Implementing policies of the Medical Staff not otherwise the responsibilities of the Medical Staff;
- (13) Coordinating the activities and general policies of the departments;
- (14) Reviewing periodically Medical Peer Review information of Practitioners, including, but not limited to, focused professional practice evaluation data, ongoing professional practice evaluation data, peer review information and credentialing data, and, as a result of such reviews, making recommendations for renewal of, and modification to, Medical Staff Membership and Clinical Privileges;
- (15) Organizing the Medical Staff's Medical Peer Review activities, including the review of the safety, effectiveness, patient-centeredness, equitability, efficiency, and timeliness<sup>55</sup> of medical and surgical care and establishing mechanisms designated to conduct, evaluate and revise such activities;<sup>56</sup>
- (16) Collaborating with other leaders in Hospital planning;
- (17) Making recommendations to the Chief Executive Officer on matters of a medico-administrative nature when requested;
- (18) Ensuring that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital;
- (19) Reporting at each general Medical Staff meeting; and
- (20) Performing any other functions as are assigned to it by these Bylaws, the Credentials Policy, the Organization Manual, the Rules and Regulations, or other applicable Hospital or Medical Staff policies.

### **6.B.3. Meetings:**

The Medical Executive Committee will meet at least monthly and more often if necessary to fulfill its responsibilities, maintain a permanent record of its proceedings and actions, and report

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<sup>55</sup> IOM, Crossing the Quality Chasm, six aims for improving healthcare

<sup>56</sup> MS.01.01.01; MS.02.01.01; MS.05.01.01; MS.05.01.03; MS.10.01.01

the activities of the Medical Staff and the Medical Executive Committee to the Board of Trustees.<sup>57</sup>

#### **6.C. CREATION OF STANDING COMMITTEES AND SPECIAL TASK FORCES**

- (1) In accordance with the amendment provisions in the Medical Staff Organization Manual, the Medical Executive Committee may, by resolution and upon approval of the Board and without amendment of these Bylaws, establish additional committees to perform one or more staff functions. The Medical Executive Committee may also dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions.
- (2) Any function required to be performed by these Bylaws, the Credentials Policy, the Organization Manual, the Rules and Regulations, or other Medical Staff policy, which is not assigned to an individual, a standing committee, or a special task force will be performed by the Medical Executive Committee.
- (3) Special task forces or ad hoc committees will be created and their members and chairpersons will be appointed by the Chief of Staff and the Medical Executive Committee. Such task forces or ad hoc committees will confine their activities to the purpose for which they were appointed and will report to the Medical Executive Committee.

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<sup>57</sup> MS.02.01.01

**ARTICLE 7**  
**MEETINGS**

**7.A. GENERAL**

**7.A.1. Meetings:**

- (1) Except as provided in these Bylaws or the Medical Staff Organization Manual, each department will meet quarterly or more often as needed to perform its designated functions, and each section and committee will meet as often as needed to perform their designated functions.
- (2) Meetings may be conducted by telephone conference or by other electronic means at the discretion of the applicable chairperson.

**7.A.2. Regular Meetings:**

- (1) The Chief of Staff, the chairperson of each department and the chief of each section, and the chairperson of each committee will schedule regular meetings of the Medical Staff Year.
- (2) The annual meeting of the Medical Staff will be the last meeting before the end of the Medical Staff Year.

**7.A.3. Special Meetings:**

- (1) A special meeting of the Medical Staff may be called by the Chief of Staff, a majority of the Medical Executive Committee, the Chief Executive Officer, the Chairperson of the Board, or by a petition signed by at least 20% of the voting Members of the Medical Staff.
- (2) A special meeting of any department, section or committee may be called by the Chief of Staff, the relevant department or committee chairperson, section chief, or by a petition signed by at least 20% of the voting members of the department, section or committee but in no event fewer than three members.
- (3) No business will be transacted at any special meeting except that stated in the meeting Notice.

**7.B. PROVISIONS COMMON TO ALL MEETINGS:**

**7.B.1. Prerogatives of the Presiding Officer:**

- (1) The Presiding Officer of each meeting is responsible for setting the agenda for any regular or special meeting of the Medical Staff, department, section, or committee.
- (2) The Presiding Officer has the discretion to conduct any meeting by telephone conference or videoconference.

- (3) The Presiding Officer shall have the authority to rule definitively on all matters of procedure. While Robert's Rules of Order may be used for reference, in the discretion of the Presiding Officer, it shall not be binding. Rather, specific provisions of these Bylaws and Medical Staff, department, section, or committee custom shall prevail at all meetings and elections.

**7.B.2. Notice:**

- (1) Medical Staff Members will either be provided with Notice of regular meetings of the Medical Staff and regular meetings of departments, sections, and committees or be alerted to the scheduling of those meetings through a posting placed in a designated location at least seven, but not more than 31 days in advance of the meeting.
- (2) When a special meeting of the Medical Staff, department, section or committee is called, the Notice period will be 72 hours. In such cases, posting may not be the sole mechanism for providing Notice.
- (3) Notices will state the date, time, and place of the meetings. In the case of a special meeting, the notice also shall state the business to be transacted or purpose of the meeting.
- (4) The attendance of any individual at any meeting will constitute a waiver of that individual's Notice of the meeting.

**7.B.3. Quorum and Voting:**

- (1) For any regular or special meeting of the Medical Staff, department, section or committee, those voting members Present (but not fewer than one member) will constitute a Quorum. As an exception to this general rule:
  - (a) For meetings of the Medical Executive Committee, the Credentials Committee, and the Peer Review Committee, the Presence of at least 50% of the voting committee members will constitute a Quorum; and
  - (b) For any amendments to these Medical Staff Bylaws, the Presence (in case of a meeting) or participation (in case of a ballot) of at least 5% of the Medical Staff Members eligible to vote will constitute a Quorum.
- (2) A Quorum is required to conduct business. Once a Quorum is established, the business of the meeting may continue and actions taken will be binding.
- (3) Recommendations and actions taken by the Medical Staff, departments, sections, and committees will be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by majority vote of the voting members participating in the vote.
- (4) As an alternative to a formal meeting, the voting members of the Medical Staff or a department, section, or committee may also be presented with an issue by mail,

facsimile, electronic voting, hand delivery, or telephone, and their votes returned to the Presiding Officer by the method designated in the Notice. The method of voting shall be selected by the chair of the department, section or committee or, in the case of a vote of the Medical Staff, by the Medical Executive Committee. Except for actions by the Medical Executive Committee, the Credentials Committee, and the Peer Review Committee (as noted in (1)(a)), the issue will be determined by a majority of the votes returned.

- (5) Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote.
- (6) There shall be no proxy voting.

**7.B.4. Minutes:**

- (1) Minutes of the Medical Staff, department, section, and committee meetings will be prepared at the direction of and signed by the Presiding Officer.
- (2) Minutes will include a record of attendance of members, the vote taken on each matter and recommendations made.
- (3) Minutes of the meetings of the Medical Staff, departments, committees and, where applicable, sections, will be forwarded to the Medical Executive Committee and a copy will be provided to the Chief Executive Officer.
- (4) The Board will be kept apprised of and act on the recommendations of the Medical Staff.
- (5) The Hospital will be the custodian of all minutes (and other records and proceedings) and maintain a permanent file of the minutes of all meetings.

**7.B.5. Confidentiality:**

- (1) Medical Staff business conducted by committees, departments, and sections is considered confidential and proprietary and should be treated as such.
- (2) Practitioners who have access to, or are the subject of, Medical Peer Review records and proceedings, including without limitation, credentialing, performance improvement, peer review, and professional practice evaluation information must agree to maintain the confidentiality of the information.
- (3) Medical Peer Review information, including without limitation, credentialing, performance improvement, peer review, and professional practice evaluation documents, and information contained in these documents, may only be disclosed as authorized by the Credentials Policy or other applicable Medical Staff or Hospital policy or as required by law.
- (4) A breach of confidentiality may result in the imposition of disciplinary action.

## **7.C. ATTENDANCE**

### **7.C.1. Regular and Special Meetings:**

- (1) Members of the Medical Staff are encouraged to attend Medical Staff and applicable department, section, and committee meetings.

Members of the Medical Executive Committee, the Credentials Committee, and the Professional Practice Evaluation Committee are required to be Present for at least 50% of the regular meetings. Failure to attend the required number of meetings may result in the Member being removed from the committee by the Chief of Staff. If the Member is a Medical Staff, department or section officer, the removal procedures in the Bylaws for that officer must be used for removal.

**ARTICLE 8**  
**BASIC STEPS FOR CREDENTIALING AND PEER REVIEW**

The details associated with the following Basic Steps are contained in the Credentials Policy in a more expansive form.

**8.A. QUALIFICATIONS FOR INITIAL OR RENEWED MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES<sup>58</sup>**

To be eligible to apply for initial or renewed Medical Staff Membership or Clinical Privileges, an individual must submit a Request for Consideration (“RFC”) or Recredentialing Request for Consideration (“RRFC”) and, through the RFC/RRFC and Application processes, demonstrate continuous satisfaction of all threshold criteria for appointment and the requested Clinical Privileges, as well as all other factors for consideration outline in the Medical Staff Credentials Policy and other Hospital and Medical Staff policies, including appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the Clinical Privileges requested.

**8.B. INITIAL PROCESS FOR CREDENTIALING AND PRIVILEGING**

The Credentialing Processing Center will forward the completed RFC/RRFC to the Medical Staff Office, which will begin processing the RFC or RRFC as an Application. As a preliminary step, the Medical Staff Office will review the Application to make sure that all questions have been answered and that the applicant satisfies all threshold eligibility criteria set forth in the Credentials Policy.

**8.C. PROCESS FOR CREDENTIALING AND PRIVILEGING<sup>59</sup>**

- (1) Complete Applications for Membership and Clinical Privileges will be transmitted to the applicable department chairperson or section chief, who will review the Applicant’s education, training, and experience and prepare a written report stating whether the Applicant meets all qualifications. The Chief Nursing Officer will also review all Advanced Practice Registered Nurse files. The report(s) will be forwarded to the Credentials Committee or, if the Applicant is an Advanced Practice Professional, the report will be forwarded to the Advanced Practice Professional Committee. The Advanced Practice Professional Review Committee will review the chairperson’s and Chief Nursing Officer’s report, if applicable and make a recommendation to the Credentials Committee.
- (2) The Credentials Committee will review the chairperson’s report, the Chief Nursing Officer’s report, if applicable, and the Advanced Practice Professional Review Committee’s recommendation, if applicable, and make a recommendation. The recommendation of the Credentials Committee will be forwarded, along with the department chairperson’s report, the Chief Nursing Officer’s report, if applicable, and the Advanced Practice Professional Review Committee’s recommendation, if applicable, to the Medical Executive Committee for review and recommendation.

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<sup>58</sup> MS.01.01.01

<sup>59</sup> MS.01.01.01

- (3) The Medical Executive Committee may accept the recommendation of the Credentials Committee, refer the Application back to the Credentials Committee or Advanced Practice Professional Review Committee, if applicable, for further review or specific questions, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the Medical Executive Committee is to grant Medical Staff Membership and/or Clinical Privileges or an otherwise Favorable Recommendation, it will be forwarded to the Board for final action. If the recommendation of the Medical Executive Committee entitles the individual to a hearing as provided in Section 8.G.1., the Applicant will be notified by the Chief Executive Officer of the right to request a hearing and all further procedures shall be as set forth in Article 7 of the Credentials Policy.
- (4) When the Hospital Emergency Operations Plan has been implemented, the CEO, CMO or Chief of Staff may use a modified credentialing process to grant disaster Privileges after verification of the volunteer's identity and professional license.

**8.D. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT<sup>60</sup> OF APPOINTMENT AND/OR PRIVILEGES**

- (1) Upon review by the MEC, membership and/or Clinical Privileges shall be automatically relinquished if a Practitioner:
  - (a) Fails to do any of the following:
    - i. Timely complete medical records as required by the Rules and Regulations or applicable policies;
    - ii. Satisfy threshold eligibility criteria as detailed in the Credentials Policy;
    - iii. Complete and comply with educational or training requirements adopted by the Medical Executive Committee or required by the Board as detailed in the Credentials Policy;
    - iv. Provide requested or required information as set forth in these Bylaws or as detailed in the Credentials Policy;
    - v. Attend a mandatory meeting requested by the Medical Staff Leaders or Hospital Administration as detailed in the Credentials Policy;
    - vi. Comply with a request for fitness for practice evaluation or clinical competency evaluation as detailed in the Credentials Policy;
  - (b) Is convicted, or pleads guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or other federal or state governmental or private third-party payer

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<sup>60</sup> MS.01.01.01

fraud or program abuse; (iv) violence; (v) sexual misconduct; (vi) moral turpitude; (vii) child or elder abuse; or violence; or (viii) military court martial (see Credentials Policy for automatic suspension in the situation of an arrest, charge or indictment related to the above); or

- (c) Makes a misstatement or omission on an Application
- (2) Automatic relinquishment will take effect immediately and will continue until the matter is resolved and the Practitioner is reinstated, if applicable as detailed in the Credentials Policy.

#### **8.E. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION OR RESTRICTION<sup>61</sup>**

- (1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the Chief Executive Officer, the Chief of Staff, the chairperson of the relevant clinical department, the Chief Medical Officer, the Medical Executive Committee, or the Board chairperson is authorized to immediately suspend or restrict all or any portion of a Practitioner's Clinical Privileges pending an investigation.
- (2) A precautionary suspension or restriction is effective immediately and will remain in effect unless it is modified by the Chief Executive Officer or the Medical Executive Committee.
- (3) The Practitioner will be provided a brief written description of the reason(s) for the precautionary suspension or restriction.
- (4) The Medical Executive Committee will review the reasons for the suspension or restriction within a reasonable time under the circumstances, not to exceed 14 days.
- (5) As part of this review, the Practitioner will be given an opportunity to meet with the Medical Executive Committee.

#### **8.F. INDICATIONS AND PROCESS FOR TEMPORARY SUSPENSION OR RESTRICTION**

- (1) The same individuals who are authorized to impose a precautionary suspension or restriction under Section 8.E above may impose a temporary suspension or restriction of any or all of the Practitioner's Clinical Privileges for a period of time not to exceed 14 days. The purpose of the temporary suspension or restriction is to enable a review or evaluation to be conducted to determine the need for initiation of corrective action.
- (2) The temporary suspension or restriction is effective upon imposition, and the Chief Executive Officer shall notify the Practitioner orally of the action and the reasons for the action as soon as possible. Oral notice shall be followed by Special Notice of the action and a general statement of the reasons for the action. The temporary suspension or

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<sup>61</sup> MS.01.01.01

restriction shall automatically expire at the end of the 14<sup>th</sup> day unless earlier terminated by the Medical Executive Committee or the Chief Executive Officer.

- (3) Although taken in the course of the Medical Peer Review process, a temporary suspension or restriction is not considered corrective action and does not entitle the Practitioner to any procedural rights of review under these Bylaws or otherwise.

#### **8.G. INDICATIONS FOR PROCESS FOR CORRECTIVE ACTION<sup>62</sup>**

Following an investigation, the Medical Executive Committee may recommend suspension, restriction or revocation of, or any other appropriate action regarding, Membership or Clinical Privileges, based on concerns about (a) clinical competence or practice; (b) violation of ethical standards or the Bylaws, policies, manuals, and Rules and Regulations of the Hospital or the Medical Staff, including but not limited to arrest or any other action involving a criminal matter; (c) conduct that is considered lower than the standards of the Hospital or its Medical Staff; (d) ability to perform, with or without reasonable accommodation, the essential functions of the Medical Staff Membership or Clinical Privileges; or (e) the Practitioner's qualification for Membership and Clinical Privileges.

#### **8.H. HEARING AND APPEAL PROCESS<sup>63</sup>**

The procedures in this Section and Article 7 of the Credentials Manual apply only to Members of the Medical Staff and to Physicians, Dentists, and Podiatrists applying to the Medical Staff.

##### **8.H.1. Grounds for Hearing:**

- (1) An individual is entitled to request a hearing whenever the Medical Executive Committee makes one of the following recommendations:
  - (a) Denial of initial Medical Staff Membership, renewed Medical Staff Membership, or requested Clinical Privileges;
  - (b) Revocation of Membership or Clinical Privileges;
  - (c) Suspension of Clinical Privileges for more than 14 days (other than precautionary suspension);
  - (d) A requirement for additional training or continuing education that must be completed before the Practitioner may exercise Clinical Privileges;
  - (e) Imposition of a mandatory concurring consultation requirement, in which the consultant must approve the course of treatment in advance;
  - (f) Imposition of a mandatory proctoring or observation requirement for more than 30 days based on clinical competence or professional conduct, in which the

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<sup>62</sup> MS.01.01.01

<sup>63</sup> MS.01.01.01

proctor or observer must be present before the practitioner may exercise clinical privileges; or

- (g) Denial of reinstatement from leave of absence as set forth in Section 6.H.(3), if the reasons relate to professional competence or conduct.
- (2) No other recommendation or action will entitle the individual to a hearing, including without limitation those listed in Section 8.G.2 below.
- (3) If the Board determines to take any of these actions following a Favorable Recommendation by the Medical Executive Committee, an individual is entitled to request a hearing. For each of use, this Article refers to adverse recommendations of the Medical Executive Committee. When a hearing is triggered by one of the above recommendations by the Board, any reference in this Article to the "Medical Executive Committee" will be interpreted as a reference to the "Board."

#### **8.H.2. Actions Not Grounds for Hearing:**

None of the following actions (or any others specifically provided for in the Bylaws or the Credentials Policy) are grounds for a hearing. These actions take effect without hearing or appeal. The individual is entitled to submit a written statement regarding these actions for inclusion in his or her file:

- (1) A letter of guidance, counsel, warning, or reprimand, or probation that does not involve any restriction on Clinical Privileges;
- (2) Conditions imposed during an initial FPPE, including but not limited to, monitoring, proctoring, or consultation requirements;
- (3) A lapse, withdrawal of, or decision not to grant temporary Privileges;
- (4) Automatic relinquishment or resignation of Membership or Clinical Privileges;
- (5) A requirement for additional training or continuing education, except as provided in Section 8.G.1 above;
- (6) Precautionary or temporary suspension or restriction
- (7) Denial of a request for leave of absence or for an extension of a leave;
- (8) Activation of a leave of absence on behalf of a Practitioner, by the Chief Executive Officer and/or CMO, in accordance with the Credentials Policy;
- (9) Removal from the on-call roster or any reading or rotational panel;
- (10) The voluntary acceptance of a performance improvement plan;
- (11) Determination that Application is not Complete;

- (12) Determination an Application will not be processed due to a misstatement or omission;
- (13) Determination of ineligibility for Membership or Clinical Privileges based on a failure to meet threshold eligibility criteria, a lack of Hospital need or resources, or because of an exclusive contract;
- (14) Changes to Medical Staff Membership prerogative (e.g., voting rights, eligibility for committee membership);
- (15) Denial of requested Staff category or failure to process such request due to ineligibility; or
- (16) Any other collegial intervention as defined in the Credentials Policy, Section 6.E.

### **8.H.3. Credentials Policy:**

The details associated with the hearing and appeals processes are contained in the Credentials Policy and shall include at least the following procedures:

- (1) The hearing will begin no sooner than 30 days after the Notice of hearing, unless an earlier date is agreed upon by the parties.
- (2) The hearing may be conducted by a Hearing Panel, which will consist of at least three members, or, in the alternative, maybe conducted by a Hearing Officer.
- (3) The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.
- (4) A stenographic reporter will be present to make a record of the hearing.
- (5) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent they are available and willing to testify; (b) to introduce exhibits; (c) to cross-examine any witness; (d) to have representation by counsel who may call, examine, and cross-examine witnesses or present the case; (e) to submit a written statement at the close of the hearing; (f) to submit proposed findings, conclusions and recommendations to the Hearing Panel; and (g) to receive the written recommendation of the Hearing Panel, including a statement of the basis for the recommendation.<sup>64</sup>
- (6) The personal presence of the affected Practitioner is mandatory. If the Practitioner who requested the hearing does not testify, he or she may be called and questioned.
- (7) The Hearing Panel (or Hearing Officer) may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

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<sup>64</sup> HCQIA, 42 USC Sec. 11112(b)(3)

- (8) The affected Practitioner and the Medical Executive Committee may each request an appeal of the recommendations of the Hearing Panel (or Hearing Officer) to the Board, and are entitled to receive the written decision of the Board, including a statement of the basis for decision.<sup>65</sup>

### **8.I. MEDIATION**

A Physician, Dentist, or Podiatrist who requests and is entitled to mediation pursuant to section 241.101(d) of the Texas Health & Safety Code based on either: (i) being subject to a recommendation or action by the Medical Executive Committee or the Board of Trustees which entitles the individual to a hearing as provided in Section 8.G.1; or (ii) a belief that the Credentials Committee has not acted on the individual's Complete Application for Medical Staff membership or Clinical Privileges within 90 days of its receipt by the committee, shall be provided with an opportunity for mediation as set forth in the Credentials Manual.

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<sup>65</sup> HCQIA, 42 USC Sec. 11112(b)(3)

**ARTICLE 9**  
**AMENDMENTS**

**9.A. MEDICAL STAFF BYLAWS**

- (1) Amendments to these Bylaws may be proposed by a petition signed by 20% of the voting Members of the Medical Staff, by the Bylaws Committee, or by the Medical Executive Committee.
- (2) Proposed amendments must be reviewed by the Medical Executive Committee prior to a vote by the Medical Staff. The Medical Executive Committee will provide Notice of proposed amendments, including amendments proposed by the voting Members of the Medical Staff as set forth above, to the voting Members of the Medical Staff. The Medical Executive Committee may also report on any proposed amendments, either favorably or unfavorably, at the next regular meeting of the Medical Staff or at a special meeting called for such purpose.<sup>66</sup>
- (3) The proposed amendments may be voted upon at any meeting if Notice has been provided at least 15 days prior to the meeting. To be adopted, the amendment must receive a majority of the votes cast by the voting Staff at the meeting.<sup>67</sup> See Section 7.B.3. for Quorum requirement.
- (4) In the alternative, the Medical Executive Committee may present any proposed amendments to the voting Members of the Medical Staff by mail or electronic voting, returned to the Medical Staff Office by the date indicated by the Medical Executive Committee. Along with the proposed amendments, the Medical Executive Committee may, in its discretion, provide a written report on them, either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast. See Section 7.B.3. for Quorum requirement.
- (5) The Medical Executive Committee will have the power to adopt any amendments to these Bylaws that are needed because of reorganization, renumbering, or punctuation, spelling or other errors of grammar or expression without compliance with the above procedures.
- (6) Amendments will be effective only after approval by the Board of Trustees.
- (7) If the Board of Trustees has determined not to accept an amendment adopted by the Medical Staff, the Medical Executive Committee shall initiate the conflict management process in Section 9.C.2 below, which purpose shall include but not be limited to further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the amendment.<sup>68</sup>

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<sup>66</sup> MS.01.01.01

<sup>67</sup> MS.01.01.01

<sup>68</sup> MS.01.01.01; LD.02.04.01

- (8) Neither the Medical Executive Committee, the Medical Staff, nor the Board can unilaterally amend these Bylaws.<sup>69</sup>

#### **9.B. ADOPTION AND AMENDMENT OF OTHER MEDICAL STAFF DOCUMENTS**

- (1) In addition to the Medical Staff Bylaws, there will be Credentials Policy, Organization Manual, Rules and Regulations, and other policies that are applicable to Practitioners. Those documents shall be considered an integral part of the Medical Staff Bylaws, but shall be amended in accordance with this Section.
- (2) The Credentials Policy, the Organization Manual, or the Rules and Regulations may be adopted or amended by a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee. Notice of any proposed adoption or amendments to these documents will be provided to each voting Member of the Medical Staff at least 15 days prior to the vote by the Medical Executive Committee. Any voting Member may submit written comments on the proposed adoption or amendments to the Medical Executive Committee.<sup>70</sup> The Medical Staff also may invoke the conflict management process in Section 9.C.1 below.
- (3) Other policies of the Medical Staff may be adopted and amended by a majority vote of the Medical Executive Committee. No prior Notice to the Medical Staff is required. The Medical Staff may invoke the conflict management process in Section 9.C.1 below.
- (4) Adoption of or amendments to the Credentials Policy, the Organization Manual, the Rules and Regulations, or any other Medical Staff policy may also be proposed by a petition signed by at least 20% of the voting Members of the Medical Staff. Notice of any such proposed adoption of or amendment to these documents will be provided to the Medical Executive Committee at least 15 days prior to being voted on by the Medical Staff. Any such proposed adoption or amendments will be reviewed by the Medical Executive Committee.<sup>71</sup>
- (a) Voting may be at any meeting of the Medical Staff if Notice has been provided to the voting Members of the Medical Staff at least 15 days prior to the meeting. The Medical Executive Committee may also report on the proposed amendments, either favorably or unfavorably, at that meeting prior to voting. To be adopted, the amendment must receive a majority of the votes cast by the voting Members at the meeting.
- (b) Alternatively, the Medical Executive Committee may conduct the voting by mail or electronic voting, returned to the Medical Staff Office by the date indicated by the Medical Executive Committee. Along with the proposed amendments, the Medical Executive Committee may, in its discretion, provide a written report on them, either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast.

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<sup>69</sup> MS.01.01.03

<sup>70</sup> MS.01.01.01

<sup>71</sup> MS.01.01.01

- (c) See Section 7.B.3. for Quorum requirements.
- (5) The Medical Executive Committee and the Board will have the power to provisionally adopt urgent amendments to the Rules and Regulations that are needed in order to comply with a law or regulation, without providing prior Notice of the proposed amendments to the Medical Staff. Notice of provisionally adopted amendments will be provided to each Member of the Medical Staff as soon as possible. The Medical Staff will have 30 days to review and provide comments on the provisional amendments to the Medical Executive Committee. If there is no conflict between the Medical staff and the Medical Executive Committee, the provisional amendments will stand. The Medical Staff also may invoke the conflict management process in Section 9.C.1. below.<sup>72</sup>
- (6) Adoption of and changes to the Credentials Policy, the Organization Manual, the Rules and Regulations, and other Medical staff policies will become effective only when approved by the Board of Trustees.
- (7) The Credentials Policy, the Organization Manual, the Rules and Regulations, and other Medical Staff policies when adopted or any amendments are to be distributed or otherwise made available to Practitioners in a timely and effective manner.<sup>73</sup>

**9.C. CONFLICT MANAGEMENT PROCESS<sup>74</sup>**

**9.C.1. Conflicts Between the Medical Staff and the Medical Executive Committee:**

- (1) When there is a conflict between the Medical Staff and the Medical Executive Committee, supported by a petition signed by 20% of the voting staff, with regard to:
  - (a) A new Medical Staff Rule and Regulation proposed by the Medical Executive Committee or an amendment to an existing Rule and Regulation; or
  - (b) A new Medical Staff policy proposed by the Medical Executive Committee or an amendment to an existing policy, including without limitation, the Credentials Policy or Organization Manual,

A special meeting of the Medical Staff to discuss the conflict will be called. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the Rules and Regulations or policy at issue.

- (2) If the differences cannot be resolved at the meeting, the Chief of Staff or the dissenting Members of the Medical Staff may request that the matter be referred to an ad hoc Joint Conference Committee within 30 days. The Joint Conference Committee shall consist of:

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<sup>72</sup> MS.01.01.01

<sup>73</sup> MS.01.01.01

<sup>74</sup> MS.01.01.01

- (a) Three officers of the Medical Staff selected by the Chief of Staff (one of which may be the Chief of Staff);
  - (b) Three voting Members of the Medical Staff who signed the petition;
  - (c) The chairperson of the Board of Trustees; and
  - (d) The Chief Executive Officer and Chief Medical Officer, or their designees.
- (3) If the matter cannot be resolved by the Joint Conference Committee, the recommendations of the Medical Staff and Medical Executive Committee will be forwarded to the Board for final action.
- (4) This conflict management Section is limited to the matters noted above. It is not to be used to address any other issues, including, but not limited to, professional review actions concerning individual Members of the Medical Staff.
- (5) Nothing in this Section is intended to prevent individual Medical Staff Members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Rules and Regulations or other Medical Staff policies directly to the Board of Trustees. Communication from Medical Staff Members to the Board of Trustees will be directed through the Chief Executive Officer, who will forward the request for communication to the Board Chairperson. The Chief Executive Officer will also provide notification to the Medical Executive Committee by informing the Chief of Staff of such exchanges. The Board Chairperson will determine the manner and method of the Board's response to the Medical Staff Member(s).

**9.C.2. Conflicts Between the Medical Executive Committee and Board of Trustees:**

- (1) When there is a conflict between the Medical Executive Committee and the Board of Trustees with regard to:
- (a) A new Medical Staff Rule and Regulation proposed by the Medical Executive Committee or an amendment to an existing Rule or Regulation; or
  - (b) A new Medical Staff policy proposed by the Medical Executive Committee or an amendment to an existing policy,

Either a member of the Board of Trustees or the Medical Executive Committee may submit a written request to the Chairman of the Board that the matter be referred to an ad hoc Joint Conference Committee within 30 days.

- (2) The Joint Conference Committee shall consist of:
- (a) Three officers of the Medical Staff selected by the Chief of Staff (one of which may be the Chief of Staff);
  - (b) One other Medical Executive Committee member selected by the Chief of Staff;

- (c) The chairperson, vice chairperson, and secretary of the Board of Trustees or other designees of the Board of Trustees; and
  - (d) The Chief Executive Officer and Chief Medical Officer, or their designees.
- (3) If the Joint Conference Committee does not reach a resolution within 30 days, the Board of Trustees shall take final action on the matter.
- (4) This conflict management Section is intended primarily for the matters noted above and in Section 9.A.(7). It also may be used by the Medical Executive Committee and the Board of Trustees for appropriate matters not listed here for which there is not an established conflict management process. It may be used for individual Medical Peer Review matters.

**ARTICLE 10**  
**HISTORY AND PHYSICAL**<sup>75</sup>

(1) Timing of the History and Physical Examination

- (a) A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or a procedure requiring anesthesia services). The history and physical examination must be performed by a Practitioner who has been granted Clinical Privileges by the Hospital to perform histories and physicals.
- (b) If a medical history and physical examination has been completed within the 30 day period prior to admission or registration, a durable, legal copy of this report may be used in the patient's medical record, if the history and physical examination was performed by a Physician, Oral Maxillofacial Surgeon, Physician Assistant, or Advanced Practice Registered Nurse. In such cases, within 24 hours after admission/registration or prior to surgery/procedure, whichever comes first, an updated examination must be completed and documented by a Practitioner who has been granted Clinical Privileges by the Hospital to perform histories and physicals. The purpose of this updated examination is to identify any changes subsequent to the original examination. The Practitioner must update the history and physical examination to reflect any changes in the patient's condition since the date of the original history and physical or state that there have been no changes in the patient's condition.
- (c) When the history and physical examination is not performed or recorded in the medical record before surgery or a procedure requiring anesthesia, the operation or procedure will be canceled unless the operating Practitioner states in writing that an emergency situation exists. If it is an emergency situation and a history and physical has been dictated but has not been transcribed, there will be a statement to that effect in the patient's chart, with an admission note by the operating Practitioner. The admission note must be documented immediately prior to surgery (same days as surgery) and will include, at a minimum, an assessment of the patient's heart rate, respiratory rate and blood pressure.

(2) Scope of History and Physical Examination

The scope of the medical history and physical examination will include, as applicable:

- (a) Admission date and time;
- (b) Chief complaint;
- (c) History of present illness;

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<sup>75</sup> MS.01.01.01; 42 C.F.R. 482.22(c)(5); MS.03.01.01 (scope)

- (d) Relevant past medical/surgical history;
- (e) Allergies;
- (f) Current medication;
- (g) Relevant family/social history;
- (h) Pertinent review of systems;
- (i) Physical examination – include vital signs if not already included in the record, heart, lungs, and other body parts appropriate to the patient's chief complaint, symptoms or the planned procedure;
- (j) Admitting diagnosis;
- (k) Treatment plan

**ARTICLE 11**  
**ADOPTION**

These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any previous Medical Staff Bylaws, and any inconsistent provisions of the Rules and Regulations, Medical Staff policies or manuals or Hospital policies pertaining to the subject matter contained herein.

Adopted by the Medical Staff:

\_\_\_\_\_  
[DATE]

Approved by the Board of Trustees:

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[DATE]