

TEXAS SPINE AND JOINT HOSPITAL LTD.
MEDICAL STAFF BYLAWS

Effective: August 1, 2007

TEXAS SPINE AND JOINT HOSPITAL L.L.P.

MEDICAL STAFF BYLAWS

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TEXAS SPINE AND JOINT HOSPITAL, L.L.P.

BYLAWS OF THE MEDICAL STAFF

PREAMBLE

Texas Spine and Joint Hospital, L.L.P. is a limited liability partnership organized under the laws of the State of Texas, with its purpose being to serve as a specialty surgical hospital, providing patient care, education, and research. It is recognized that the Medical Staff is responsible for the quality of care in Texas Spine and Joint Hospital, L.L.P., and it must accept and discharge this responsibility, subject to the ultimate authority of the Hospital's Board of Directors.

The physicians practicing in this Hospital shall organize their activities in order to carry out the functions delegated to the Medical Staff by the Board in conformity with these Bylaws. These Bylaws, the Fair Hearing Plan and the Rules are created to set forth principles, requirements, and procedures within which the physicians shall carry out the responsibilities delegated to the Medical Staff, subject to the ultimate authority of the Board.

A. DEFINITIONS

1. "Administrator" means the Administrator or equivalent officer of the Hospital as designated by the Board.
2. The term "Adverse Action" means a final action by the Board with respect to an individual Physician, which begins with an Adverse Recommendation and results in denying a material portion of an application (including initial, renewal, or modification) for appointment to the Medical Staff, or terminating, suspending, or materially diminishing membership on the Medical Staff or clinical privileges, as more specifically defined in the Fair Hearing Plan.
3. The term "Adverse Recommendation" means a recommendation for Adverse Action with respect to a Physician.
4. "Board of Directors" or "Board" means the governing body of Texas Spine and Joint Hospital, L.L.P.
5. "Bylaws" means these Medical Staff Bylaws of the Hospital.
6. "Complete application" means an application in which all questions have been

answered and for which all information requested has been provided and all documentation and verification solicited by the Hospital have been received.

7. “DEA” means the United States Drug Enforcement Agency.
8. “DPS” means the Texas Department of Public Safety.
9. “Fair Hearing Plan” means the Fair Hearing Plan of the Medical Staff, which is specifically made a part of these Bylaws.
10. “Hospital” means Texas Spine and Joint Hospital, L.L.P. of Tyler, Texas.
11. “Medical Executive Committee” or “MEC” means the Executive Committee of the Medical Staff.
12. “Medical Staff” or “Staff” means the formal organization of all licensed physicians who have been granted privileges in accordance with these Bylaws.
13. “Medical Staff Development Plan” means that certain staffing plan developed by the Board periodically to address the medical staffing needs of the Hospital.
14. “Medical Staff Year” means a year which commences on the first day of January and ends on the thirty-first day of December each year.
15. “Physician” means, unless otherwise expressly limited, any physician applying for or having privileges in this Hospital.
16. “Rules” means the Rules and Regulations of the Medical Staff, which are specifically made a part of these Bylaws.
17. “Special Notice” means written notification sent by personal delivery or certified or registered mail, return receipt requested.
18. “Staff Member” or “Member” means a physician who has been granted membership on the Medical Staff.

B. OBJECTIVES

The objectives of this organization are:

1. To strive that all patients admitted and/or treated in any of the Hospital departments or services, shall receive care of the quality and level appropriate to their needs by:
 - (a) Granting clinical privileges appropriate to the Physician’s documented training

and experience, and peer recommendations regarding demonstrated competence.

- (b) Using criteria approved by the Medical Staff and meeting national standards of practice, establish and adhere to a planned and systematic process for on-going review, monitoring and evaluation of each Physician's performance.
 - (c) Utilizing the findings in (b) above for corrective actions as/if needed and to be considered at the time of reappointment.
2. Establish, and adhere to, Bylaws, Rules and Regulations that establish a framework for self-governance, reflect national standards of practice and accountability to the Board.
 3. Provide a means for effective communication among the Medical Staff, Board and the Administrator.
 4. To strive for Medical Staff representation and participation in any official deliberation of issues affecting or concerning the Medical Staff and their responsibilities.
 5. To strive that all Physicians with clinical privileges participate in medical education programs offered at the Hospital and/or those appropriate to their clinical privileges or area of clinical practice offered by the various local, state or national organizations.

ARTICLE I. MEDICAL STAFF MEMBERSHIP

1.1 GENERAL

No applicant or member of the Medical Staff has a right to apply for or be granted staff privileges. Membership on the Medical Staff or the exercise of temporary privileges is a privilege and not a right. These Bylaws should not be construed in a manner as to create a contract, employment, property or liberty right, or interest in privileges or the continuation of privileges at the Hospital. Privileges may be extended only to professionally competent Physicians who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment to and membership on the Staff shall confer on the appointee or member only such clinical privileges as have been granted by the Board in accordance with these Bylaws. No Physician shall admit or provide services to patients in the Hospital unless he or she has been granted privileges in accordance with the procedures set forth in these Bylaws.

No individual shall be entitled to appointment to the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that such individual (a) is licensed to practice a profession in this or any other state, (b) is a member of any particular professional

organization, (c) has had in the past, or currently has, medical staff appointment or privileges at any hospital, or (d) resides in the geographic service area of the Hospital as defined by the Board.

The Board of the Hospital specifically reserves the authority to take any direct action that is appropriate with respect to any individual appointed to the Medical Staff or given clinical privileges or the right to practice in the Hospital entity. Actions taken by the Board may, but need not, follow the procedures outlined in the Medical Staff Bylaw or Fair Hearing Plan.

An applicant or member is neither an employee nor an independent contractor of the Hospital, unless such a relationship is separately established between the Hospital and such Medical Staff Applicant or Member. In the event of any conflict between the language of these Medical Staff Bylaws or Fair Hearing Plan, and a specific contract between the Hospital and a Medical Staff Member, the language of the contract shall control.

1.2 BASIC QUALIFICATIONS FOR MEMBERSHIP

1.2.1 Basic Qualifications

To be eligible for membership on the Medical Staff, Physicians must continuously meet the following prerequisites, unless otherwise provided in these Bylaws:

- (a) Licensure - be licensed to practice in the State of Texas (except as to exceptions set forth for telemedicine privileges), and to be currently registered at both the State of Texas and Federal levels to prescribe all medications typically used by physicians in the same field.
- (b) Proximity - agree to establish his/her primary medical within fifteen (15) miles of the Hospital or within a distance greater than fifteen (15) miles and less than thirty (30) miles provided that a written plan for coverage of the Physician's patients when the Physician is not available is submitted to and approved by the MEC and the Board.
- (c) Health Status - attest as to his/her ability to perform the essential functions of the privileges requested (with or without accommodation), including freedom from dependence on alcohol or other substances, as more specifically set forth in Section 1.5.
- (d) Experience - have sufficient documented experience, background, training, ability and physical and mental health status to demonstrate to the Medical Staff and the Board:
 - (i) that any patient treated by them will receive care of the

- generally recognized professional level of quality and efficacy;
 - (ii) their ability to practice in an economically efficient manner taking into account the patient's medical needs, the Hospital's services and resources; and
 - (iii) that they are qualified to provide a needed service within the Hospital;
- (e) Cooperation - is determined to adhere to the ethics of their respective professions, to work cooperatively with others, and to be willing to participate in the discharge of Staff responsibilities;
- (f) Competence - possesses sufficient character, competence, training, experience, and judgment to provide medical services at the Hospital;
- (g) Professional Liability Insurance - maintain not less than the minimum amount of professional liability insurance coverage as determined by resolution of the Board after consultation with the MEC. A current certificate of professional liability insurance from an insurance company recognized as acceptable by the Texas Department of Insurance must be presented. In addition, each Physician must report final judgments or settlements involving any individual professional liability action or claim.
- (h) Policies - compliance with Hospital policies, Bylaws, Rules and Regulations, and federal and state regulations;
- (i) Cooperative Interaction - maintains quality of care and harmonious Hospital operations, including cooperative interactions with Hospital personnel and staff;
- (j) Records - adequately maintains Hospital records; and
- (k) Physician Examination - have provided adequate documentation to demonstrate these qualifications (the MEC and the Board reserve the right to request that a Physician undergo a physical examination if the MEC or Board doubts a Physician's documented condition of health)
- (l) Ethics - agree that he/she will strictly abide by the ethics of his/her profession, as they may be amended from time to time.

1.2.2 Effect of Other Affiliations

No Physician shall be automatically entitled to membership on the Medical Staff or to the exercise of particular Clinical Privileges merely because he/she is licensed to practice in this or in any other state, or because he/she is a member of any professional organization, or because

he/she is certified by any clinical board, or because he/she had, or presently has, staff membership or privileges at the Hospital or at another healthcare facility or in another practice setting.

1.2.3 Nondiscrimination

No aspect of Medical Staff membership or particular Clinical Privileges shall be denied on the basis of sex, sexual preference, race, age, creed, color, national origin, or any other basis prohibited by law.

1.3 BASIC RESPONSIBILITIES OF INDIVIDUAL STAFF MEMBERSHIP

Basic Responsibilities of Staff Members shall include:

- (a) Providing patient care at the level of quality and efficiency achievable by the state of the healing arts and the resources locally available and meeting the professional standards of the Medical Staff and the applicable profession.
- (b) Abiding by the terms, conditions and procedures of these Bylaws, the Rules, and the Corporate Bylaws and governing policies of the Hospital.
- (c) Accepting and discharging in a responsible and cooperative manner committee assignments and such other reasonable duties as may be assigned by the Medical Staff, MEC and/or the Board, including, but not limited to, participation in the Emergency Department “on call” system to the extent required by the Hospital and federal and state law.
- (d) Accepting consultation assignments.
- (e) Staffing the emergency service area and other special care units in accordance with the Staff Member’s clinical privileges, as may be required by the Board and/or the MEC. Nothing herein shall preclude the Board from contracting with a third person(s) for such emergency room coverage.
- (f) Furnishing continuous care and/or making arrangements for the continuous care of the Staff Member’s patients.
- (g) Participating in peer review or the review of the quality of professional services provided as may be requested or required by the MEC or Board. This includes cooperating in any review of a Physician’s (including one’s own) credentials, qualifications or compliance with these Bylaws, and refraining from directly or indirectly interfering, obstructing or hindering any such review, whether by threat of harm or liability, by withholding information by refusing to serve or participate in assigned responsibilities or otherwise.

- (h) Furnishing any release and immunity from civil liability required by these Bylaws.
- (i) Working cooperatively and professionally with members of the Medical Staff, nurses, Hospital administration, Board, and refraining from disruptive behavior which has or could interfere with patient care or the smooth operation of the Hospital and its Medical Staff.
- (j) Participating in continuing education programs as required by the MEC, Board, or Medical Staff.
- (k) Perform a sufficient number of procedures, a sufficient number of cases, and have sufficient patient care contacts within the Hospital to permit the Medical Staff to assess the Physician's current competency for all privileges, whether being requested or already granted.
- (l) Work cooperatively with the MEC and administration to meet and practice within the guidelines established by the Hospital and/or the Medical Staff.
- (m) Provide services to medical assistance patients and other patients without personal physicians in accordance with the protocol adopted by the Staff delineating responsibilities for services to such patients.
- (n) As a condition to the exercise of clinical privileges at the Hospital, each Staff Member agrees, upon request of the Hospital or its Medical Staff, to provide appropriate and necessary emergency or non-emergency medical treatment within the scope of such Physician's privileges to any patient seeking such treatment, regardless of such patient's ability to pay.
- (o) Discharging such other Staff obligations as may be lawfully established from time to time by the MEC, Board or Medical Staff.

The foregoing qualifications shall not be deemed exclusive of other qualifications and conditions deemed by the Hospital or Medical Staff to be relevant in considering a Physician's qualifications for exercising privileges in the Hospital.

1.4 CONDITIONS AND DURATION OF APPOINTMENT

Appointments and reappointments to the Medical Staff will be made by the Board. The Board shall act on appointments, reappointments or revocation of appointments after there has been a recommendation from the MEC as provided in these Bylaws. In the event of unwarranted delay on the part of the MEC, however, the Board may act without such recommendation on the basis of documented evidence of the applicant's or Staff Member's professional and ethical qualifications obtained from reliable sources other than the MEC. Unwarranted delay as used herein is a delay inconsistent with the appointment guidelines provided in Article IV.

Reevaluation of Medical Staff qualifications can be made at any time. No Physician has a right to continued staff privileges. Appointment to the Medical Staff will confer only those privileges as set forth on the approved privilege delineation form.

Initial appointments to the Medical Staff shall be for a period of two (2) Medical Staff Years.

1.5 HEALTH STATUS

In order to promote the quality and safety of patient care in the Hospital, whenever the physical and/or mental health status of a Staff Member is called into question, the MEC may at any time require such Staff Member to submit to a mental or physical examination by a physician approved by the MEC. The results of such examination shall be reported to the chairman of the MEC and shall at a minimum address:

- whether the Staff Member has the ability to continue to provide patient care in the Hospital at a general professionally recognized level of quality and efficiency;
- whether such ability is compromised by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of any mental or physical condition; and
- whether there should be any restriction, limitation or consultation requirement placed upon the Staff Member's Medical Staff membership or clinical privileges as a result of any such illness, use or condition.

Every person who shall apply for or accept the privilege of Medical Staff membership at the Hospital shall be deemed to have given his or her consent to submit to such mental or physical examination, and if such person fails at any time to submit to such an examination when properly directed to do so, his/her Medical Staff membership and privileges may be suspended by the MEC. Such Staff Member shall thereupon have access to the hearing and appellate review procedures set forth in the Fair Hearing Plan.

1.6 TERMINATION OF CONTRACT

The Staff appointment and clinical privileges of any Medical Staff member who has a contractual relationship with the Hospital, or is either an agent, employee, or principal of, or partner in, an entity that has a contractual relationship with the Hospital, relating to providing services to patients at the Hospital, shall terminate automatically and immediately upon (i) the expiration or other termination of the contractual relationship with the Hospital, or (ii) the expiration or other termination of the relationship of the Staff member with the entity that has a contractual relationship with the Hospital. In the event of such a termination of Medical Staff appointment and/or clinical privileges, no rights to a hearing or appellate review provided in the Fair Hearing Plan shall apply.

1.7 CONTINUING NOTIFICATION

Each Staff Member must promptly notify the Chairperson of the Medical Staff of

- (i) the revocation or suspension of his/her professional license, or the imposition of terms of probation or limitation of practice by any state licensing agency;
- (ii) his/her loss of staff membership or loss, curtailment or restriction of privileges at any hospital or healthcare institution;
- (iii) the cancellation or restriction of his/her professional liability coverage or DEA number;
- (iv) an adverse determination by a peer review organization or a third party payor reimbursement program concerning his/her quality of care;
- (v) the commencement of formal investigation or the filing of charges by the Department of Health and Human Services or any law enforcement agency or health regulatory agency of the United States or the State of Texas, or any other state;
- (vi) or the filing of a claim or action against the Staff Member alleging professional liability.

ARTICLE II. CATEGORIES OF THE MEDICAL STAFF

2.1 CATEGORIES

The Staff shall include an Active, Provisional, Courtesy, Consulting, Honorary, Emergency, Contract, and Telemedicine category.

2.2 ACTIVE STAFF

2.2.1 Qualification

The Active Staff shall consist of Physicians, each of whom:

- (a) meets the basic qualifications set forth in Section 1.2.1 of these Bylaws.

2.2.2 Prerogatives

The prerogatives of an Active Staff Member shall be to:

- (a) admit patients to the Hospital without limitation; unless otherwise provided in the Medical Staff Rules and Regulations.
- (b) exercise such Clinical Privileges as are granted to him/her pursuant to Article V.
- (c) vote on all matters presented at a general and special meeting of the Medical Staff, and of the committees of which he/she is a member, unless otherwise provided by resolution of the Staff.

- (d) hold office in the Staff organization and committees of which he/she is a member, unless otherwise provided by resolution of the Staff.

2.2.3 Responsibilities

Each member of the Active Staff shall:

- (a) meet the basic responsibilities set forth in Section 1.3 of the Bylaws.
- (b) retain responsibility within his/her area of professional competence for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services or arrange a suitable alternative for such care and supervision by other members of the Staff.
- (c) actively participate in the patient care performance (quality) improvement program and other quality and utilization review, evaluation and monitoring activities required by the Hospital, in supervising initial appointees of his/her same profession, in the emergency services program, in at least on regular Staff committee, and in discharging such other Staff functions as may be required from time to time.
- (d) satisfy the requirements set forth in Article X for meeting attendance.
- (e) participate in continuing education programs as required and recommended by the Joint Commission on Accreditation of Healthcare Organizations and other applicable professional laws or guidelines.
- (f) have obligations for emergency room coverage as determined by the Medical Staff according to the limitations of Member's clinical competence and privileges; specialists in limited practice shall be available on an established schedule for consultation and special service in response to the needs of the emergency room patients.

2.3 COURTESY STAFF

2.3.1 Qualifications

The Courtesy Staff shall consist of physicians, each of whom:

- (a) meets the basic qualifications set forth in Section 1.2.1, and
- (b) is a member of the active or associate staff of another hospital where he/she actively participates in a patient care performance (quality) improvement and other quality and utilization review, evaluation and monitoring activities similar

to those required of the Active Staff of this Hospital.

2.3.2 Prerogatives

The prerogatives of a Courtesy Staff member shall be to:

- (a) admit patients to the Hospital within the limitations provided as follows:
 - (i) May not admit a patient without co-admitting by member of the Active or Provisional Staff.
 - (ii) Must have as co-surgeon or assistant surgeon a member of the Active Staff for major surgeries.
 - (iii) May be subject to 100% chart review and/or assigned a member of the Active Staff as proctor or monitor.
- (b) exercise such Clinical Privileges as are granted to him/her pursuant to Article V.
- (c) attend meetings of the Staff, serve on committees of the Staff, and participate in any Staff or Hospital education programs.
- (d) consult with other members of the Staff who request consultation on matters related to the provisions of quality patient care. Members of the Courtesy Staff shall not be eligible to vote or to hold Medical Staff Office.
- (e) admit only twelve (12) patients per year. When more than this number are admitted, the Courtesy Medical Staff member will be required to seek Active Staff Membership.

2.3.3 Responsibilities

Each member of the Courtesy Staff shall be required to discharge the basic responsibilities specified in Section 1.3 and, further, shall retain responsibility within hi/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision by other Medical Staff Members.

2.4 CONSULTING STAFF

The Consulting Medical Staff shall consist of those Physicians named and approved by the MEC and certified by the Board for approval who serve primarily in the role of specialist or consultant. Members of the Consulting Medical Staff must be a member of the Active Medical Staff at another hospital acceptable to the Board, where they participate regularly in quality assessment activities and their performance is evaluated. Consulting Medical Staff members shall not be eligible to admit patients, to vote, hold office or to serve on standing Medical Staff committees. They may attend Medical Staff and Department meetings.

2.5 CONTRACT STAFF

To the extent the Hospital has specific Emergency Service Physicians, they must meet the general qualifications required for Medical Staff membership. Temporary appointment to the Contract Staff may be made by the concurrent approval of both the Administrator and the Chairperson of the Medical Staff, this temporary appointment to be valid only until action by the Medical Staff is completed and in no instance to exceed six months. Emergency Staff privileges may be terminated, effective instantly, at any time by the concurrent written notice of the Administrator and the Chairperson of the Medical Staff, subject to review and reinstatement by the Medical Staff. Where a Contract Physician's activities in the Hospital are the result of a contract with the Hospital or with a group with whom the Hospital contracts, the Physician shall *ipso facto* lose all Medical Staff membership and privileges whatsoever upon the termination of the contractual relationship either between the Physician's employer and Physician or the Hospital and Physician's employer.

2.6 TELEMEDICINE STAFF

Physicians who diagnose or treat patients via telemedicine link are subject to the credentialing and privileging processes of the Hospital related to Consulting Staff privileges and as more specifically set forth in Section 5.9. Any Physician who prescribes, renders a diagnosis or otherwise provides clinical treatment to a Hospital patient through any electronic or telemedicine technology shall be required to obtain privileges in this category. The Medical Staff shall recommend the types of clinical services to be provided by Telemedicine Physicians. Telemedicine Physicians shall not have any admission privileges, nor shall they be entitled to vote or hold office on the Medical Staff. To the extent a Physician is licensed outside the State of Texas, such Physician will satisfy the Texas Board of Medical Examiners requirements for a Special Purpose License for practice of medicine across state lines.

2.7 HONORARY STAFF

2.7.1 Qualifications

The Honorary Staff shall consist of Physicians who are not currently active in the Hospital and who are recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences, or their previous long-standing service to the Hospital

2.7.2 Prerogatives

Honorary Staff members are not eligible to admit patients to the Hospital or to exercise Clinical Privileges in the Hospital. They may, however, attend Staff meetings and any Staff or Hospital education meetings. Honorary Staff members shall not be eligible to vote or to hold office in this Medical Staff organization.

2.7.3 Responsibilities

Honorary Staff Members are not required to assume responsibilities of the Hospital.

2.8 OPTIONAL ADDITION OF CATEGORIES OF STAFF

2.9 LIMITATION OF PREROGATIVES

The Prerogatives set forth under each Staff category are general in nature and may be subject to limitation by special conditions attached to a Physician's Staff membership by other Sections of these Bylaws, the Rules and Regulations of the Medical Staff, and other Rules and policies of the Staff, the Department or the Hospital.

2.10 WAIVER OF QUALIFICATIONS

Any qualification may be waived at the discretion of the Board upon determination that such waiver will serve the best interests of the patients and the Hospital.

ARTICLE III. ALLIED HEALTH PROFESSIONALS

3.1 QUALIFICATIONS

Only Allied Health Professionals (which shall mean without limitation podiatrists, dentists, certified registered nurse anesthetists, psychologists, nurse practitioners, and physician assistants) (collectively "AHP(s)") holding a license, certificate or other legal credentials required by Texas Law, are not eligible for membership on the Staff because they are not licensed Physicians, but those who meet the following qualifications, shall be eligible to provide specified services in the Hospital:

- (a) have documented their experience, background, training, demonstrated ability, physical health status and upon request of the MEC or of the Board, mental health status, with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency and that they are qualified to provide a needed service within the

Hospital; and

- (b) are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions as applicable and to work cooperatively with others.

When appropriate, the MEC may establish particular qualifications required of members of a specific category of AUP's provided that such qualifications are not founded on an arbitrary or discriminatory basis and are in conformance with applicable laws.

The Chairperson of the Medical Staff or his/her designee shall oversee an AHP's activities and ensure compliance with pertinent aspects of these Bylaws, the Rules, and policies and procedures.

AHP's who are employees of Physicians shall be the direct responsibility of each employing Physician in accordance with the applicable provisions of these Bylaws and Rules.

AHP's who are employees of the Hospital shall be subject to Hospital personnel policies and procedures. Termination of employment shall automatically terminate Allied Health Professional status at the Hospital. Specified personnel may be assigned to individual Staff Members, and shall carry out their activities subject to the applicable policies and procedures and in conformity with the applicable provisions of these Bylaws and Rules.

3.2 PROCEDURE FOR SPECIFIED SERVICES

An application for specified services for an AHP shall be submitted and processed in the same manner as provided in Article VII for Clinical Privileges, provided that the Board may delegate to the Administrator the authority to take action for it on any such applications from specific categories of AHP's. An AHP who applies for specific privileges must document his/her experience, background, training, demonstrated ability, current competence and health status and provide references as requested. AHP's must be reappraised and reappointed

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biannually. By filing an application to provide specified services in the Hospital as an AHP, an applicant specifically consents to be bound by these Bylaws, the Medical Staff Rules and Regulations, and all other rules and policies of the Staff, or the Hospital. Such limitations are subject to waiver by the Board in individual cases. An AHP shall be individually assigned to the clinical area appropriate to his/her professional training and shall be subject in general to the same terms and conditions as specified in Section 1.4 for Medical Staff Appointments' provided, however, that AHP's are not and shall not be considered members of the Medical Staff and that corrective action with regard to AHP's, including termination or suspension of services authorized, shall be accomplished in accordance with usual Hospital personnel practices or the individual's employment, if any. The hearing and appellate procedures specified in Article VII for members of the Medical Staff and as more fully set forth in the Fair Hearing Plan shall not apply to AHP's for any actions taken by the MEC or the Board.

3.3 PREROGATIVES

The prerogatives of an AHP shall be to:

- (a) provide specified patient care services under the supervision or direction of a Physician member of the Medical Staff (except as otherwise expressly provided by resolution of the MEC approved by the Board).
- (b) write orders only to the extent established by the Medical Staff, but not beyond the scope of the AHP's license, certificate or other legal credentials.
- (c) serve on Staff and Hospital committees, but not serve as Chairperson of a standing committee of the Medical Staff.
- (d) attend meetings of the Medical Staff, and Hospital education programs.
- (e) exercise such other Prerogatives as shall, by resolution or written policy duly adopted by the Staff or by any of its committees and approved by the MEC and by the Board, be accorded to AHP's as a group or to any specific category of AHP's, such as the right to vote on specified matters, to hold defined offices, or any other Prerogatives for which medical education, training and experience, beyond that which an AHP can demonstrate, is not a prerequisite.

3.4 RESPONSIBILITIES

Each AHP shall:

- (a) meet the same basic responsibilities as required by Section 1.3 of these Bylaws for Medical Staff members.
- (b) retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision.
- (c) participate as appropriate in the patient care evaluation and other quality review, evaluation and monitoring activities required of the Staff, in supervising initial appointees of his/her same profession during the observation period, and in discharging such other Staff functions as may be required from time to time.
- (d) satisfy the requirements set forth in Article X for attendance at meetings of the department and committees of which he/she is a member.
- (e) satisfy requirement of a minimum of \$200,000/\$600,000 for professional liability insurance.

3.5 DENTAL SERVICES

The scope and extent of surgical procedures that each dentist may perform in the Hospital shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical privileges performed by dentists shall be under the overall supervision of the Chairperson of the Medical Staff or his/her designee. Dentist members of the Medical Staff shall be responsible for the part of their patients' history and physical examinations that relate to dentistry, and a physician member shall perform a baseline history and physical exam to the extent that he/she deems appropriate; provided that qualified oral and maxillofacial surgeons may perform the medical history and physical if they have such privileges. Admission of a dental patient is the dual responsibility of the dentist and a physician member of the Medical Staff. A physician member of the Medical Staff shall be responsible for the general medical care of the patient, including any medical problem that may be present at the time of admission or that may arise during hospitalization.

3.6 PODIATRIC SERVICES

The scope and extent of surgical procedures that each podiatrist may perform in the Hospital shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by podiatrists shall be under the overall supervision of the Chairperson of the Medical Staff or his/her designee. Podiatrist members of the Medical Staff shall be responsible for the part of their patients' history and physical examinations that relate to podiatry, and a physician member shall perform a baseline history and physical to the extent that he/she deems appropriate. Admission of a podiatric patient is the dual responsibility of the podiatrist and a physician member of the Medical Staff. A physician member of the Medical Staff shall be responsible for the general medical care of the patient, including any medical problem that may be present at the time of admission or that may arise during hospitalization. A podiatrist may write orders and prescribe medications only within the limits of his/her license to practice podiatry.

ARTICLE IV. PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

4.1 INTENTIONALLY LEFT BLANK

4.2 APPLICATION FORM

All applications for appointment to the Medical Staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form that the Board has approved after consultation with the MEC. The applicant must indicate on the form his/her desired Medical Staff category and clinical privileges. The application shall require detailed information concerning the applicant's professional qualifications and shall include the names of at least three (3) persons who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's professional competence and ethical character. An applicant shall complete this form, without limitation, with information on the following:

- i. All previous medical education and training;
- ii. Previous and current medical staff memberships at other hospitals or health care entities and any denials, suspensions, non-renewals, or voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital or entity;
- iii. Proof of current licensure to practice medicine, dentistry or podiatry, as appropriate, in Texas;
- iv. Proof of controlled substance certification to prescribe such substances in the United States and Texas;
- v. Any previously successful or currently pending challenges to any of the applicant's licensure, certification, or registration (*e.g.*, state or district, DEA, or DPS) or voluntarily relinquishment of such licensure, certification, or registration;
- vi. Past and current malpractice history, including final judgments and settlements, evidence of adequate malpractice insurance, and a consent to the release of information from his past and current malpractice insurance carrier(s);
- vii. Present membership in any professional societies and any previous clinical or disciplinary actions by such a society;
- viii. Investigations commenced, charges filed, or final actions taken against the applicant by the Department of Health and Human Services, a peer review organization, or any law enforcement agency or health regulatory agency of the United States or any state; and
- ix. Certification by the applicant, or by a physician, if so requested by the MEC, that his/her physical and mental health status (including, but not limited to, drug or alcohol abuse) does not impair his/her ability to exercise the clinical privileges requested and to fulfill the essential functions of Medical Staff membership with or without accommodation.
- x. Such other information as the Board may require.

4.3 ACKNOWLEDGEMENTS

The application form shall include a statement that the applicant has received and read the most current Bylaws and Rules and that he/she agrees to be bound by the terms thereof (including but not limited to provisions regarding release and immunity from civil liability). Every application shall also contain the applicant's specific acknowledgment of his/her obligations:

- (i) to provide Continuous care and supervision of his/her patients,
- (ii) to provide as it occurs, with or without request, new or updated

- information that is pertinent to any question on the application form,
- (iii) to consent to the inspection of records and documents pertinent to his/her licensure, specific training, experience, current competence, and ability to perform the privileges requested, and, if requested, to appear for an interview,
- (iv) to accept Medical Staff committee assignments,
- (v) to participate in staffing the emergency service area, and
- (vi) to accept consultation assignments.

By applying for appointment or reappointment to the Medical Staff and/or clinical privileges, each applicant thereby:

- (a) Authorizes Hospital representatives to solicit and act upon information, including otherwise privileged or confidential information, provided by third parties bearing on his or her credentials and agrees that any information so provided shall not be required to be disclosed to him or her if the third party providing such information does so on the condition that it be kept confidential.
- (b) Authorizes third parties to release information, including otherwise privileged or confidential information, as well as reports, records, statements, recommendations and other documents in their possession, bearing on his or her credentials to any Hospital representative, and consents to the inspection and procurement by any Hospital representative of such information, records and other documents.
- (c) Authorizes the Hospital and Hospital representatives to release such information, when requested by the applicant, to other hospitals, health care facilities and their agents, who solicit such information for the purpose of evaluating the individual's professional qualifications pursuant to the individual's request for appointment, reappointment or clinical privileges;
- (d) Agrees to appear for a personal interview at any reasonable time requested by any Hospital representative.
- (e) Consents to the reporting by any Hospital representative of information to the National Data Bank established pursuant to the Health Care Quality Improvement Act of 1986, which such Hospital representative believes in good faith is required by law to be reported;
- (f) Releases from any liability (1) all Hospital representatives, employees, or agents for their acts performed in connection with evaluating his or her credentials or releasing information to their institutions for the purpose of evaluating his or her credentials, in compliance with the Bylaws; and (2) all third parties who provide information, including otherwise privileged or confidential information, to the Hospital and Hospital representatives concerning his or her credentials, unless such information is false and the third party providing it knew it was false.

- (g) Agrees that, if any Adverse Action or Adverse Recommendation is made with respect to him or her, (1) he or she will follow and exhaust the administrative remedies afforded by the Medical Staff Bylaws and the Fair Hearing Plan as a prerequisite to any other action, and (2) he or she will have the burden of demonstrating that he or she meets the standards for appointment or continued appointment to the Medical Staff or for the clinical privileges requested.
- (h) Agrees that the foregoing provisions are in addition to any agreements, understandings, covenants, waivers, authorizations or releases provided by law or contained in any application or request forms.

4.4 INITIAL APPOINTMENT PROCESS

4.4.1 Administrative Review

The applicant shall submit the application to the Administrator or his/her designee. If the Hospital has contracted with a delegated or centralized credentialing verification service or otherwise delegated the credentials-gathering function, then the Hospital may direct the submission of the application to that service or entity. The Administrator (or his/her designee) or the delegated credentialing service or entity shall review the application to determine that all questions have been answered, file a query with the National Practitioner Data Bank, collect necessary references, and verify all pertinent information or materials (such as licensure, specific training, experience, and current competence) from primary sources whenever required. The Hospital may also seek information about the applicant from other sources, such as the American

Medical Association Physician Masterfile and the Federation of State Medical Boards Physician Disciplinary Data Bank.

There shall be no obligation to process an application that is incomplete. An application that is in any manner deficient may be returned to the applicant. The applicant shall have the burden of producing all necessary information, including references, for a proper evaluation of his/her credentials within sixty (60) days of the date the application was submitted. If the Administrator determines that the application is not complete, he/she shall so notify the applicant and the application shall not be processed further until all apparent deficiencies have been corrected and the application has been resubmitted. The applicant's failure to furnish the information initially or subsequently requested in connection with an application shall constitute a waiver of the applicant's right, if any, to further processing and shall not give rise to any right of review.

4.4.2 MEC Review

The Administrator shall transmit a complete application and all supporting materials to the Credentials Committee for evaluation. The Credentials Committee will review the clinical

privileges requested and determine whether the requested privileges fall within the scope of training of the applicant. Furthermore, the Credentials Committee will determine if the privileges requested are within the restraints of the hospital's capacity. After approval of the Credentials Committee, the approved applications will be forwarded to the MEC for approval. MEC shall examine evidence of the character, professional competence, qualifications, and ethical standing of the Physician and shall determine through information provided by the Physician's references and from other sources available to the MEC whether the Physician meets all of the necessary qualifications for staff membership and the clinical privileges requested. Within ninety (90) days after an application is complete, the MEC shall forward its written report and recommendation to the Administrator for transmittal to the Board. All recommendations for appointment must specifically recommend the clinical privileges to be granted, with or without qualification.

- i. Limited Membership Departments. If a Physician has applied for participation in a department, subspecialty, or staff category for which limited or no openings are currently available, as openings subsequently arise in such department, subspecialty or staff category, the MEC shall make recommendations to the Board for filling such positions by selecting from the available list of deferred Physicians whose applications are current those Physicians found to be best qualified for staff appointment, regardless of the date of application. If a Physician is not selected for staff appointment within the six-month period following the date of his or her application, the application will be considered to have been withdrawn unless it is adequately and properly renewed in writing.
- ii. Denial for Hospital's Inability to Accommodate. Upon a recommendation by the MEC or a decision by the Board to deny Staff membership, or Staff category assignment, or particular Clinical Privileges based upon either:
 - the Hospital's present inability to provide adequate facilities or supportive services for the applicant and his/her patients, or
 - inconsistency with the Hospital's Medical Staff Development Plan, including the mix of patient care services to be provided, as currently being implemented, or
 - an insufficient patient population (current or expected) to support an additional Physician with skills and education of applicant:

Upon written request by the applicant to the Administrator, the application shall be kept in a pending status for the next succeeding six (6) months. If during this period, the Hospital finds it possible to accept Staff applications for which the applicant is eligible the Administrator shall promptly so notify him/her. Within thirty (30) days of receipt of such notice, the applicant shall

provide, in writing on the prescribed form, such supplemental information as is

required to update all elements of his/her original application. Thereafter, the procedure provided in Article IV for initial appointments shall apply,

- iii. Adverse Recommendation. In the event of an Adverse Recommendation by the MEC, the provisions of the Fair Hearing Plan shall apply.

4.4.3 Board Action Review

Within ninety (90) days after a favorable recommendation of the MEC, the Board shall act on the matter. If the Board's decision is also favorable, the applicant will be appointed to the Medical Staff with clinical privileges specifically delineated. If the Board's decision is adverse to the Physician, the provisions of the Fair Hearing Plan shall apply.

4.4.4 Notice of Final Decision

When the Board's decision is final, the Administrator shall, within twenty (20) days, send written notice thereof to the Physician.

4.4.5 Time Requirements

The time requirements referenced in this section shall be measured from the time a complete application was submitted. Such time requirements, however, shall be suspended pending waiver or completion of the hearing and/or appellate review procedures.

4.5 APPLICATION FOR REAPPOINTMENT

The reappointment application form shall request data necessary to update the Hospital and Medical Staff files on the staff member's qualifications. A staff member shall complete this

form, without limitation, with information about the following:

- i. Request for specific clinical privileges;
- ii. Justification for new or expanded privileges;
- iii. Continuing medical education, training, and experience since the previous appointment that demonstrates current competence and qualifies the staff member for the privileges sought on reappointment;
- iv. The name and address of any other health care organization or practice setting where the staff member has provided clinical services during the preceding period;
- v. Membership, awards, or other recognition conferred or granted by professional

health care societies, institutions, or organizations during the preceding period;

- vi. Update of information set forth in Section 4.2 as required in the reappointment application form; and
- vii. Such other specifics about the staff member's professional ethics, qualifications, and ability that may bear on his/her ability to provide quality patient care in the Hospital.

Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon such member's professional ability and clinical judgment in the treatment of patients, his/her professional ethics, discharge of Medical Staff obligations, compliance with these Bylaws and the Rules, cooperation with other Physicians, Hospital employees, and patients, documented continuing medical education, and other matters bearing on his/her ability and willingness to contribute to quality patient care in the Hospital, including findings from the Hospital's Performance Improvement Program.

4.6 REAPPOINTMENT PROCESS

4.6.1 Delivery of Form

The Administrator or his/her designee shall, at least ninety (90) days prior to expiration of the present staff appointment of each Medical Staff member, provide such staff member with an application for reappointment. At least sixty (60) days prior to the final scheduled meeting of the Board in the current Medical Staff Year, each Medical Staff member who desires reappointment shall send his/her reappointment application form to the Administrator or his/her designee. Failure, without good cause as determined by the MEC, to so return the form shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership and clinical privileges at the expiration of the member's current term, without a right to a hearing under the Fair Hearing Plan. A Physician whose membership is so terminated may reapply to the Medical Staff and his/her application shall be processed as an application for initial appointment.

4.6.2 Administrative Review

The Administrator or his/her designee, or a delegated credentialing verification service or other delegated credentials-gathering entity, shall seek to collect additional information or verify the information on each reappointment application form and collect any other materials or information deemed pertinent, including findings from the Hospital's Performance Improvement Program and information regarding the Medical Staff member's professional activities, performance, and conduct in the Hospital. The Administrator or his/her designee shall also obtain any necessary information from the National Practitioner Data Bank.

There shall be no obligation to process an application that is incomplete. An application that is in any manner deficient may be returned to the applicant. The applicant shall have the burden of producing all necessary information for a proper evaluation of his/her credentials within twenty (20) days of the date the application was submitted.

4.6.3 Review by Credentials Committee

The Administrator shall transmit the completed application for reappointment and supporting materials to the Credentials Committee. The Credentials Committee shall review each reappointment form and all other relevant available information and shall forward its report and recommendation to the Administrator for transmittal to the Board.

4.6.4 Board Action Review

As soon as practicable after a favorable recommendation of the MEC, the Board shall act on the matter. If the Board's decision is also favorable, the applicant will be reappointed to the Medical Staff with clinical privileges specifically delineated.

4.6.5 Compliance with Procedures for Appointment

Where applicable and not in conflict, the procedures provided in Section 4.4 relating to the initial appointment process shall be followed in this section. For purposes of reappointment, the terms "applicant" and "appointment" as used in that section shall be read, respectively, as "Medical Staff member" and "reappointment."

4.7 MISCELLANEOUS

4.7.1 Withdrawal

An applicant may, with the written approval of the Administrator, withdraw his/her application for appointment or reappointment at any time prior to the effective date of a final decision without prejudice to subsequent reapplication; provided, however, the Hospital shall make any reports regarding the withdrawal of an application that are required by law.

4.7.2 Eligibility for Reapplication after Adverse Action

A Physician may not apply to the Medical Staff of the Hospital for two (2) years if he/she has been denied membership at the Hospital due to his/her professional competence or conduct. Further, such a Physician shall accompany any application submitted after two (2) years with clear and convincing written evidence that the basis for the previous Adverse Action no longer exists.

4.7.3 Denial for Hospital's Inability to Accommodate Applicant

A decision by the Board to deny Medical Staff membership or clinical privileges because of an exclusive contractual arrangement or the Hospital's present inability to provide adequate facilities or support services shall not constitute an Adverse Action and shall not entitle the applicant to a hearing and appellate review in accordance with the Fair Hearing Plan.

4.7.4 Custody of Application

A written record of all matters considered in each Physician's initial appointment and reappointment appraisal(s) shall be maintained separately as part of the confidential peer review files of the Medical Staff. All Medical Staff applications and credentials shall remain in the custody of the Administrator or his/her designee.

4.8 IMMUNITY FROM LIABILITY

4.8.1 Persons Protected

By applying for and/or accepting appointment to the Medical Staff and by applying for, accepting and/or exercising clinical privileges within the Hospital, each applicant and Medical Staff Member extends absolute immunity to, and releases from all claims, damages and liability whatsoever:

- (a) The Hospital and any Hospital representative, employee or agent, for any Adverse Action taken or statement or Adverse Recommendation made by any Hospital representative within the scope of his or her duties as a Hospital representative in compliance with the Bylaws, including disclosures made to other health care facilities pursuant to the Bylaws.
- (b) Any third party for releasing or disclosing information, including otherwise privileged or confidential information, to any Hospital representative concerning any former or current applicant or Medical Staff appointee unless such information is false and the third party providing it knew it was false.

4.8.2 Acts Covered

The immunity provided by the Medical Staff Bylaws shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with the Hospital's activities, including, but not limited to:

- (a) Applications for appointment and/or clinical privileges;
- (b) Periodic reappraisals undertaken for reappointment or for changes in clinical privileges;
- (c) Corrective action;
- (d) Hearings and appellate reviews;
- (e) Patient care audits;

- (f) Medical care evaluations;
- (g) Utilization reviews;
- (h) Other Hospital, staff, department, service, committee and subcommittee activities related to monitoring and maintaining quality patient care and appropriate professional conduct;
- (i) Matters or inquiries concerning the credentials of any applicant or Medical Staff appointee;
- (j) Matters directly or indirectly affecting patient care or the efficient operation of the Hospital; and
- (k) Reports to the National Data Bank established pursuant to the Act.

4.9 LEAVE OF ABSENCE

Members of the Medical Staff may apply for a leave of absence not to exceed 24 months, but renewable under appropriate conditions. During the leave of absence, Medical Staff privileges and membership will be administratively inactive. Reinstatement of Medical Staff privileges may be requested through the Department chairperson and Credentials Committee without formal reapplication, and with the concurrence of the MEC. When requesting reinstatement, the Physician should submit a summary of clinical activities during the leave of absence. Failure to request reinstatement will be deemed a voluntary resignation.

ARTICLE V. DETERMINATION OF CLINICAL PRIVILEGES

5.1 CLINICAL PRIVILEGES RESTRICTED

Medical Staff appointment or reappointment shall not confer any clinical privileges or right to practice at the Hospital. Every Physician at this Hospital by virtue of Medical Staff membership or otherwise, is entitled to exercise only those clinical privileges specifically granted to his/her by the Board, and such privileges shall be subject to removal or curtailment in accordance with the provisions of these Bylaws. The scope of each level of privileges shall be well-defined, and the standards to be met by the Physician shall be stated clearly.

5.2 BASIS FOR CLINICAL PRIVILEGES

The MEC is responsible for developing the criteria for and recommending clinical privileges. The evaluation of all requests for clinical privileges shall be based upon the applicant's demonstrated current competence, including documented experience in treatment areas or procedures, results of treatment, and (when available) conclusions from the Hospital's Performance Improvement Program (as set forth in Section 5.4). Education, training, experience, references, the Hospital's available resources and personnel, and other relevant information shall also be used in making this determination. While not a requirement for membership on the Medical Staff, board eligibility or board certification may be considered in delineating clinical privileges. When privilege delineation is based primarily on experience, the Physician's credentials record must reflect his/her specific experience and successful results that formed the

basis for the granting of privileges. The applicant shall have the burden of establishing his/her qualifications and competency for the clinical privileges he/she requests.

5.3 CLINICAL PRIVILEGES RESTRICTED OR EXPANDED

Periodic redetermination of clinical privileges and the expansion or curtailment of clinical privileges shall be made at least every two (2) years in conjunction with the application for reappointment. In addition, any Medical Staff member may request, in writing and on a prescribed form, additional specific clinical privileges at any time with information on relevant recent training and/or experience. This application shall be processed in the same manner as an application for initial appointment.

5.4 PERFORMANCE IMPROVEMENT PROGRAM

As a result of performance improvement program findings, the MEC may recommend practice changes, continuing education or proctorship to a Physician, and the Physician shall be afforded the opportunity to implement those recommendations by written agreement with the MEC. Although the recommendations shall be made in the course of professional review activity, the implementation of the recommendations shall not constitute a complete or final professional review action and shall not entitle the Physician to the rights under the Fair Hearing Plan.

5.5 TERMINATION OF EXISTING PRIVILEGES

If the Hospital contracts with a Physician or Physicians for professional services on an exclusive basis, non-contracting Medical Staff Physicians with clinical privileges that are encompassed within the contract's exclusivity clause shall not be authorized to exercise those privileges during the pendency of the contract. There shall be no procedural rights of review under the Fair Hearing Plan afforded as a result of the inability to exercise the privileges.

5.6 TEMPORARY PRIVILEGES

The Administrator may, with the written concurrence of the Chairperson of the Medical Staff, grant temporary admitting and/or clinical privileges only under those conditions described in this section. It may be acceptable to grant temporary privileges to (i) fulfill an important patient care need, or (ii) when a new applicant with a complete medical staff application raises no concerns and is awaiting review and approval of the MEC and the Board. Special requirements of supervision and reporting may be imposed by the Chairperson of the Medical Staff for any Physician who is awarded temporary privileges.

5.6.1 Requirements. In all cases, licensure must be verified through primary sources (a documented telephone call to the relevant state board is sufficient) and copies of a malpractice insurance policy summary must be submitted before the granting of temporary privileges may be considered. Before any such privileges are granted, the individual requesting temporary

privileges must agree to be bound by the terms of these Bylaws and the Rules. Additionally, temporary privileges for new applicants may be granted while awaiting review and approval of the MEC, upon verification of:

- (1) current licensure;
- (2) relevant training or experience;
- (3) current competence;
- (4) ability to perform privileges requested;
- (5) a query and evaluation of the National Practitioner Data Bank;
- (6) a complete application;
- (7) no current or previously successful challenge to licensure or registration;
- (8) not been subject to involuntary termination of medical staff membership at another institution; and
- (9) any other criteria required by these Bylaws.

5.6.2 Grant of Temporary Privileges.

- (a) **Prior to Membership.** Temporary privileges may be granted to an initial applicant to the Medical Staff for the duration of the application process, if good cause is shown. The applicant shall then act only under the supervision of the Chairperson of the Medical Staff or his/her designee. Temporary privileges granted under this subsection will be limited to a period of up to one hundred twenty (120) days, after which they must be reviewed and may be extended for additional periods of up to thirty (30) days by the Administrator and the Chairperson of the Medical Staff. Temporary privileges for new applicants may not exceed one hundred twenty (120) days.
- (b) **For Specific Patients.** Temporary clinical privileges may be granted for the care of a specific patient, if good cause is shown. Temporary clinical privileges granted under this subsection will expire when the patient is discharged. Any Physician who has treated three (3) patients in any one Medical Staff Year shall be required to apply for membership on the Medical Staff before attending additional patients during that year.
- (c) **Locum Tenens.** Temporary privileges may be granted to a Physician serving as a *locum tenens* for a member of the Medical Staff. After ninety (90) days, the Physician serving as *locum tenens* must apply for membership on the Medical Staff to continue to provide care for patients at the Hospital. The Physician serving as a *locum tenens* shall be under the authority of the Chairperson of the Medical Staff or his/her designee.
- (d) **Peer Review.** Temporary non-clinical privileges may be granted to a Physician to serve as a member of or consultant to a medical peer review committee during the pendency of an investigation and corrective action.

5.6.3 Termination. The Administrator or the Chairperson of the Medical Staff may, at any time, terminate a Physician's temporary privileges. The Chairperson of the Medical Staff shall assign a member of the Medical Staff to assume responsibility for the care of the terminated Physician's patient(s) until they are discharged from the Hospital, considering the wishes of the patient where feasible. The denial or termination of temporary privileges shall not entitle the Physician to any of the rights provided in the Fair Hearing Plan.

5.7 EMERGENCY PRIVILEGES

In case of an emergency, any Physician who is a member on the Medical Staff, to the degree permitted by his/her license and regardless of Medical Staff category, shall be permitted to do everything possible to save the life of or prevent serious permanent harm to a patient, including the calling for any necessary or desirable consultation. When an emergency situation no longer exists, such Physician must request the privileges necessary to continue to treat the patient if he/she does not have the proper clinical privileges. In the event such privileges are denied or the Physician does not have the desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff.

5.8 TELEMEDICINE PRIVILEGES

Telemedicine Privileges means the authorization granted by the Hospital to render a diagnosis or otherwise provide clinical treatment to a patient at the Hospital through the use of electronic communication or other communications technologies. After considering the recommendations of the administrator, the MEC shall make a recommendation to the Board regarding the clinical services that should be offered through telemedicine. Specific services provided at the Hospital via telemedicine will be recommended by the Medical Staff.

5.8.1 Qualifications of Applicants for Telemedicine Privileges. Any Physician who wishes to be granted Telemedicine Privileges must provide documentation of the following:

- (a) current license(s) to practice medicine;
- (b) current DEA certificate, if applicable;
- (c) professional liability insurance coverage in such minimum amounts as may be required by the Hospital from time to time;
- (d) current Texas controlled substance certificate, if applicable;
- (e) no exclusion from any federal health care program;
- (f) active medical staff appointment and clinical privileges in good standing at another accredited hospital; and
- (g) such additional information as may be requested by the Hospital.

The loss or suspension of any license, certificate or authorization described above must be reported immediately to the Hospital and shall result in the immediate relinquishment of any and all Telemedicine Privileges with no right to a hearing or appeal as outlined in the Medical Staff Bylaws or credentialing policies.

5.8.2 Processing Requests for Telemedicine Privileges.

- (a) Required documentation shall be submitted to the Hospital Medical Staff office or its designee.
- (b) The Administrator or his or her designee shall submit a query to the National Practitioner Data Bank.
- (c) The OIG's List of Excluded Providers shall be checked to determine that the applicant has not been excluded from any federal health care program.
- (d) The Administrator or his or her designee shall verify the applicant's status at his or her primary hospital.
- (e) The documentation, results of the query and information from the Applicant's primary hospital shall be reviewed by the relevant department chief, who shall forward a report to the Administrator.
- (f) The Administrator shall make a recommendation to the MEC regarding whether the physician's request for Telemedicine Privileges should be granted.
- (g) The MEC shall make a recommendation to the Board regarding whether the request for Telemedicine Privileges should be granted. The decision of the Board shall be final.

ARTICLE VI. CORRECTIVE ACTION

6. No Volume/Low Volume Practitioners

If you do not have any cases at TSJH you will be required to submit an OPPE report or proof of clinical competency from you primary facility within the time frame determined, in order to maintain your existing privileges. Failure to submit the requested documentation will result in automatic status change of your current active staff to another category.

Two peer references from the same field and/or specialty that are not partners in the practitioners group and have first hand current knowledge of the practitioner's ability.

6.1 ROUTINE CORRECTIVE ACTION

6.1.1 Criteria for Initiation

Whenever a member of the Medical Staff engages in conduct which fails to meet the letter or the spirit of the Medical Staff Bylaws, or makes or exhibits, acts, statements, demeanor or professional conduct detrimental to the delivery of quality patient care, disruptive or detrimental

to Hospital operations (including repetitive use of the Hospital's resources for himself or his/her patients in a manner which is adverse to the financial interests of the Hospital), or detrimental to the Hospital or to patient safety, corrective action against such Physician may be initiated by any officer of the Medical Staff, Administrator, or by the Board.

6.1.2 Requests and Notice

All requests for corrective action shall be in writing, submitted to the MEC and may be supported by reference to the specific activities or conduct, which constitute the grounds for request. Requests for corrective action initiated within a standing committee at which such request was considered. The MEC shall promptly notify the Administrator in writing of all requests for corrective action received by the MEC and shall continue to keep him/her fully informed of all action taken in conjunction therewith.

6.1.3 MEC Action

The MEC shall immediately investigate the matter or appoint an ad hoc committee composed of Active Staff members to investigate. A Medical Staff Member initiating the request for corrective action may not serve on the investigating committee. The affected Staff Member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating committee deems appropriate, including an opportunity for an interview. At such interview, the Staff Member shall be informed of the general nature of the charges and shall be invited to discuss, explain or refute them. This interview shall not constitute a "hearing," as that term is used in the Fair Hearing Plan and shall be preliminary in nature, and none of the procedural rules provided in the Fair Hearing Plan shall apply thereto. A record of such interview may be made by the investigating committee.

As soon as is practicable after the receipt of request of corrective action, the MEC shall prepare a written report and recommendation regarding the request. Before issuing such report, the MEC may investigate the allegations, as it deems appropriate. The MEC may interview witnesses, and the affected individual may have an opportunity to meet with the MEC after being informed of the general nature of the evidence supporting the investigation. The recommendations of the MEC may include, without limitation:

- (a) Rejecting the request for corrective action.
- (b) Issuing a warning, a letter of admonition, or a letter of reprimand.
- (c) Recommending terms of non-voluntary probation or individual requirements of non-voluntary consultation.
- (d) Recommending denial, reduction, suspension or revocation of Clinical Privileges.
- (e) Recommending unrequested reduction of Staff category or limitation of any Staff Prerogatives directly related to patient care.

- (f) Recommending suspension or revocation of Staff membership or other Adverse Recommendation.

6.1.4 Procedural Rights

Any action by the MEC pursuant to Section 6.1.3 which shall entitle the Physician to the procedural rights as provided in Article VII, and as otherwise set forth in Section 1.1 of the Fair Hearing Plan, and the matter shall be processed in accordance, with the provisions of the Fair Hearing Plan.

6.1.5 Other Action

If the MEC's recommended action is as provided in Section 6.1.3 (a), or (b), such recommendation shall be transmitted to the Board. Thereafter, the procedure to be followed shall be as provided in Section 4.7.2, as applicable.

6.2 . SUMMARY SUSPENSION

6.2.1 Criteria and Initiation

- (a) Whenever a Physician's conduct requires that immediate action be taken to protect the life or welfare of any patient(s) or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other person present in the Hospital, either the Chairperson of the MEC, the Chairperson of the Medical Staff, or the Administrator shall have the authority to summarily suspend the Medical Staff membership status or all or any portion of the Clinical Privileges of such Physician. Such suspension shall not imply any final finding of responsibility for the situation that caused the suspension.
- (b) Such summary suspension shall become effective immediately upon imposition. All such summary suspensions shall be promptly reported to the Board, the MEC, the Chairperson of the Medical Staff and the Administrator. The Chairperson of the Medical Staff shall give notice, pursuant to the Fair Hearing Plan, of the suspension of the Physician within three (3) days of the action. In the event of any such suspension, the Physician's patients then in the Hospital whose treatment by such Physician is terminated by the summary suspension shall be assigned to another Physician by the Chairperson of the Medical Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute Physician.
- (c) An investigation of the matter resulting in summary suspension shall be completed within fourteen (14) days of the suspension or reasons for the delay shall be transmitted to the Board so that it may consider whether the suspension should be lifted.

6.2.2 MEC Action

As soon as possible after such summary suspension, a meeting of the MEC shall be convened to review and consider the action taken. The MEC may recommend to the Board whether the summary suspension should be modified, continued or terminated including whether further corrective action should be taken. Unless the summary suspension was imposed by action of the Board, such recommended action by the MEC shall take immediate effect and remain in effect pending a final decision by the Board.

6.2.3 Procedural Rights

Unless the MEC recommends immediate reinstatement and the suspension and cessation of all further corrective action, the Physician shall be entitled to the procedural rights as provided in Article VII, and the matter shall be processed in accordance with the provisions of the Fair Hearing Plan. The terms of the summary suspension as originally imposed shall remain in effect pending a final decision by the Board.

6.3 AUTOMATIC SUSPENSION

6.3.1 License

A Staff Member or Allied Health Professional whose license, certificate or other legal credential authorizing him/her to practice in the State of Texas has been revoked or suspended shall immediately and automatically be suspended from practicing in the Hospital. Such automatic suspension shall not entitle the affected Physician to the procedural rights provided under Article VII nor the provisions contained in the Fair Hearing Plan.

6.3.2 DPS Number and DEA Number.

A staff member whose DPS or DEA number is revoked or suspended shall immediately and automatically be divested at least of his/her right to prescribe medications covered by such number. As soon as practicable after such automatic suspension, the MEC shall convene to review and consider the facts under which the DPS or DEA number was revoked or suspended. The MEC may then take such further corrective action as is appropriate to the facts disclosed in its investigation. The affected Staff member shall be entitled to the procedural rights provided under Article VII and the matter shall be processed in accordance with the provisions of the Fair Hearing Plan.

6.3.3 Medical Records

Incomplete charts greater than thirty (30) days old shall be counted delinquent. Incomplete and delinquent charts shall be readily accessible for physician completion at all times. Records pending completion are filed by physician name in the Hospital's medical record department. Physicians with incomplete/delinquent charts will receive a weekly list of charts showing the age

of the chart(s). The list will serve as first notice to the Physician to complete charts.

In the event that charts are not completed within 15 days of discharge the medical records department will call the Physician as a reminder.

Physicians with delinquent charts greater than 50% of their average monthly discharges or 9 records (whichever is greatest) shall receive written notification of pending corrective action/suspension. Upon receipt of notification the Physician will have 15 days to complete all delinquent records.

Should notification fail to be effective, letters will be mailed to the Administrator and Chairperson of the Medical Staff for further recommendations and action, which may include temporary or permanent suspension of medical staff privileges.

Recommendations for suspension shall be recorded in the Physician profile (credentialing/recredentialing).

A physician examination and medical history will be done on patients who are admitted to the Hospital no more than thirty (30) days before or within 24 hours after an admission. Any changes in the patient's condition should be noted in the medical record if the history and physical was completed within 30 days before admission. The medical history and physical examination must be placed in the medical record within 24 hours after admission. In elective surgery, the history and physical must be documented prior to surgery.

6.3.3.1 Post-Anesthesia Assessment

The anesthesiologist or nurse anesthetist shall record an assessment of the patients' blood pressure, respirations, oxygen saturation and level of consciousness, along with an evaluation of their recovery from anesthesia, prior to the patient's transfer from the recovery room. All post-operative patients shall be evaluated again for recovery from anesthesia within 48 hours of surgery using the criteria below. Out-patients may be discharged from the hospital after evaluation by a registered nurse against these criteria:

- a. Vital signs stable and within 20% of pre-anesthesia levels.
- b. Swallow and cough reflex present
- c. Absence of respiratory distress.
- d. Tolerates PO fluids with minimal nausea or vomiting
- e. Alert and oriented or at pre-surgery level
- f. Pain controlled with analgesics.

6.3.4 Malpractice Insurance

A Physician who fails to maintain the amount of professional liability insurance required of his/her under Section 12.2 shall immediately be voluntarily relinquished or restricted until the matter is resolved and insurance coverage is restored consistent with the Bylaws.

6.3.5 Procedural Rights

A physician under automatic suspension by operation of Section 6.3.3 or Section 6.3.4 shall not be entitled to the procedural rights provided in Article VII, or in the Fair Hearing Plan.

6.3.6 Voluntary Separation from Staff

Any Medical Staff member may voluntarily terminate his/her membership on the Medical Staff, and/or his/her Privileges, in whole or in part, by submission of a written notice of his/her intentions to the MEC which shall forward notice of such termination to the Board. The MEC shall arrange for notice of termination of membership, clinical area affiliation, and/or Privileges to be disseminated as appropriate.

6.3.7 Conviction of a Felony

In the event a physician is convicted of a felony, his/her Privileges at the Hospital will be automatically suspended.

6.3.8 Loss of Medicare/Medicaid Participation

A Physician whose participation in the Medicare or Medicaid programs is suspended, terminated or voluntarily relinquished shall immediately cease treating Medicare or Medicaid beneficiaries, as appropriate, at the Hospital. The MEC may make an additional Adverse

Recommendation after review of the facts that led to suspension, termination, or relinquishment of participation, which would entitle the Physician to a hearing.

6.4 APPLICATION FOR REINSTATEMENT TO STAFF MEMBERSHIP.

6.4.1 Immediate Application for Reinstatement

A former Medical Staff member may apply for reinstatement to the Medical Staff at any time following denial of reappointment, revocation, or suspension of membership status if such change in status was predicted on the occurrence of any of the following:

- (a) Failure to fulfill requirements for attendance at meetings, as required in these Bylaws.
- (b) Failure to attend Medical Staff committee meetings, as required in these Bylaws.
- (c) Failure to pay membership dues on a timely basis, without good cause for such delinquency, as approved under Article XII of these Bylaws.
- (d) Failure to submit timely application for reappointment to membership on the

Medical Staff, as required under Section 4.6.1 of these Bylaws.

- (e) Failure to submit timely application for reinstatement from leave of absence, as required under Section 4.9 of these Bylaws.
- (f) Failure to adhere to these Bylaws, to the Rules and Regulations of the Medical Staff, or to the Medical Staff or Hospital policies.

6.4.2 Delayed Application for Reinstatement to Medical Staff Membership

- (a) Notwithstanding any other provision to the contrary, a former member of the Medical Staff may not apply for reinstatement to the Medical Staff until at least five (5) years following denial of reappointment, suspension, or revocation of Medical Staff membership, if such denial, suspension, or revocation was predicted on the occurrence of any of the following events:
 - (1) Revocation or suspension of the affected Staff member's license, certificate, or other authority to practice medicine within the State by the licensing board, authority, or other entity with jurisdiction over issuance of such licensure.
 - (2) Conviction of a felony.
 - (3) Failure to conform to relevant standards of professional competence or ethical conduct.
- (b) Where a former member of the Medical Staff has had an application for reinstatement to the Medical Staff denied, or had membership status on the Medical Staff revoked or suspended, for reasons other than those set forth in Section 6.4.1 (a-e) and 6.4.2(a), the former Staff member may not apply again for reinstatement to the Medical Staff until at least two (2) years following the denial of reinstatement, or the suspension or revocation of his/her Medical Staff membership status.

ARTICLE VII. INTERVIEWS, HEARINGS AND APPELLATE REVIEW

7.1 INTERVIEWS

When the MEC, other relevant Staff committee, or the Board or any appropriate committee thereof receives or is considering initiating an unfavorable recommendation concerning a Physician, the Physician may be afforded an interview. The interview shall not constitute a hearing, shall be preliminary in nature, and shall not be conducted according to the procedural rules provided with respect to hearings. The Physician shall be informed of the general nature of the circumstances and may present information relevant thereto.

7.2 HEARINGS AND APPELLATE REVIEW

7.2.1 Unfavorable MEC Recommendation or Board Action

Except as otherwise set forth in these Medical Staff Bylaws, when any Physician receives notice of an unfavorable recommendation of the MEC or unfavorable action of the Board, he/she may be entitled, upon request, to a hearing and procedures set forth in the Fair Hearing Plan.

7.2.2 Procedure and Process

All hearings and appellate reviews shall be in accordance with the procedure and safeguards set forth in the Fair Hearing Plan attached to these Bylaws.

7.2.3 Exceptions

Neither the issuance of a warning, a letter of admonition, or a letter of reprimand, nor the denial, termination or reduction of temporary privileges, nor any other actions except those specified in the Fair Hearing Plan shall give rise to any right to a hearing or appellate review.

ARTICLE VIII. OFFICERS

8.1 GENERAL OFFICERS OF THE STAFF

8.1.1 Identification

The general officers of the Staff shall be accountable to the Medical Staff for implementing the policies and directives of its various committees. The officers shall be:

- (a) Chairperson of the Medical Staff.
- (b) Vice Chairperson of the Medical Staff.
- (c) Secretary-Treasurer.

8.1.2 Qualifications

General officers must be members of the Active Staff at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

8.1.3 Nominations

The MEC shall convene at least thirty (30) days prior to the election meeting and shall submit one or more qualified nominees for each office. The names of such nominees shall be reported to the Staff at least fifteen (15) days prior to the election meeting.

8.1.4 Election

Officers shall be elected at the election meeting of the Staff every other year. Only Staff members accorded the prerogative to vote for general Staff officers under Article II shall be eligible to vote. Voting shall be by secret written ballot, and voting by proxy shall be permitted. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes.

8.1.5 Term of Elected Office

Each officer shall serve a two (2) year term, commencing on the first day of the Medical Staff year following his/her election. Each officer shall serve until the end of his/her term and until a successor is elected, unless he/she shall sooner resign or be removed from office.

8.1.6 Removal of General Staff Officers

Except as otherwise provided, removal of a general Staff officer may be initiated by the Board acting upon its own recommendation or by a two-thirds (2/3) vote of the members of the Staff eligible to vote for the Staff officers. Removal may be based only upon failure to perform the duties of the position held as described in these Bylaws. If a general Staff officer is deemed a medico-administrative officer, his/her removal shall be accomplished pursuant to Section 7.3 of these Bylaws.

8.1.7 Vacancies in Elected Office

Vacancies of offices, other than Chairperson of the Medical Staff, shall be fulfilled by the MEC. If there is a vacancy in the office of Chairperson of the Medical Staff, the Vice Chairperson of the Medical Staff shall serve out the remaining term.

8.2 DUTIES OF GENERAL OFFICERS

8.2.1 Chairperson of the Medical Staff

The Chairperson of the Medical Staff shall serve as the chief medical officer of the Hospital and as the principal elected official of the Staff. As such, he/she shall be responsible for implementing the general responsibilities of the Medical Staff, including, without limitation to:

- (a) aid in coordinating the activities and concerns of the Hospital administration and of the nursing and other patient care services with those of the Medical Staff.
- (b) be accountable to the Board, in conjunction with the MEC, for the quality and efficiency of clinical care and performance within the Hospital and for the effectiveness of the patient care audit and other quality and utilization review, evaluation and monitoring functions delegated to the Staff by means of regular

reports and recommendations based on the results of these activities.

- (c) develop and implement, in cooperation with the MEC, methods for retrospective patient care audits, ongoing monitoring of practice, credentials review, delineation of privileges and specified services, continuing education, and utilization review.
- (d) communicate and represent the opinions, policies, concerns, needs and grievances of the Medical Staff to the board, the Administrator, and other officials of the Staff.
- (e) be responsible for the enforcement of the Medical Staff Bylaws, Rules and Regulations, and Fair Hearing Plan, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Physician.
- (f) call, preside at, and be responsible for the agenda of all general and special meetings of the Medical Staff and of the MEC.
- (g) serve as chairperson of the MEC and as ex-officio member of all other Medical Staff committees.
- (h) report Medical Staff disciplinary decisions to the appropriate licensing agency.

8.2.2 Vice Chairperson of the Medical Staff

The medical staff may, but is not required, to have a Vice Chairperson. If a Vice Chairperson is elected by the medical staff, the Vice Chairperson of the Medical Staff shall be a member of the MEC and shall be required to assist the Chairperson of the Medical Staff and to perform such duties as may be assigned to him/her by the Chairperson of the Medical Staff. In the absence of the Chairperson of the Medical Staff or upon the occurrence of a vacancy in the office of the Chairperson of the Medical Staff or upon the occurrence of a vacancy in the office of the Chairperson of the Medical Staff, the Vice Chairperson of the Medical Staff shall assume the responsibilities, exercise the authority, and perform the duties assigned to the Chairperson of the Medical Staff until the Chairperson of the Medical Staff returns or that office is filled.

8.2.3 Secretary-Treasurer

The secretary-treasurer shall be a member of the MEC and an ex-officio member without vote of all other Staff committees. His/her duties shall be to:

- (a) give proper notice of all Staff and MEC meetings on order of the Chairperson of the Medical Staff.
- (b) prepare accurate and complete minutes for all Staff and MEC meetings and furnish such minutes to the Board.

- (c) supervise the collection and accounting for any funds that may be collected in the form of Staff dues, assessments, or application fees.
- (d) supervise the conduct of elections.
- (e) record and codify these Bylaws Medical Staff Rules and Regulations, and Fair Hearing Plan, the changes therein or amendments thereto
- (f) attend to all correspondence.
- (g) submit a complete financial report at the annual general meeting of the Staff and a quarterly financial report and a report on spending policies to the MEC.
- (h) perform such other duties as ordinarily pertain to his office.

ARTICLE IX. COMMITTEES AND FUNCTIONS

9.1 DESIGNATION AND SUBSTITUTION

There shall be a Medical Executive Committee (MEC) that will function as a committee-of-the-whole to perform the Staff functions listed in Section 9.7, as well as such other functions as the Board shall direct and elsewhere in these Bylaws.

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

9.2 ORGANIZATION OF COMMITTEES

Each standing and special committee shall be organized as a separate part of the Medical Staff and shall undertake the responsibilities and have the authority set forth in these Bylaws and any resolution of the MEC defining such responsibilities and authority. No Committee shall have authority, responsibility, or jurisdiction in excess of that conferred upon the MEC, which shall be ultimately responsible to the Medical Staff and shall exert jurisdiction on behalf of the Medical Staff in all matters relating to the Medical Staff and the general welfare of the Hospital.

9.3 COMMITTEE CHAIRPERSON

9.3.1 Selection

With the exception of the MEC, the Chairperson of each standing or special committee shall be appointed by the Chairperson of the Medical Staff.

9.3.2 Term

Each committee Chairperson shall serve a term of one (1) year, coinciding with the Medical Staff year beginning on January 1 next following the date of his/her respective appointment.

9.4 MEMBERSHIP AND APPOINTMENT

9.4.1 Eligibility

Members of the Active Staff shall be eligible for appointment to any standing or special committee of the Medical Staff established to perform one or more of the functions required by these Bylaws. Members of the Courtesy and Provisional Staffs shall be eligible for appointment to any standing or special committee of the Medical Staff established to perform one or more of the functions required by these Bylaws, with the exception of the MEC. Where specified in these Bylaws, or where the MEC deems it appropriate to the functions of a committee of the Medical Staff, members of other categories of the Medical Staff, Health Professional Affiliates, and representatives from various departments of the Hospital, including, without limitation, the Administration and the Dietary, Laboratory, Radiology, Nursing, Housekeeping, Medical Records, and Pharmacy departments, shall be eligible for appointment to specific committees of the Medical Staff.

9.4.2 Selection

Unless otherwise provided in these Bylaws, Medical Staff members of any Medical Staff committees, other than the MEC, shall be appointed by the Chairperson of that committee. Health Professional Affiliates shall be appointed to such committees by the Chairperson of the respective committee.

Members of Medical Staff committees representing non-Medical Staff Hospital departments shall be appointed by the Administrator.

9.4.3 Administrator

The Administrator or his/her designee shall serve as an ex-officio member of all Medical Staff committees.

9.4.4 Term

Each Medical Staff committee member shall serve a term of two (2) years, coinciding with the Medical Staff Year beginning on January 1 next following his/her appointment.

9.5 REQUIREMENTS FOR MEDICAL STAFF COMMITTEE SERVICE

All members of the Active, Courtesy and Provisional Staffs are expected to participate in designated and committee activities. Failure to so participate, when requested, shall be grounds for appropriate disciplinary action, including, without limitation, denial of reappointment to the Medical Staff.

9.6 MEDICAL EXECUTIVE COMMITTEE

9.6.1 Composition

The Medical Executive Committee (MEC) shall consist of at least six (6) members, including the following:

- (a) Chairperson of the Medical Staff.
- (b) Vice Chairperson of the Medical Staff (if one is selected).
- (c) Secretary-Treasurer of the Staff.
- (d) Other Medical Staff members as deemed appropriate by the Chairperson of the Medical Staff.
- (e) Immediate past Chairperson of the Medical Staff.
- (f) The Administrator and Chief Nursing Officer shall serve as an ex-officio member without vote.

A quorum shall consist of fifty percent of the current voting membership of the committee.

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9.6.2 Duties

The duties of the MEC shall be to:

- (a) Receive and act upon reports and recommendations from the clinical areas, committees and officers of the Staff and recommend to the Board specific programs and systems to implement these functions.
- (b) Coordinate and implement the activities of and policies adopted by the Staff, clinical areas and committees.
- (c) Review application for appointment and reappointment and recommend to the Board all matters relating to appointments, reappointments, Staff category, clinical area assignments, Clinical Privileges and corrective action.
- (d) Account to the Board and to the Staff for the overall quality and efficiency of patient care in the Hospital.

- (e) Take reasonable steps to insure professionally ethical conduct and competent clinical performance on the part of Staff members, including initiating investigations and initiating and pursuing corrective action, when warranted, and in accordance with the provisions of these Bylaws.
- (f) Make recommendations on medico-administrative and Hospital management matters.
- (g) Inform the Medical Staff of the accreditation program and the accreditation status of the Hospital.
- (h) Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs.
- (i) Serve as a liaison between the Medical Staff and the Board and the Administration of the Hospital, including considering and recommending action of the Joint Commission Committee, the Board, and Administration of the Hospital on all medico-administrative matters
- (j) Undertake all steps necessary to provide that the Hospital meet or exceed the requirements for accreditation imposed by relevant entities and authorities, including, without limitation, the Joint Commission on Accreditation of Healthcare Organizations, the Texas Medical Association, and the Texas Department of Human Services.
- (k) Evaluate and recommend proposed steps and policies to provide that variations from relevant accreditation standards are noted and corrected by the Medical Staff, the Board, and Administration.
- (l) Provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other designee.
- (m) Evaluate the quality of services to include equipment, space, and operating policies and practices of all ancillary services and make appropriate recommendations to the Administrator and the Board.
- (n) Represent and act on behalf of the Staff, subject to such limitations as may be imposed by these Bylaws.

9.6.3 Meetings and Procedures

- (a) The MEC shall meet by-monthly, at least six (6) times and nine (9) months per year, and maintain a permanent record of its proceedings and actions. The MEC may meet the requirement for by-monthly meetings by holding such meetings with a committee of the entire Medical Staff.

- (b) The MEC shall present at each regular meeting of the Medical Staff a report of any action undertaken by the MEC since the last prior meeting of the Medical Staff.
- (c) The MEC shall meet in executive session when necessary, thereby excluding all non-Medical Staff members except the Administrator and Chief Nursing Officer. The Administrator and Chief Nursing Officer can be requested by the Committee as a whole to leave any such executive session, and shall then do so unless he/she believes in good faith that his/her failure to be present would be detrimental to the best interests of the Hospital.
- (d) Any member of the MEC may request that any vote of the MEC be taken by secret ballot.

9.7 STAFF FUNCTIONS

Provision shall be made in these Bylaws or by resolution of the MEC approved by the Board, either through assignment to the clinical departments, to Staff committees, to the Staff as a whole or to interdisciplinary Hospital committees, or an individual, for the effective performance of the Staff functions specified in this Section 9.7 and described in Section 9.8 of all other Staff functions required by these Bylaws, and of such other Staff functions as the MEC or the Board shall reasonably require.

- (a) Conduct, coordinate and review patient care audit and monitoring activities, including tissue, blood usage and antibiotic reviews and analysis of autopsy reports.
- (b) Conduct, coordinate and review, or oversee the conduct of utilization review activities.
- (c) Conduct, coordinate and review credentials investigations and recommendations regarding Staff membership and grants of Clinical Privileges and specified services.
- (d) Monitor and evaluate care provided in and develop clinical policy for: special care units, patient care support services, such as respiratory therapy, and emergency, outpatient, home care, and other ambulatory care services.
- (e) Provide continuing education opportunities responsive to quality activity findings, new state-of-the-art developments and other perceived needs and supervise the Hospital's professional library services.
- (f) Review the completeness, timeliness and clinical pertinence of patient medical

and related records.

- (g) Develop and maintain surveillance over drug utilization policies and practices.
- (h) Prevent, investigate and control Hospital-acquired infections and monitor the Hospital's infection control program.
- (i) Plan for response to fire and other disasters, for Hospital growth and development, and for the provision of services required to meet the needs of the community.
- (j) Supervise and train medical and dental students and graduate trainees.
- (k) Direct Staff organizational activities, including Staff Bylaws review and revision, Staff officer and committee nominations, liaison with the Board and Hospital administration, and review and maintenance of Hospital accreditation.

9.8 BYLAWS

9.8.1 Composition

Unless a separate Bylaws Committee is established, the Bylaws Committee responsibilities shall be fulfilled by the MEC acting as committee-of-the-whole. At the discretion of the MEC, members may be appointed and a separate committee established. The members shall be appointed by the Chairperson of the Medical Staff, subject to the approval of the MEC. Membership shall be for a two year term.

9.8.2 Responsibilities

The duties involved in maintaining the appropriate Bylaws, Rules, Regulations, Fair Hearing Plan, and other organizational documents pertaining to the Staff are to:

- (a) Conduct regular review of these Bylaws, of the Rules, Regulations, Fair Hearing Plan, and other organizational documents pertaining to the Medical Staff, and of procedures and forms promulgated in connection with the Bylaws, Rules and Regulations, and Fair Hearing Plan to reflect current practices within the Medical Staff and the Hospital.
- (b) Conduct an annual comprehensive review of the Bylaws, of the Rules and Regulations of the Medical Staff, and of the procedures and forms promulgated in connection with the Bylaws, and submit recommendations based on such review and evaluation, including proposed changes, to the Board.

9.8.3 Procedures

- (a) The Bylaws Committee shall meet as frequently as necessary to perform its functions, and at least annually, shall maintain a permanent record of its findings, proceedings and actions.
- (b) The Bylaws Committee shall report to the Board as frequently as necessary to carry out its required functions. The Committee shall submit a report of its findings and recommendations in connection with its annual review of these Bylaws and related documents to the Board as frequently as may be necessary to carry out its required functions, and at least annually.

9.9 CONTINUING EDUCATION COMMITTEE

9.9.1 Composition

Unless, a separate Continuing Education Committee is established, the Continuing Education Committee responsibilities shall be fulfilled by the MEC acting as a committee-of-the-whole. At the discretion of the MEC, members may be appointed and a separate committee established. The members shall be appointed by the Chairperson of the Medical Staff, subject to the approval of the MEC. Membership shall be for a two (2) year term.

9.9.2 Responsibilities

The duties involved in organizing continuing education programs and supervising the Hospital's professional library services are to:

- (a) develop and plan, or participate in, programs of continuing education that are designed to keep the Medical Staff informed of significant new developments and new skills in medicine and that are responsive to audit findings.
- (b) evaluate, through the patient care audit function, the effectiveness of the educational programs developed and implemented.
- (c) analyze, on a continuing basis, the Hospital's and Staff's needs for professional library services.
- (d) act upon continuing education recommendations from the MEC, clinical areas, the Staff, or committees responsible for patient care audit and other quality review, evaluation and monitoring functions.
- (e) maintain a record of education activities and submit periodic reports to the MEC concerning these activities, specifically including their relationship to the findings of the patient care audit and other quality review, evaluation and monitoring functions.

9.9.3 Procedures

- (a) The Continuing Education Committee shall meet as frequently as necessary to carry out its required functions, and at least annually and shall maintain a permanent record of its findings, proceedings and actions.
- (b) The Continuing Education Committee shall make reports on a regular basis to the MEC as frequently as may be necessary to carry out its required functions, and at least annually.
- (c) The Continuing Education Committee may hold its meetings jointly with appropriate representatives of other local hospitals.

9.10 ENVIRONMENT OF CARE COMMITTEE

9.10.1 Composition

- (a) Unless a separate Environment of Care Committee is established, the Environment of Care Committee responsibilities shall be fulfilled by the MEC acting as a committee-of-the-whole. At the discretion of the MEC, members may be appointed and a separate committee established. The Administrator or his/her designee, and at least one (1) representative from Nursing, shall serve as ex-officio members of the Committee. The members shall be appointed by the Chairperson of the Medical Staff, subject to the approval of the MEC. Membership shall be for a two year term.

9.10.2 Responsibilities

The duties involved in planning to provide appropriate response to, and the protection and care of Hospital patients and others at the time of, internal and external disasters are to:

- (a) Develop and periodically review, in cooperation with the Hospital administration, a written plan designed to safeguard patients at the time of an internal disaster and require that all personnel rehearse fire and other types of disaster drills at least four times a year for each shift.
- (b) Develop and periodically review, in cooperation with the Hospital Administration, a written plan for the care, reception and evacuation of mass casualties, and assure that such plan is coordinated with the inpatient and outpatient services of the Hospital that is adequately related to other available resources in the community and coordinates the Hospital's role with other agencies in the event of disasters in the Hospital and nearby communities, and that the plan is rehearsed by all personnel involved at least twice yearly.
- (c) Oversee the practice of emergency medicine within the Hospital and administration of the Emergency Room.

- (d) Formulate and implement plans for emergency care of patients within the Hospital.
- (e) Review and evaluate the quality and appropriateness of patient care provided within the Emergency Room, through monitoring the quality and appropriateness of patient care and establishing appropriate quality control mechanisms.
- (f) Formulate and implement written policies and procedures regarding the provision of emergency patient care, including the scope and conduct of patient care to be rendered in the Emergency Room.
- (g) Monitor the facility's compliance with all Federal and State Guidelines with regard to patient transfer.

9.10.3 Procedures

- (a) The Committee shall meet monthly, and shall maintain a permanent record of its findings, proceedings and actions.
- (b) The Committee shall report on a quarterly basis to the MEC on such activities and recommendations.
- (c) The Committee shall perform reviews of relevant policies, procedures, and plans as often as necessary and at least annually, including written policies and procedures for emergency patient care and disaster and mass casualty plans. The Committee shall be responsible for submitting recommendations to the MEC regarding its evaluation and review of such policies, plans, and procedures as frequently as necessary to perform its required functions, and at least annually.

9.11 INFECTION CONTROL COMMITTEE

9.11.1 Composition

- (a) Unless a separate Infection Control Committee is established, the Infection Control Committee responsibilities shall be fulfilled by the MEC acting as a committee-of-the-whole. At the discretion of the MEC, members may be appointed and a separate committee established. These responsibilities are Hospital-wide, and their fulfillment will require the involvement of administrative (to include Laboratory, Housekeeping, and Dietary) and nursing personnel. The members shall be appointed by the Chairperson of the Medical Staff, subject to the approval of the MEC. Membership shall be for a two (2) year term.

9.11.2 Responsibilities

The duties involved in preventing, investigating, and controlling Hospital-acquired infections are to:

- (a) maintain surveillance over the Hospital infection control program.
- (b) develop a system for reporting, identifying and analyzing the incidence and cause of all infections.
- (c) develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques.
- (d) develop, evaluate and revise preventive, surveillance and control policies and procedures relating to all phases of the Hospital's activities, including: operating rooms, delivery room (Emergency Room), special care units; central service, housekeeping and laundry; sterilization and disinfecting procedures by heat, chemicals, or otherwise; isolation procedures prevention of cross-infection by anesthesia apparatus of inhalation therapy equipment; testing of Hospital personnel for carrier status; disposal of infectious materials; food sanitation and waste management; and other situations as requested.
- (e) coordinate action on findings from the Medical Staff's review of the clinical use of antibiotics.
- (f) act upon recommendations related to infection control received from the Chairperson of the Medical Staff, the MEC, the departments and other Staff and Hospital committees.
- (g) maintain a record of all activities relating to infection control and submit periodic reports thereon to the MEC and the Administrator, and to the Director of Nursing Service.

9.11.3 Procedures

- (a) The Infection Control Committee shall meet monthly, at least ten (10) times per year and shall maintain a permanent record of its findings, proceedings and actions.
- (b) The Committee shall report such findings, proceedings and actions to the MEC, to the Board, and to the Director of Nursing services as frequently as necessary, and at least quarterly.

9.12 MEDICAL RECORDS COMMITTEE

9.12.1 Composition

Unless a separate Medical Records Committee is established, the Medical Records Committee responsibilities shall be fulfilled by the MEC acting as a committee-of-the-whole. At the discretion of the MEC, members may be appointed and a separate committee established. The fulfillment of these responsibilities will require the active involvement of the administrative and nursing members of the Hospital-wide quality committee, including the Administrator, the Director of Nursing and the Director of Medical Records. Membership shall be for a period of two years and the terms shall be staggered so that the Committee always includes experienced voting members.

9.12.2 Responsibilities

The duties involved in reviewing the completeness, timeliness and clinical pertinence of patient medical records are to:

- (a) review and evaluate medical records to determine that they: (1) properly describe the condition and progress of the patient, the therapy provided, the results thereof, and the identification of responsibility for all actions taken; and (2) are sufficiently complete at all times so as to facilitate continuity of care and communications between all those providing patient care services in the Hospital.
- (b) review Staff and Hospital policies, Rules and Regulations relating to medical records, including medical records completion, forms, formats, filing, indexing, storage, destruction and availability, and recommend methods of enforcement thereof and changes therein.
- (c) act upon recommendations from the MEC, the departments and other committees responsible for patient care audit and other quality review, evaluation and monitoring functions.
- (d) provide liaison with Hospital administration and the medical records professionals in the employ of the Hospital on matters relating to medical records practices.
- (e) maintain a record of all actions taken and submit periodic reports and recommendations to the MEC concerning medical records practices in the Hospital.

9.12.3 Procedures

- (a) The Medical Records Committee shall meet as often as necessary to perform its functions and at least quarterly.
- (b) The Committee shall maintain a permanent record of all evaluations performed on individual medical records, of all medical records policies and procedures, and of

all recommendations and conclusions resulting there from. The Committee shall submit regular reports to the MEC and the Board regarding its activities and recommendations, as often as it may deem necessary, and at least quarterly.

9.13 ANCILLARY SERVICE COMMITTEE.

9.13.1 Composition

Unless a separate Ancillary Service Committee is established, the Committee's responsibilities shall be fulfilled by the MEC acting as a committee-of-the-whole. At the discretion of the MEC, members may be appointed and a separate committee established. There may be appointed other ex-officio members as the Chairperson may select. If possible, the Chairperson shall appoint at least one (1) member from each Service to serve as a member of the Committee and one (1) member who is directly involved in the provision of laboratory services and transfusion practices

at the Hospital. The members shall be appointed by the Chairperson of the Medical Staff, subject to the approval of the MEC. Membership shall be for a two year term.

9.13.2 Pharmacy Responsibilities

The duties of the Pharmacy/Therapeutics portion of this committee are to:

- (a) Develop and evaluate on an ongoing basis pharmacy policies and practices within the Hospital, including, without limitation, drug utilization policies and practices relating to the selection, intra-Hospital distribution and handling, and safe administration of drugs and chemicals.
- (b) Evaluate and make recommendations to the Pharmacist, Nursing services, and the Medical Staff regarding the choice of drugs to be made available within the Hospital, the stocking of drugs within nursing units and Services, and other matters concerning availability of drugs within the Hospital.
- (c) Develop and review for adequacy, on an annual or more frequent basis, a formulary or drug list for utilization within the Hospital.
- (d) Monitor and evaluate possible unnecessary duplication in the stocking of drugs, including availability of drugs and combinations having substantially identical proportions or similar therapeutic ingredients.
- (e) Review and evaluate clinical data, and formulate recommendations concerning new drugs or preparations requested for availability and use within the Hospital. .
- (f) Monitor and review all unexplained or untoward drug reactions.
- (g) Review, evaluate and approve protocols and standards for the use of investigational or experimental drugs and for research in the use of recognized

drugs within the Hospital.

- (h) Review and analyze the clinical use of antibiotics, including, without limitation, establishing criteria for the prophylactic and therapeutic use of antibiotics, reviewing departures from such criteria, and making clinical reviews and statistical prevalence studies of utilization of antibiotics.
- (i) Document ongoing antibiotic usage review within the Hospital, including findings, conclusions, actions recommended and undertaken, and corrective measures specified.
- (j) Perform such other duties as may be assigned to it by the Chairperson of the Medical Staff or the MEC.
- (k) Maintain a record of all activities relating to the pharmacy and therapeutics function and submit periodic reports and recommendations to the MEC concerning drug utilization policies and practices in the Hospital.
- (l) The term “therapeutics” used in this Section 9.13.2, is considered to include all dietary and total parenteral responsibilities. The Pharmacy and Therapeutics Committee shall be responsible for reviewing special menus and approving the Hospital Dietary Manual and for retrospective reviews of all patients on hyperalimentation.

9.13.3 Laboratory and Transfusion Responsibilities

The duties of the Laboratory and Transfusion portion of this Committee are to:

- (a) Develop, review and continuously evaluate written policies and procedures to provide that Hospital laboratory services are furnished in a timely and accurate fashion, that accurate records and reports of all laboratory procedures are kept, and that the laboratory operates in accordance with sound medical practice.
- (b) Continuously review and evaluate the performance of procedures by the Hospital laboratory, and assist in providing consistency with relevant policies, procedures, and standards for the performance of laboratory functions.
- (c) Undertake such activities and formulate such recommendations for the Chairperson of the Medical Staff, and Board as the committee may deem appropriate and necessary to ensure that the Hospital laboratory operates in accordance with sound medical practice.
- (d) Continuously review and evaluate blood transfusion practices in the Hospital, evaluation of actual or suspected patient reactions to transfusions, and to the amounts of blood requested, the amounts used, and the amount of waste, if any.

- (e) Develop and continuously review and evaluate policies relating to transfusions, including, without limitation, formulating policies providing that actual or suspected patient reactions to blood transfusions shall be evaluated and reported on a timely and complete basis.
- (f) Review and evaluate on a regular basis the performance of specific transfusions within the Hospital to the extent necessary to achieve the provision of quality patient care.

9.13.4 Other Ancillary Services

In addition, to Pharmacy/Therapeutics, Laboratory and Transfusion, the Ancillary Services Committee (if one is established), or the MEC acting as a committee-of-the-whole may also review and evaluate physical therapy, respiratory therapy, or other such services as the Committee (if applicable) or the MEC shall dictate.

9.13.5 Procedures

- (a) The Committee shall meet as often as necessary to perform its required functions, and at least quarterly.
- (b) The Committee shall carry out patient specific reviews of transfusions by whatever method it deems appropriate, and as frequently as necessary, but not less than quarterly. Such reviews shall be documented.
- (c) The Committee shall maintain permanent records of its activities and recommendations, including written reports of all evaluations performed and actions taken, and shall submit such reports to the MEC and Board as frequently as necessary, and at least quarterly.

9.14 TISSUE REVIEW COMMITTEE

9.14.1 Composition

Unless a separate Tissue Review Committee is established, the Tissue Review Committee responsibilities shall be fulfilled by the MEC acting as a committee-of-the-whole. At the discretion of the MEC, members may be appointed and a separate committee established. The members shall be appointed by the Chairperson of the Medical Staff, subject to the approval of the MEC. Membership shall be for a two (2) year term.

9.14.2 Responsibilities

The duties of the Tissue Review Committee shall be to:

- (a) review all surgical cases where specimens both were or were not removed.
- (b) analyze indications for surgery and conduct continuing education and utilization review.
- (c) analyze and evaluate all cases in which major disagreements existed between preoperative and postoperative diagnoses as well as any pathological diagnoses.
- (d) formulate screening mechanisms, based on pre-determined criteria, for cases in which no specimens were removed.

9.14.3 Procedures

- (a) The Tissue Review Committee shall meet quarterly, at least four times per year.
- (b) The Committee shall maintain written records that reflect the results of all evaluations performed and actions taken. The Committee shall report to the MEC and the Board regarding all of its activities and recommendations as often as necessary to perform its functions, and at least quarterly.

9.15 PERFORMANCE (QUALITY) IMPROVEMENT COMMITTEE

9.15.1 Composition

The Performance Improvement Committee functions shall be fulfilled by the Hospital-wide Quality Committee, which includes the MEC, acting as a committee-of-the-whole. At the discretion of the Hospital-wide Quality Committee, members may be appointed and a separate committee established. The members shall be appointed by the Chairperson of the Medical Staff, subject to the approval of the MEC. Membership shall be for a two year term.

9.15.2 Responsibilities

The duties of the Performance Improvement Committee shall be to:

- (a) Develop a written (Quality) Improvement Plan designed to promote the quality of patient care at the Hospital.
- (b) Coordinate all Performance Improvement activities throughout the Hospital into a well integrated system.
- (c) Identify problems and assess their cause and significance.

- (d) Set priorities for both investigation and resolution.
- (e) Implement decisions or actions designed to eliminate any significant problems.
- (f) Monitor to assure that the desired result has been attained.
- (g) Document the effectiveness of the overall program.

9.15.3 Procedures

- (a) The Performance (Quality) Improvement Committee shall meet on a monthly basis, at least ten (10) times per year.
- (b) The Committee shall make a monthly report of its activities and recommendations to the MEC and the Board.

9.16 UTILIZATION REVIEW COMMITTEE

9.16.1 Composition

Unless a separate Utilization Review Committee is established, the Utilization Review Committee responsibilities shall be fulfilled by the Hospital-wide Quality Committee, which includes the MEC, acting as a committee-of-the-whole. At the discretion of the Hospital-wide committee, members may be appointed and a separate committee established.

9.16.2 Responsibilities

The duties of the Utilization Review Committee shall be to:

- (a) Develop a written utilization review plan which will be a part of the Hospital-wide Performance Improvement Plan that is appropriate to the Hospital and meets the requirements of law, of the Joint Commission on Accreditation of Healthcare Organizations, and of the area Professional Standards Review Organization, including without limitation, delineation of the responsibility provisions for review of admissions and of continued Hospital stays, patterns of patient care, discharge planning, data collection and recording and cost-effectiveness and appropriate utilization of healthcare resources.
- (b) Submit such an approved plan to the MEC, Administration, and Board for review, evaluation and approval.
- (c) Provide that the utilization review plan is in effect, known to Medical Staff members, and functioning.
- (d) Conduct such studies, take such actions, submit such reports, and make such

recommendations as are required by the utilization review plan, as reviewed and approved by the MEC and the Board of Trustees.

- (e) Perform Hospital-wide medical care evaluation studies as required by the Joint Commission on Accreditation of Healthcare Organizations and/or the area Professional Standards Review Organization.

9.16.3 Procedures

- (a) The Utilization Review Committee shall meet monthly, at least ten times per year and shall maintain a permanent record of its findings, proceedings, and actions.
- (b) The Committee shall make a monthly report of its activities and recommendations to the MEC and to the Board.

9.17 MORTALITY/MORBIDITY COMMITTEE

9.17.1 Composition

Unless a separate Mortality/Morbidity Committee is established, the Mortality/Morbidity Committee responsibilities shall be fulfilled by the MEC acting as a committee-of-the-whole. At the discretion of the MEC, members may be appointed and a separate committee established. The members shall be appointed by the Chairperson of the Medical Staff, subject to the approval of the MEC. Membership shall be for a two year term.

9.17.2 Responsibilities

The Committee shall conduct a regular review of all deaths occurring in the Hospital.

9.17.3 Procedures

- (a) The Committee shall meet on an as needed basis, at least ten (10) times per year.
- (b) The Committee shall maintain a permanent record of all reviews performed and of all recommendations and conclusions resulting there from. An annual report of its findings shall also be submitted to the MEC.

9.18 STANDING COMMITTEES

Standing Committees of the Medical Staff shall consist of those committees named in these Bylaws. Additionally, any Standing Committee subsequently created by action of the Medical Staff, subject to approval of the Board, shall be considered to be a Standing Committee of the Medical Staff for purposes of these Bylaws or for any other purposes.

9.19 SPECIAL COMMITTEES

- (a) The Chairperson of the Medical Staff, with the approval of the MEC, may appoint such Special Committees as may be necessary to perform the required functions of the Medical Staff.
- (b) A Special Committee shall be responsible for those specific functions designated by the Chairperson of the Medical Staff, with the approval of the MEC, and shall have such authority as may be necessary to carry out such responsibilities. The authority of a Special Committee shall be limited to that necessary to carry out the special functions for which it was created.
- (c) A Special Committee shall conduct such meetings, carry out such evaluations, make such findings and recommendations, and undertake such reports to the Chairperson of the Medical Staff, the Executive Committee, and the Board as may be deemed necessary to the performance of its required functions. Upon completion of its required functions, as determined by the MEC and the Board, a Special Committee shall cease to exist.

ARTICLE X. MEETINGS

10.1 GENERAL STAFF MEETINGS

10.1.1 Annual Election Meeting

- (a) Business to be transacted: The Medical Staff shall hold an election meeting on an annual basis, which meeting shall be the last regularly scheduled meeting before the conclusion of the Medical Staff Year. The business to be conducted at such meeting shall include, without limitation:
 - (1) Election of officers of the Medical Staff and at large members of the MEC.
 - (2) Presentation and consideration of reports and recommendations from the current officers of the Staff and from any or all of such committees of the Staff as may desire to make such reports.
 - (3) Such other business as may be deemed appropriate or relevant by the MEC.
- (b) Notice: written mailed notice of each annual election meeting shall be sent to each Active Staff member to the address of each such member appearing on the records of the Staff, and shall be posted not less than twenty (20) days before such meeting. Such notice shall state the following, without limitation:

- (1) The place, day, and hour of the meeting.
- (2) The nominees.
- (3) The specific hour at which the election of Staff officers is scheduled to be held.
- (4) Such other matters as the MEC may deem appropriate.

Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

(c) Conduct of Elections

- (1) Election proceedings shall not begin until such time as a quorum of Active Staff members is present in the room.
- (2) After establishment of a quorum of Active Staff members, the report of the Nominating Committee shall be presented.
- (3) Nominations from the floor shall be entertained, when made with the consent of the nominee and properly seconded.
- (4) Upon the close of nominations, written ballots shall be distributed, which ballots shall list the nominees and shall contain space for the inclusion of the names of persons nominated from the floor.
- (5) Voting by proxy may be permitted.
- (6) Officers of the Staff shall be elected by a majority of those Active Staff members voting in the election. In the event that no nominee receives a majority of the votes, a second ballot shall be held for the particular office in question, at which time the two (2) nominees who received the largest number of votes in the prior tally shall be included in the balloting.
- (7) If, at any time, prior to or during the conduct of an election, a quorum of Active Staff members is not present, further proceeding shall be suspended and the election shall not take place until a quorum is attained. If, in the discretion of the Chairperson of the Medical Staff or other person presiding at the meeting, it is determined that a quorum cannot be attained or maintained, the meeting shall be recessed or suspended. In such event, the meeting shall be recalled and held within 30 days of its originally scheduled date. Notice shall be given as provided in Section 10.1.1, except that notice by mail need be given only seven (7) days before such meeting. Mail notice to individual members of the Staff may be dispensed with

entirely in the event that said meeting is rescheduled not more than seven (7) days after the date of its original scheduling, provided that general notice of the time, place, and hour of such meeting shall be posted in prominent places in the Hospital.

10.1.2 Regular Meetings

See Section 10.2.1

10.1.3 Notice

The MEC shall provide for written notice of each regular meeting to each member of the Staff. The Staff or the MEC may establish the time for holding regular meetings by resolution, without notice other than such resolution.

(a) Order of Business and Agenda

The order of business at a regular meeting shall be determined by the Chairperson of the Medical Staff. The agenda shall include at least:

- (1) Reading and acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting.
- (2) Administrative reports from the Chairperson of the Medical Staff, the Administrator, clinical areas and committees.
- (3) Review and evaluation of continuing education materials prepared by the MEC, clinical area, or any other individual or entity, which materials relate to enhancement of the care of patients within the Hospital.
- (4) Reports and recommendations from the current officers, committees and clinical areas on the overall results of patient care audit and other quality review, evaluation and monitoring activities of the Staff and on the fulfillment of the other required Staff functions.
- (5) Recommendations for improving patient care within the Hospital
- (6) Such other business as may be deemed appropriate or relevant by the MEC and any new business.
- (7) Adjournment.

10.1.4 Closed Meetings

Executive sessions of the Staff may be conducted by the Active Staff for a part of any Medical

Staff meeting or for the entirety thereof. Upon vote of a majority of the Active Staff members present and voting, all persons other than Active Staff members, the members of the Board and the Administrator, may be so excluded from Medical Staff meetings.

10.2 COMMITTEE MEETINGS

10.2.1 Regular Meetings

Committees and departments may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall then be required. The frequency of such meetings shall be as required by these Bylaws.

10.2.2 Special Meetings

A special meeting of any committee may be called by, or at the request of, the Chairman thereof, the Board, the Chairperson of the Medical Staff, or by two-thirds (2/3) of the group's current members. No business shall be transacted at any special meeting except that stated in the meeting notice.

10.2.2 Notice

Written or oral notice stating the place, day, and hour of any regular or special meeting, except a meeting held pursuant to resolution, shall be given by the person or persons calling the meeting, to each member of the committee or department that is to meet, not less than ten (10) days before the date of such meeting. If mailed, the notice of the meeting shall be posted to the member, at his/her address as it appears on the records of the Hospital, at least ten (10) days before the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

10.3 QUORUM

10.3.1 Annual Election Meeting

The presence of fifty percent (50%), plus one or more of the total membership of the Active Staff shall constitute a quorum at any annual election meeting. Where an annual election meeting is held by mail vote of the membership of the Active Staff, the mail vote of fifty percent (50%), plus one or more of the total membership of the Active Staff shall make such vote official and binding.

10.3.2 General and Special Staff Meetings

The presence of fifty percent (50%) plus one of the voting members of the Active Medical Staff at any regular or special meeting shall constitute a quorum for the transaction of all business.

10.3.3 Committee Meetings

Fifty percent (50%), plus one of the voting members of a committee, but not less than two members, shall constitute a quorum at any meeting of such department or committee.

10.4 MANNER OF ACTION

Except as otherwise specified, the action of a majority of which the members present and voting at a meeting at which a quorum is present shall be the action of the Staff. Action may be taken without a meeting by a department or committee by a unanimous written consent setting forth the action so taken and signed by each member who would be entitled to vote at that meeting.

10.5 AGENDA

10.5.1 Regular Staff Meetings

The agenda at any regular meeting shall be as set forth in Section 10.1.3(a).

10.5.2 Special Meetings.

The agenda at special meetings shall be as follows:

- (a) Reading of the notice calling the meeting.
- (b) Transaction of the business for which the meeting was called.
- (c) Adjournment

10.6 MINUTES

Minutes of all meetings shall be prepared by the secretary of the meeting and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer, approved by the attendees and forwarded to the MEC. A permanent file of the minutes of each meeting shall be maintained in the Medical Staff office.

10.7 ATTENDANCE REQUIREMENTS

10.7.1 Regular Attendance

Each member of the Active Staff is required to attend:

- (a) the annual Medical Staff election meeting.
- (b) at least four meetings per calendar year and may be met by one representative of a group practice of all other general Medical Staff meetings duly convened pursuant

to these Bylaws.

- (c) at least fifty percent (50%) of all meetings of each department and committee of which he/she is a member.

10.7.2 Courtesy Staff

Members of the Courtesy Staff shall not be required to attend Medical Staff meetings, but it is expected that they will attend and participate in these meetings unless they are unavoidably prevented from doing so.

10.7.3 Absence from Meeting

Any member who is compelled to be absent from any Medical Staff, department or committee meeting shall promptly provide to the regular presiding officer thereof, the reason for such absence. Unless excused for good cause, failure to meet the attendance requirement of Section 10.7.1 may be grounds for any other corrective actions specified in Section 6.3.3 and including, in addition removal from such department or committee. Reinstatement of a Staff member's whole membership after having been revoked because of absence from meetings, shall be made only on application, and any such application shall be processed in the same manner as an application for initial appointment.

ARTICLE XI. CONFIDENTIALITY, IMMUNITY AND RELEASES

11.1 SPECIAL DEFINITIONS

For the purposes of this Article, the following definitions shall apply:

- (a) **INFORMATION** means records of proceedings, minutes, records, reports, memoranda, statements, recommendations, data and other disclosures whether in written or oral form relating to any of the subject matter specified in Section 11.4.2
- (b) **MALICE** means the dissemination of a known falsehood or of information with a reckless disregard for whether or not it is true or false.
- (c) **PHYSICIAN** means a Staff member or applicant or an Allied Health Professional.
- (d) **REPRESENTATIVE** means a board and any director or committee thereof; a Administrator or his/her designee; a Medical Staff organization and any member, officer, service or committee thereof, and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.
- (e) **THIRD PARTIES** means both individuals and organizations providing information to any Representative.

11.2 CONFIDENTIALITY OF INFORMATION

Information with respect to any Physician submitted, collected or prepared by any Representative of this or any other healthcare facility or organization or medical staff for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality, or contributing to clinical research shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a Representative nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to Information of like kind that may be provided by Third Parties. This Information shall not become part of any particular patient's file or of the general Hospital records.

11.3 IMMUNITY FROM LIABILITY

11.3.1 For Action Taken

No Representative of the Hospital, the Hospital itself, or Medical Staff shall be liable to a Physician for damages or other relief for any action taken or statement or recommendation made within the scope of his/her duties as a Representative, if such Representative acts after a reasonable effort under the circumstances to ascertain the truthfulness of the facts and in a reasonable belief that the action, statement, or recommendation is warranted by such facts. Regardless of the provisions of State law, truth shall be an absolute defense in all circumstances.

11.3.2 For Providing Information

No representative of the Hospital or Medical Staff and no Third Party shall be liable to a Physician for damages or other relief by reason of providing Information, including, otherwise privileged or confidential information to a Representative of this Hospital or Medical Staff, or to any other healthcare facility or organization of health professionals concerning a Physician or Allied Health Professional who is, or has been, an applicant to, or member of, the Staff or who did or does exercise Clinical Privileges or provide specified services at this Hospital

11.4 ACTIVITIES AND INFORMATION COVERED

11.4.1 Activities

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other healthcare facility's or organization's activities concerning, but not limited to:

- (a) applications for appointment, Clinical Privileges or specified services.
- (b) periodic reappraisals for reappointment, Clinical Privileges or specified services.
- (c) corrective action.

- (d) hearings and appellate reviews.
- (e) patient care audits.
- (f) utilization review.
- (g) other Hospital, department, committee or Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

11.4.2 Information

The acts, communications, reports, recommendations, disclosures and other information referred to in this Article may relate to a Physician's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

11.5 RELEASES

Each Physician shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith, absence of malice and exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of Texas. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

11.6 CUMULATIVE EFFECT

Provision in these Bylaws and in application forms relating to authorization, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof, and in the event of conflict, the applicable law shall be controlling.

ARTICLE XII. GENERAL PROVISIONS

12.1 STAFF RULES AND REGULATIONS

Subject to approval by the Board, the Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found in these Bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each Physician or Allied Health Professional in the Hospital. Such Rules and Regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Board.

12.2 PROFESSIONAL LIABILITY INSURANCE

Each Physician in the Hospital shall maintain in force professional liability insurance in not less than the minimum amounts, if any, as from time to time may be determined by the Board. A current Certificate of Insurance for the professional liability insurance must be provided to the Administrator which shall indicate that the insurance carrier will provide to the Hospital not less than thirty (30) days' advance written notice of any changes to or cancellation of such insurance. Failure to provide a current Certificate of Insurance shall result in the automatic suspension of the Physician pursuant to Section 6.3.4. Subject to the approval of the Board, the MEC may, for good cause shown by a Physician, waive this requirement with regard to such Physician provided that any such waiver is not granted or withheld on an arbitrary, discriminatory or capricious basis.

In determining whether an individual exception is appropriate, the following factors may be considered:

- (a) whether the applicant has applied for the requisite insurance.
- (b) whether he/she has been refused insurance, and if so, the reasons for such refusal.
- (c) whether insurance is available to the applicant, and if not, the reasons for its unavailability.
- (d) whether there is an available alternative means of assuring that the applicant possesses satisfactory financial solvency in the event he/she is sued as a defendant in a civil action or actions involving his/her professional capability.

12.3 INTENTIONALLY LEFT BLANK

12.4 FORMS

Application forms and any other prescribed forms required by these Bylaws for use in connection with Staff appointments, reappointments, delineation of Clinical Privileges, corrective action, notices, recommendations, reports, and other matters shall be subject to adoption by the Board after considering the advice of the MEC.

12.5 CONSTRUCTION OF TERMS AND HEADINGS

Words used in these Bylaws shall be read as the masculine or feminine gender and as the singular or plural, as the context requires. The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

12.6 TRANSMITTAL OF REPORTS

Reports and other information which these Bylaws require the Medical Staff to transmit to the
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Board shall be deemed so transmitted when delivered, unless otherwise specified, to the Administrator.

12.7 CREDENTIAL FILES

- (a) A separate credential file shall be maintained for each Physician and Health Professional Affiliate on the Staff.
- (b) All credential files are the property of the Hospital and shall not be removed from the Hospital's office without authorization.
- (c) Credential files may be reviewed by clinical departments, Medical Staff committees and/or the Board and the MEC as may be required to conduct quality and utilization review, credentialing and privileging, and/or quality of care monitoring studies.
- (d) No individual Physician shall have the right to inspect the credentials of another except as outlined in item (c) above.

ARTICLE XIII. ADOPTION AND AMENDMENT OF MEDICAL STAFF BYLAWS

13.1 ADOPTION

These Bylaws will be deemed to be adopted and effective upon the affirmative vote of a majority of the Board.

13.2 AMENDMENT

These Bylaws may be revised or amended by an affirmative vote of a majority of the Board in conjunction with recommendation(s) issued by the MEC acting on behalf of the entire Medical Staff.

ARTICLE XIV. PHYSICIAN HEALTH

The Medical Staff will implement a process to identify and manage matters of individual physician health that is separate from the Medical Staff disciplinary function. In general, this process is to provide education about physical health, address prevention of physical psychiatric or emotional illness and facilitate confidential diagnosis, treatment and rehabilitation of physicians who suffer from a potentially impairing condition.

The purpose of the process is assistance and rehabilitation, rather than discipline, to aid a physician in retaining or regaining optimal professional functioning, consistent with protection of patients. If at any time during the diagnosis, treatment, or rehabilitation phase of the process, it is

determined that a physician is unable to safely perform the privileges he or she had been granted, the matter is forwarded to Medical Staff leadership for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.

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Process design should include mechanisms for the following:

- Education of the Medical Staff and other organization staff about illness and impairment recognition issues specific to physicians;
- Self-referral by a physician and referral by other organization staff;
- Referral of the affected physician to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern;
- Maintenance of the confidentiality of the physician seeking referral or referred for assistance, except as limited by law, ethical obligation, or when the safety of a patient is threatened;
- Evaluation of the credibility of a complaint, allegation, or concern;
- Monitoring of the affected physician and the safety of patients until the rehabilitation or any disciplinary process is complete; and
- Reporting to the Medical Staff leadership instances in which a physician is providing unsafe treatment.

ADOPTED EFFECTIVE THIS _____ DAY OF _____ 2002.

BOARD:

SIGNATURE:

DATE:

Corporations Section
P.O. Box 13697
State
Austin, Texas 78711-3697

Gwyn Shea
Secretary of

Office of the Secretary of State

The undersigned, as Secretary of State of Texas, does hereby certify that the document, Certificate of Registration for Texas Spine and Joint Hospital, LLP (filing number: 800002563), a Domestic Limited Liability Partnership (LLP), was filed in this office on August 16, 2001.

It is further certified that the entity status in Texas is active.

In testimony whereof I have hereunto signed my name officially and caused to be impressed hereon the Seal of State at my office in Austin, Texas on July 22, 2002.

Gwyn Shea
Secretary of State

Come visit us on the internet at <http://www.sos.state.tx.us/>

PHONE (512) 463-5555

FAX (512) 563-5709

TTY7-1-1

SUPPLEMENTAL GOVERNANCE BYLAWS
OF
TEXAS SPINE AND JOINT HOSPITAL, L.L.P.

These Supplemental Governance Bylaws (referred to as the “Bylaws”) are intended to supplement that certain First Amended and Restated Partnership Agreement of Texas Spine and Joint Hospital, L.L.P., and together they govern the affairs of Texas Spine and Joint Hospital, L.L.P., a Texas Registered Limited Liability Partnership (referred to as the “Hospital”) organized under the Texas Revised Partnership Act (referred to as the ‘Act’). For purposes of Texas state law, the Board of Directors of Texas Spine and Joint Hospital, L.L.P. is considered the governing body.

ARTICLE 1

PURPOSES

Section 1.1: This Hospital is formed to operate and manage a specialty surgical hospital and otherwise provide medical care in Smith County, Texas, and such other locations as shall be determined by the Partners of Texas Spine and Joint Hospital, L.L.P., and to such extent as may be proper, to achieve any of its purposes as set forth in its First Amended and Restated Partnership Agreement of Texas Spine and Joint Hospital, L.L.P. (or any subsequent amendments (the “Partnership Agreement”).

ARTICLE 2

OFFICES

Section 2.1: Principal Office. The principal office of the Hospital shall be located in the City of Tyler, County of Smith. The Hospital may have such other offices, either within or without the State of Texas, as the Partners may determine or as the affairs of the Hospital may require from time to time.

ARTICLE 3

BOARD OF DIRECTORS

Section 3.1: General Powers. Except as otherwise stated herein or in the Partnership Agreement, the affairs of the Hospital shall be managed by its Board of Directors. The powers

vested in the Board of Directors are subject to the laws of the State of Texas and in accordance with the Partnership Agreement.

Section 3.2: Composition. The Board of Directors shall be composed and structured as set forth in the Partnership Agreement.

Section 3.3: Annual Review. The Board of Directors of this Hospital shall annually review the attendance and participation of each member of the Board and submit its report to the Secretary of the Partnership in advance of its meeting to elect Directors to this Hospital.

Section 3.4: Vacancies. Any vacancy occurring in the Board of Directors (by expiration of term, death, resignation, removal, or otherwise) shall be filled in accordance with the Partnership Agreement.

Section 3.5: Duties of Directors. Directors shall exercise ordinary business judgment in managing the affairs of the Hospital. In acting in their official capacity as Directors of this Hospital, Directors shall act in good faith, with ordinary care, and in a manner in the best interests of the Hospital and that are not unlawful.

ARTICLE 4

OFFICERS

Section 4.1: Officers. The officers of the Hospital shall be an Administrator/Chief Financial Officer, a Secretary, a Treasurer, and such other officers as may be elected in accordance with the provisions of this Article. The offices of Secretary and Treasurer may be held by one person and the designation of the person to hold that office shall be made each year by the Partners. The Partners may elect or appoint such other officers and assistant officers as it shall deem desirable, such officers to have the authority and perform the duties prescribed, from time to time, by the Partners. Any two or more offices may be held by the same person, except the offices of Administrator and Secretary.

Section 4.2: Election and Term of Office. The officers of the Hospital, except for the Administrator, shall be elected annually by the Partners at the regular annual meeting of the Partners. If the election of officers shall not be held at such meeting, such election shall be held as soon thereafter as conveniently may be. New offices may be created and filled at any meeting of the Partners. Each officer shall hold office until his successor shall have been duly elected and shall have qualified.

Section 4.3: Removal. Any officer elected or appointed by the Partners may be removed by the Partners whenever in its judgment the best interests of the Hospital would be served thereby, but such removal shall be without prejudice to the contract rights, if any,

of the officer so removed.

Section 4.4: Vacancies. A vacancy in any office because of death, resignation, disqualification or otherwise, may be filled by the Partners for the unexpired portion of the term.

Section 4.5: Administrator. The Administrator shall be elected to such office by the Partners when it has determined that such person is qualified through education and experience to carry out the responsibilities of such office in the Hospital, and such person shall serve in such office at the pleasure of the Partners. The Administrator shall be in charge of the day-today operation of the Hospital and shall have such other and further duties as the Board and the Partners shall designate. The Administrator shall report to the Board on the actions and activities of the Hospital and particularly those for which the Administrator is responsible and those of which the Administrator is aware. Such report shall contain such things as competency of Medical Staff members, the general abilities and skills of members of the staff and their proficiency. A specific report shall be made at least annually. This paragraph is subject to any restrictions set forth in the Partnership Agreement or contractual agreement with the Administrator or Board policy.

The Administrator shall preside at all meetings of the Board of Directors. He may sign, with the Secretary or any other proper officer of the Hospital authorized by the Board of Directors, any deeds, mortgages, bonds, contracts, or other instruments which the Board of Directors have authorized to be executed, except in cases where the signing and execution thereof shall be expressly delegated by the Partners or by these Bylaws or by statute to some other officer or agent of the Hospital; and in general he shall perform all duties incident to the office of Administrator and such other duties as may be prescribed by the Partners from time to time.

More specifically, the authority and duties of the Administrator shall be:

- a. **Organization.** To develop and submit to the Board of Directors for approval a scheme of organization of the personnel and others concerned with the operation of the Hospital.
- b. **Personnel.** To be responsible for the selection (subject to election of officers by the Board), employment, and supervision of all employees of the Hospital, except officers, and to have the authority to discharge any employee when he deems it necessary (subject to any management agreement, Board policies or other contractual agreements). To develop and maintain personnel policies and procedures for the Hospital.
- c. **Personnel Competency.** To implement a process of performance evaluation based on job descriptions designed to assure that all individuals who provide patient care services not subject to the Medical Staff privileges delineation process are competent to provide such service and submit reports of such to the Board of Directors at least annually.
- d. **Properties.** To see that the building and grounds are kept in a good state of repair,

conferring with the Board in major matters, but carrying on routine repairs and maintenance without such consultation.

- e. Fiscal. To supervise all business affairs, such as records of financial transactions, collection of accounts, and purchase and issue of all supplies, and to be certain that all funds are collected and expended to the best possible advantage.
- f. Professional Relationships. To serve as the official liaison between the Board of Directors and the official organization of the Medical Staff to insure cooperation and coordination to the end that the individual patient may receive the best possible care.
- g. Reports. To submit regularly to the Board of Directors or its authorized committees periodic reports showing the professional service and financial activities of the Hospital and to prepare and submit any special reports that may be required by the Board of Directors.
- h. Quality Improvement/Risk Management. To implement a quality improvement program, provide necessary support for Medical Staff quality assessment and improvement functions, and to promote safety within the facility.
- i. Standards of Care. To implement a hospital-wide mechanism designed to assure the provision of a comparable level of care to all patients.
- j. Planning. To implement a system of strategic planning for hospital services, involving the leaders of the organization.
- k. Regulatory Requirements. To insure compliance with all applicable Federal, State, local laws (including licensure, fire inspection, safety measures), and regulatory agencies to include prompt response to reports.
- l. Budget. To prepare an annual operating and capital budget including Medical Staff input for Board consideration and approval.
- m. Miscellaneous. To perform any and all duties that may be necessary in the best interest of the Hospital.

Section 4.6: Chief Financial Officer. In the absence of the Administrator or in the event of his inability or refusal to act, the Chief Financial Officer shall perform the duties of the Administrator, and when so acting shall have all the powers of and be subject to all the restrictions upon the Administrator. The Chief Financial Officer shall perform such other duties as from time to time may be assigned to him by the Administrator or Partners.

Section 4.7: Treasurer. If required by the Partners, the Treasurer shall give a bond for the faithful discharge of his duties in such sum and with such surety or sureties as the Partners shall

determine. He shall have charge and custody of and be responsible for all funds and securities of the Hospital; receive and give receipts for moneys due and payable to the Hospital from any source whatsoever, and deposit all such moneys in the name of the Hospital in such banks, trust companies, or other depositories as shall be selected in accordance with the provisions of Article 7 of these Bylaws; and in general perform all the duties incident to the office of Treasurer and such other duties as from time to time may be assigned to him by the Administrator or by the Partners, all in accordance with policies established by the Partners.

Section 4.8: Secretary. The Secretary shall keep the minutes of the meetings of the members and of the Board of Directors in one or more books provided for that purpose; give all notices in accordance with the provisions of these Bylaws or as required by law; be custodian of the corporate records and of the seal of the Hospital; and, in general, perform all duties incident to the office of Secretary and such other duties as from time to time may be assigned to him by the Administrator or by the Partners.

Section 4.9: Assistant Treasurers and Assistant Secretaries. If required by the Partners, the Assistant Treasurers shall give bonds for the faithful discharge of their duties in such sums and with such sureties as the Partners shall determine. The Assistant Treasurers and Assistant Secretaries in general shall perform such duties as shall be assigned to them by the Treasurer or the Secretary or by the Administrator or the Partners.

Section 4.10: Resignation. Any officers or Administrator may resign at any time (subject to any contractual obligations to the contrary) by giving written notice thereof to the Administrator or Secretary of the Hospital. Unless otherwise specified in the notice, the resignation shall take effect upon receipt thereof, and the acceptance of the resignation shall not be necessary to make it effective.

Section 4.11: Removal. Any officer or administrator may be removed, either with or without cause, by the Board of Directors at any meeting of the Board of Directors at which a quorum is present, provided that the Partners consents to such removal. Additionally, the Partners may remove any officer or administrator, either with or without cause.

ARTICLE 5

COMMITTEES

Section 5.1: Committees of Directors. The Board of Directors, by resolution adopted by a majority of the Directors in office, may designate and appoint one or more committees, each of which shall consist of one or more Directors, which committees, to the extent provided in said resolution, shall have and exercise the authority of the Board of Directors in the management of the Hospital. However, no such committee shall have the authority of the Board of Directors or the Partners where authority has been specifically reserved to the Board or the Partners. The designation and appointment of any such committee and the delegation thereto of authority shall not operate to relieve the Board of Directors, or any individual Director, of any responsibility imposed on it or him by law.

Section 5.2 Other Committees. Other committees not having and exercising the authority of the Board of Directors in the management of the Hospital may be designated by a resolution adopted by a majority of the Directors present at a meeting at which a quorum is present. The Administrator of the Hospital shall appoint the members thereof. Any members thereof may be removed by the Administrator or Board of Directors authorized to appoint such member whenever in their judgment the best interests of the Hospital shall be served by such removal. Membership on such committees may, but need not be, limited to Directors.

Section 5.3 Term of Office. Each member of a committee shall continue as such until the next annual meeting of the members of the Hospital and until his successor is appointed, unless the committee shall be sooner terminated, or unless such member be removed from such committee, or unless such member shall cease to qualify as a member thereof.

Section 5.4 Chairman. One member of each committee shall be appointed chairman by the Administrator.

Section 5.5 Vacancies. Vacancies in the membership of any committee may be filled by the Administrator.

Section 5.6 Quorum. Unless otherwise provided in the resolution of the Board of Directors designating a committee, a majority of the whole committee shall constitute a quorum and the act of a majority of the members present at a meeting at which a quorum is present shall be the act of the committee.

Section 5.7 Rules. Each committee may adopt rules for its own government not inconsistent with these Bylaws or with rules adopted by the Board of Directors or the Partners.

Section 5.8 Notice of Committee Meetings. The Chairman shall call and deliver written notice of a committee meeting to each member of a committee not less than seven (7) days before the date of the meeting. The notice shall state the place, day, and time of the meeting, and the purpose or purposes for which the meeting is called.

Section 5.9 Action of Committees. Committees shall try to take action by consensus. However, the vote of a majority of committee members present and voting at a meeting at which a quorum is present shall be sufficient to constitute the act of the committee unless the act of a greater number is required by law or the Bylaws. A committee member who is present at a meeting and abstains from a vote is considered to be present and voting for the purpose of determining the act of the committee.

ARTICLE 6

CONTRACTS, CHECKS, DEPOSITS, AND FUNDS

Section 6.1: Contracts. Subject to the Partnership Agreement or any other contractual document (i.e., Management Agreement, employment agreement, etc.), the Board of Directors may authorize any officer or officers, agent or agents of the Hospital, in addition to the officers so authorized by these Bylaws, to enter into any contract or execute and deliver any instrument in the name of and on behalf of the Hospital. Such authority may be general or confirmed to specific instances. The Board of Directors, by and through the Hospital Administrator, shall require that any contractor of services to the Hospital, provides such services in a manner to allow the Hospital to comply with the Conditions of Participation and standards for contracted services. This includes requiring that contracted services are provided in a safe and effective manner. The Administrator will maintain a list and a description of such contracted services.

Section 6.2: Checks and Drafts. Subject to the Partnership Agreement or any other contractual document (i.e., Management Agreement, employment agreement, etc.), all checks, drafts, or orders for the payment of money, notes, or other evidences of indebtedness issued in the name of the Hospital shall be signed by such officer or officers, agent or agents of the Hospital and in such manner as shall from time to time be determined by resolution of the Board of Directors. In the absence of such determination by the Board of Directors, such instruments shall be signed by the Treasurer or an Assistant Treasurer and countersigned by the Administrator or an Assistant Administrator of the Hospital.

Section 6.3: Deposits. Subject to the Partnership Agreement or any other contractual document (i.e., Management Agreement, employment agreement, etc.), all funds of the Hospital shall be deposited from time to time to the credit of the Hospital in such banks, trust companies, or other depositories as the Board of Directors may select.

Section 6.4: Gifts. Subject to the Partnership Agreement or any other contractual document (i.e., Management Agreement, employment agreement, etc.), the Board of Directors may accept on behalf of the Hospital any contribution, gift, bequest, or devise for the general purposes or for any special purpose of the Hospital.

ARTICLE 7

BOOKS AND RECORDS

The Hospital shall keep correct and complete books and records of account and shall also keep minutes of the proceedings of its members, Board of Directors, and committees having any of the authority of the Board of Directors.

ARTICLE 8

FISCAL YEAR

The fiscal year of the Hospital for financial reporting and federal income tax purposes, is the calendar year.

ARTICLE 9

INDEMNIFICATION

The Partnership Agreement shall govern indemnification issues as they may arise.

ARTICLE 10

MEDICAL STAFF

Section 10.1: Medical Staff. There shall be established within the Hospital a Medical Staff, which shall consist of all physicians who have been granted the right to exercise clinical privileges within the Hospital. No physician shall admit or provide medical or health-related services to any patient in the Hospital unless he or she has been appointed to the Medical Staff or granted temporary privileges. The Board of Directors shall, in the exercise of its discretion, delegate to the Medical Staff the responsibility for providing appropriate professional care to the Hospital's patients. The Medical Staff shall conduct a continuing review and appraisal of the quality of professional care rendered in the Hospital and shall report such activities and their results to the Board of Directors.

Section 10.2: Authority of Board of Directors. The Board of Directors specifically reserves the authority to take any direct action that is appropriate with respect to any individual appointed to the Medical Staff or given clinical privileges or the right to practice in the Hospital. Actions taken by the Board of Directors may, but need not, follow the procedures outlined in the Medical Staff Bylaws, Fair Hearing Procedure or Rules and Regulations.

Section 10.3: Adoption of Medical Staff Bylaws and Rules and Regulations. Subject to approval by the Board of Directors, the Medical Staff shall adopt Bylaws governing the organization, operation and self-discipline of the Medical Staff and such Rules and Regulations

as may be necessary to implement the general principles found within such Bylaws, to promote the delivery of quality health care within the Hospital and to provide for the efficient operation of the Hospital. Each appointee to the Medical Staff shall exercise his or her clinical privileges within the Hospital subject to the provisions contained within such Bylaws and Rules and Regulations and further subject to the policies, procedures and directives of the Board of Directors and any restrictions or limitations attached to his or her appointment.

Section 10.4: Appointment Procedure. The Board of Directors shall adopt an Appointment Procedure for the Medical Staff setting forth the procedures governing:

- (1) appointments and re-appointments to the Medical Staff;
- (2) delineation of clinical privileges; and
- (3) assignments to staff categories. The Appointment Procedure also shall set forth the manner in which the credentials (including, without limitation, the medical education, training, clinical ability, professional competence, judgment, character, and ability to work with others) of each applicant and staff appointee will be evaluated. The Appointment Procedure shall provide for the MEC, which shall be responsible for making recommendations directly to the Board of Directors and shall assist the Board of Directors in conducting professional review activities (as such term is defined in the Health Care Quality Improvement Act of 1986).

Section 10.5: Fair Hearing Procedure. The Board of Directors shall adopt a Fair Hearing Procedure for the Medical Staff setting forth:

- (1) the hearing rights which will be afforded to applicants and appointees to the Medical Staff in the event of a reduction, restriction, suspension, revocation, denial or failure to renew staff appointment or clinical privileges, or a recommendation for any of the foregoing;
- (2) the circumstances under which such hearing rights will be made available;
- (3) the manner in which such hearings will be conducted; and
- (4) the method of selecting members of the Hearing and Appellate Review Committees. To the extent possible, the Fair Hearing Procedure shall include all provisions necessary under the Health Care Quality Improvement Act of 1986 and applicable state law to protect the Hospital, the Board of Directors and all other persons assisting the Board of Directors in professional review activities from civil liability.

Section 10.6: The Medical Staff of the Hospital shall be organized and composed and is delegated the authority as is set forth in the Bylaws and Rules and Regulations of the Medical Staff, as the same are and have been approved from time to time by the Directors and the Partners of this Hospital. The Bylaws and Rules and Regulations of the Medical Staff shall not be considered a contract between the Hospital and any other person.

Section 10.7: In general, the basic purpose of the staff's operation will be to:

- a. develop, adopt, and periodically review a hospital-wide quality assurance plan the goal of which will strive to provide that all patients admitted to Hospital, or who

are treated In the outpatient departments of the Hospital receive appropriate medical care and efficiency achievable with the resources locally available.

- b. provide the means whereby problems of a medical-administrative nature may be discussed and resolved.
- c. supervise the development, adoption, enforcement and periodic review of the Medical Staff Bylaws, Rules and Regulations by the Medical Staff and determine that they are consistent with Hospital policy and with applicable legal and other requirements.
- d. provide a program of continuing education for its membership.
- e. insure that each member of the Medical Staff observes all ethical principles of the profession.

Section 10.8: In connection with the requirements that the Medical Staff be responsible for the quality of medical care rendered by the Medical Staff, it is charged with the following basic responsibilities (as further detailed in the Medical Staff Bylaws):

- a. It shall investigate and evaluate the credentials and competence of all applicants for initial staff appointment, re-appointment, and the thorough appraisals of the clinical performance and discharge of staff membership obligation of the applicant at that point in time, and a clear and specific delineation of each practitioner's clinical privileges in connection with any appointment or re-appointment, and a full recommendation to the Board as to any such evaluations.
- b. It shall evaluate the quality of all medical care rendered in the Hospital and report periodically to the Board of Directors regarding its findings and recommendations as may be appropriate. The investigation shall include a concurrent utilization review involving the surveillance of appropriateness of admissions, length of stay and the provision of hospital ancillary services, and a retrospective medical audit which establishes a criteria of care and compares actual performance to that criteria, identifying deficiencies and developing and creating education programs or policies to bring the performance of the practitioners to an acceptable level of care as well as reporting changes and alterations in the rules and regulations.
- c. It shall establish policies to insure that only licensed practitioners with clinical privileges are responsible for a patient's admittance, a patient's diagnosis and treatment, that these responsibilities are within the areas of his privileges, that each patient's general medical condition is the responsibility of a physician member of the Medical Staff and that direct medical care provided to patients is provided only by allied health or other specified professional personnel under appropriate supervision of a licensed practitioner with clinical privileges.
- d. The Medical Staff appointment and clinical privileges of any Medical Staff

member who has a contractual relationship with the Hospital, or is either an agent, independent contractor, employee or principal of, or partner in, an entity that has a contractual relationship with the Hospital, relating to providing services to patients at the Hospital, shall terminate automatically and immediately upon:

- (i) the expiration or other termination of the contractual relationship with the Hospital; or
- (ii) the expiration or other termination of the relationship of the Medical Staff member with the entity that has a contractual relationship with the Hospital.

In the event of such a termination of Medical Staff appointment and/or clinical privileges, no rights to a hearing or appellate review provided in the medical staff Bylaws shall apply.

ARTICLE 11

NOTICES

Section 11.1: **Notice by Mail or Facsimile.** Any notice required or permitted by the Bylaws to be given to a Director, officer, or member of a committee of the Hospital may be delivered personally, or sent by mail, facsimile or any other form of written communication. The notice will be deemed to be given when such notice is actually received by the intended recipient. A person may change his or her address by giving written notice to the Secretary of the Hospital.

Section 11.2: **Signed Waiver of Notice.** Whenever any notice is required to be given under the provisions of the Act or under the provisions of the articles of incorporation or the Bylaws, a waiver in writing signed by a person entitled to receive a notice shall be deemed equivalent to the giving of the notice. A waiver of notice shall be effective whether signed before or after the time stated in the notice being waived.

Section 11.3: **Waiver of Notice by Attendance.** The attendance of a person at a meeting shall constitute a waiver of notice of the meeting unless the person attends for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened.

ARTICLE 12

AMENDMENTS TO BYLAWS

These Bylaws may be altered, amended or repealed or new and other Bylaws may be made and adopted only by the Board of Directors.

ARTICLE 13

SPECIAL PROCEDURES CONCERNING MEETINGS

Section 13.1: **Meeting by Telephone.** The Board of Directors and any committee of the Hospital may hold a meeting by telephone conference-call procedures in which all persons participating in the meeting can hear each other. The notice of a meeting by telephone conference must state the fact that the meeting will be held by telephone as well as all other matters required to be included in the notice. Participation of a person in a conference-call meeting constitutes presence of that person at the meeting.

Section 13.2: **Decision without Meeting.** Any decision required or permitted to be made at a meeting of the Board of Directors, or any committee of the Hospital may be made without a meeting. A decision without a meeting may be made if a written consent to the decision is signed by a majority of the people entitled to vote on the matter. The original signed consents shall be placed in the Hospital minute book and kept with the Hospital's records.

ARTICLE 14

MISCELLANEOUS PROVISIONS

Section 14.1: **Legal Authorities Governing Construction of Bylaws.** The Bylaws shall be construed in accordance with the laws of the State of Texas. All references in the Bylaws to statutes, regulations, or other sources of legal authority shall refer to the authorities cited, or their successors, as they may be amended from time to time.

Section 14.2: **Legal Construction.** If any Bylaw provision is held to be invalid, illegal, or unenforceable in any respect, the invalidity, illegality, or unenforceability shall not affect any other provision and the Bylaws shall be construed as if the invalid, illegal, or unenforceable provision had not been included in the Bylaws. To the extent any provision in these Bylaws conflicts with the Partnership Agreement, the Partnership Agreement shall control.

Section 14.3: **Headings.** The, headings used in the Bylaws are used for convenience and shall not be considered in construing the terms of the Bylaws.

Section 14.4: **Gender.** Wherever the context requires, all words in the Bylaws in the male gender shall be deemed to include the female or neuter gender, all singular words shall include the plural, and all plural words shall include the singular.

Section 14.5: **Seal.** The Board of Directors may provide for a corporate seal. Such a seal would consist of a circle containing the words “TEXAS SPINE AND JOINT HOSPITAL, L.L.P.,” and the words “Texas Registered Limited Liability Partnership.”

Section 14.6: **Power of Attorney.** A person may execute any instrument related to the Hospital by means of a power of attorney if an original executed copy of the power of attorney is provided to the Secretary of the Hospital to be kept with the Hospital records.

Section 14.7: **Parties Bound.** The Bylaws shall be binding upon and inure to the benefit of the Directors, Partners, officers, committee members, employees, and agents of the Hospital and their respective heirs, executors, administrators, legal representatives, successors, and assigns except as otherwise provided in these Bylaws.

Section 14.8: **Conflicts of Interest.** Any member of the Board, administrative staff, or medical staff shall disclose, as necessary, any outside interest which may conflict with the best interests of Hospital, whether acting as individuals, trustees of trusts, beneficiaries of trusts, officers, directors or agents for other persons or corporations and may participate in establishing a quorum but shall excuse himself from deliberating and voting on any issue presented to the Board in which any conflicting interest or interests are involved. The Hospital shall have a specific policy as established by the Hospital governing conflicts of interest by which the officers, Directors and other applicable parties shall abide. **[NB: This will need to be looked at further.]**

Section 14.9: **Formation of Auxiliary Organizations.** The Board of Directors may authorize the formation of such auxiliary organizations as it deems necessary to provide special services to patients, to support Hospital, and for other purposes consistent with the purpose of Hospital.

Section 14.10: **Continuing Education of Board.** The Administrator shall develop and carry out a program of continuing education of members of the Board of Directors.

Section 14.11: **Evaluation of Board Members.** There shall be a program developed whereby members of the Board of Directors evaluate the actions or inactions of the Board each year and, as well, a self-evaluation by each member of the Board of Directors.

Section 14.12: **Evaluation of Administrator.** The Board of Directors shall cause the performance and proficiency of the Administrator to be evaluated at least annually.

Section 14.13: **Corporate Compliance.** The Board of Directors shall cause to be implemented and maintained an ongoing corporate compliance program to enable the Hospital to

remain in compliance with applicable laws and regulations.

Section 14.14: Policies and Procedures. The Board of Directors shall implement, institute and update such policies and procedures as required by applicable law, regulations or licensing agencies. Examples of such include the Texas Department of Health Rules and Regulations for Hospitals, Medicare requirements as a Condition of Participation, and JCAHO Required Policies (i.e., nursing standards such as critical care protocols, discharge planning, and the like).

CERTIFICATE OF SECRETARY

I certify that I am the duly elected and acting secretary of Texas Spine and Joint Hospital, L.L.P., and that the foregoing Bylaws constitute the Bylaws of the Hospital. These Bylaws were duly adopted at a meeting of the Board of Directors held on 11-27-02.

Secretary of the Hospital

