BAYLOR SCOTT & WHITE
MEDICAL CENTER – HILLCREST

MEDICAL STAFF BYLAWS, POLICIES AND RULES AND REGULATIONS

POLICY ON APPOINTMENT, REAPPOINTMENT AND CLINICAL PRIVILEGES

Approved by M.S. Executive Committee: April 12, 2018

Approved by Board of Directors: April 18, 2018

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The following definitions shall apply to terms used in this Policy:

(1) "AMERICAN BOARD" means the appropriate Specialty Board of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists. Equal recognition shall be given to certification programs approved by the American Board of Medical Specialties and the Bureau of Osteopathic Specialists;

(2) "BOARD" means the Board of Trustees of Hillcrest Baptist Medical Center, which has the overall responsibility for the conduct of the Medical Center;

(3) "BOARD QUALIFIED" means the status of a physician, dentist, or podiatrist in relation to obtaining certification by the American Board of the specialty for which clinical privileges have been granted or for which application is made, which status, according to the standards or rules of the particular American Board, is one of being "in the examination system," "active status," "board eligible," or a similar status meaning that the physician, dentist or podiatrist is in the process of obtaining or actively pursuing certification;

(4) "CHIEF EXECUTIVE OFFICER" means the President of the Medical Center or the President's designee who has been appointed by the Board to act on its behalf in the overall management of the Medical Center;

(5) "DENTIST" means a person who is duly licensed to practice dentistry in the State of Texas who is board qualified or is, and remains, certified by the applicable American Board;

(6) "EXECUTIVE COMMITTEE" means the Executive Committee of the Medical Staff unless specifically written "Executive Committee of the Board";

(7) "MEDICAL CENTER" means Hillcrest Baptist Medical Center, unless otherwise specified;

(8) "MEDICAL STAFF" means all medical physicians and osteopathic physicians licensed to practice medicine in the State of Texas and dentists licensed to practice dentistry in the State of Texas and podiatrists licensed to practice

podiatry in the State of Texas who have been appointed by the Board of Trustees to a category of the Medical Center Medical Staff and, except for Honorary Staff and Affiliate Staff members who have been granted by the Board of Trustees specific clinical privileges in a specific clinical department or departments, are thereby privileged to attend patients and furnish patient care in the Medical Center;

(9) "MEMBER" means any physician, dentist, and podiatrist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Medical Center;

(10) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, hospital mail, or hand delivery;

(11) "PHYSICIAN" means a medical physician or osteopathic physician who is duly licensed to practice medicine in the State of Texas and who is, and remains, board certified by the American Board applicable to such physician's specialty or subspecialty and specified clinical privileges, or who is qualified for such certification;

(12) "PODIATRIST" means a person who is duly licensed to practice podiatry in the State of Texas who is, and remains, board certified by the American Board applicable to such podiatrist's specialty or subspecialty and specified clinical privileges, or who is qualified for such board certification;

(13) "PRACTITIONER" means a duly licensed medical physician, osteopathic physician, dentist, or podiatrist who is a member of the Medical Staff;

(14) "PRECAUTIONARY SUSPENSION" means the imposition of an immediate suspension or restriction of clinical privileges which is based on concerns that the failure to take action may result in imminent danger to the health and/or safety of any individual;

(15) "SELF-GOVERNMENT" means the duty of the officers, committees and departments of the Medical Staff to initiate and carry out the functions delegated by the Board and to fulfill the obligations provided for in these bylaws;

(16) "SPECIAL NOTICE" means hand delivery, certified mail/return receipt requested, or overnight delivery service providing receipt;

(17) "TELEMEDICINE" means the use of electronic communication or other communication technologies to provide or support clinical care from a distance; and

(18) "TELEMEDICINE PRIVILEGES" means the authorization to prescribe, render a diagnosis or otherwise provide clinical treatment to a patient through the use of electronic communication or other communication technologies.

1.B. TIME LIMITS

Time limits referred to in this Policy are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

When a function is to be carried out by a person or committee, the person, or the committee through its chairperson, may delegate performance of the function to one or more qualified designees.

1.D. MEDICAL STAFF BYLAWS AND POLICIES AND RULES AND REGULATIONS

In addition to the Medical Staff Bylaws, there shall be policies, procedures, and rules and regulations that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. All Medical Staff policies, procedures, and rules and regulations shall be considered an integral part of the Medical Staff Bylaws, subject to the amendment and adoption provisions contained in each document.

ARTICLE 2

QUALIFICATIONS, CONDITIONS AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Eligibility Criteria:

To be eligible to apply for initial appointment or reappointment to the Medical Staff, physicians, dentists, and podiatrists must:

(a) have a current unrestricted license to practice in this state and have never had a license to practice revoked or suspended by any state licensing agency;

(b) where applicable to their practice, have a current, unrestricted DEA registration and state controlled substance license;

(c) be located (office and residence) within the geographic service area of the Medical Center, as defined by the Board, close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Medical Center;

(d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Medical Center;

(e) have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil penalties for the same;

(f) have never been, and are not currently, excluded or precluded from participation in Medicare, Medicaid or other federal or state governmental health care program;

(g) have never had Medical Staff appointment or clinical privileges denied, revoked, resigned, relinquished, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

(h) have never been convicted of any felony, or of any misdemeanor relating to controlled substances, illegal drugs, insurance fraud or abuse or violence;

(i) have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education or the AOA in a specialty in which the applicant seeks clinical privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation

of the American Dental Association ("ADA"), or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association (This requirement is applicable only to those individuals who apply for initial staff appointment on or after the date of adoption of this Policy.);

(j) be certified by the appropriate specialty board of the ABMS, the AOA, the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, as applicable. Those applicants who are not board certified at the time of application but who have completed their residency training within the last five years shall be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification within five years from the date of completion of their residency training (This requirement is applicable only to those individuals who apply for initial staff appointment after the date of adoption of this Policy. All individuals appointed previously shall be governed by the board certification requirements in effect at the time of their appointments.); and

(k) to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. (This requirement is applicable only to those individuals who apply for initial staff appointment after the date of adoption of this Policy. All individuals appointed previously shall be governed by the board certification requirements in effect at the time of their appointments.)

2.A.2. Waiver of Criteria:

(a) Any individual who does not satisfy a criterion may request that it be waived. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to, or exceed, the criterion in question.

(b) The Board may grant waivers in exceptional cases after considering the findings of the Credentials Committee, Executive Committee, or other committee designated by the Board, the specific qualifications of the individual in question, and the best interests of the Medical Center and the community it serves. The

granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

(c) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver.

(d) A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges.

2.A.3. Factors for Evaluation:

(a) Only those individuals who can document that they are highly qualified in all regards will be appointed to the Medical Staff. The following factors will be evaluated as part of the appointment and reappointment processes:

(1) relevant training, experience, demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, and an understanding of the contexts and systems within which care is provided;

(2) adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and a responsible attitude toward patients and their profession;

(3) good reputation and character;

(4) ability to perform, safely and competently, the clinical privileges requested;

(5) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families and other members of health care teams; and

(6) recognition of the importance of, and willingness to support, the Medical Center's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

(b) These factors will be interpreted in accordance with applicable accreditation and regulatory requirements.

2.A.4. No Entitlement to Appointment:

No individual is entitled to receive an application or to be appointed or reappointed to the Medical Staff or to be granted particular clinical privileges merely because he or she:

(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 health care facility;

(d) resides in the geographic service area of the Medical Center; or

(e) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

2.A.5. Nondiscrimination:

No individual shall be denied appointment on the basis of gender, race, creed, or national origin.

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

As a condition of consideration for appointment or reappointment, and as a condition of continued appointment, every applicant and member specifically agree to the following:

(a) to provide continuous and timely care to all patients for whom the individual has responsibility;

(b) to abide by all Bylaws, policies, and Rules and Regulations of the Medical Center and Medical Staff in force during the time the individual is appointed;

(c) to accept committee assignments, emergency service call obligations, and such other reasonable duties and responsibilities as assigned;

(d) to provide, with or without request, new or updated information to the Medical Center, as it occurs, pertinent to any question on the application form;

(e) to acknowledge that the individual has had an opportunity to read a copy of this Policy and any other applicable Bylaws, Rules and Regulations and agrees to be bound by them in all matters relating to consideration of the application without

regard to whether or not appointment to the Medical Staff and/or clinical privileges are granted;

(f) to appear for personal interviews in regard to an application for initial appointment or reappointment;

(g) to use the Medical Center sufficiently to allow continuing assessment of current competence;

(h) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(i) to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;

(j) to refrain from deceiving patients as to the identity of any individual providing treatment or services;

(k) to seek and/or provide consultation whenever necessary;

(l) to participate in monitoring and evaluation activities;

(m) to complete in a timely manner all medical and other required records, containing all information required by the Medical Center;

(n) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;

(o) to promptly pay any applicable dues and assessments;

(p) to satisfy continuing medical education requirements;

(q) that any misstatement in, or omission from, the application shall constitute cause for automatic and immediate rejection of the application, resulting in denial of appointment or clinical privileges (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to a hearing or appeal;

(r) to abide by generally recognized ethical principles applicable to the individual's profession;

(s) to provide continuous care for patients in the Medical Center; and

(t) to give 30 days' advance notice of resignation of appointment and clinical privileges to allow for appropriate coverage for the applicable on-call schedule.

2.B.2. Burden of Providing Information:

(a) Individuals seeking appointment and reappointment have the burden of producing information deemed adequate by the Medical Center for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts.

(b) Individuals seeking appointment or reappointment have the burden of providing evidence that all the statements made and information given on the application are accurate.

(c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.

(d) The individual seeking appointment or reappointment is responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

2.C. APPLICATION

2.C.1. Information:

(a) Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the individual's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of this Policy.

(b) In addition to other information, the applications shall seek the following:

(1) information as to whether the applicant's Medical Staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other

conditions, reduced, limited, terminated, or not renewed at any other hospital or health care facility or are currently being investigated or challenged;

(2) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;

(3) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, the Executive Committee, or the Board may request;

(4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested; and

(5) a copy of a government-issued photo identification.

(c) The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

2.C.2. Grant of Immunity and Authorization to Obtain/Release Information:

By applying for appointment, reappointment, or clinical privileges, the applicant expressly accepts the following conditions during the processing and consideration of the application, whether or not appointment or clinical privileges are granted, and throughout the term of any appointment or reappointment.

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Medical Center, the Medical Staff, their authorized representatives, and appropriate third parties for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This includes any actions,

recommendations, reports, statements, communications, or disclosures involving the individual which are made, taken, or received by the Medical Center, its authorized agents, or appropriate third parties.

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Medical Center, Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Medical Center and its authorized representatives upon request.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Medical Center representatives to release information to other hospitals, health care facilities, managed care organizations, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility when the appointee has provided written authorization for any such release. An appointee also authorizes the release of any information in the Medical Center's possession to the extent required by law or as may be necessary for the Medical Center to fulfill the obligations set forth in this Policy.

(d) Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in this Policy shall be the sole and exclusive remedy with respect to any professional review action taken by the Medical Center.

(e) Legal Actions:

If, notwithstanding the provisions in this Section, an individual institutes legal action and does not prevail, he or she shall reimburse the Medical Center and any member of the Medical Staff named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT TO THE MEDICAL STAFF

3.A. PROCEDURE FOR INITIAL APPOINTMENT

3.A.1. Request for Application:

(a) Applications for appointment shall be in writing and shall be on forms approved by the Board upon recommendation by the Credentials Committee.

(b) An application for appointment to the Medical Staff shall be processed only for those individuals who, according to Medical Staff Bylaws and this policy: (1) meet the threshold criteria for appointment to the Medical Staff set forth in Section 2.A.1 of this policy; (2) desire to provide care and treatment to patients for conditions and diseases for which the Medical Center has facilities and personnel; and (3) indicate an intention to utilize Medical Center facilities as requested by the staff category to which they seek appointment.

(c) An individual seeking initial appointment shall be sent a letter that outlines the eligibility criteria for appointment and the applicable criteria for clinical privileges, and the application form.

3.A.2. Initial Review of Application:

(a) A completed application form with copies of all required documents must be returned to the Chief Executive Officer within 30 days after receipt. The application must be accompanied by the application fee, if applicable.

(b) As a preliminary step, the application will be reviewed by the Chief Executive Officer to determine that all questions have been answered and that the individual satisfies all threshold criteria. Incomplete applications will not be processed. The President of the Medical Staff shall be notified if the applicant does not meet the threshold criteria. Individuals who fail to return completed applications or fail to meet the threshold criteria will be notified that their application will not be processed. Such individuals shall also be notified that they do not have a right to request a hearing.

(c) The Chief Executive Officer shall oversee the process of gathering and verifying relevant information with the primary sources, and confirming that all references and other information or materials deemed pertinent have been received.

(d) The names of applicants shall be posted so that members of the Medical Staff may submit, to the Credentials Committee, in writing, information bearing on the applicant's qualifications for appointment or clinical privileges. In addition, any current Medical Staff appointee shall have the right to appear in person before the Credentials Committee and the Executive Committee to discuss in private and in confidence any concerns the appointee may have about the applicant.

3.A.3. Steps to Be Followed for All Initial Applicants:

(a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current department chiefs at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

(b) An interview with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview may be conducted by a combination of any of the following: the department chairperson, the Credentials Committee, and/or the President of the Medical Staff.

3.A.4. Department Chairperson Procedure:

(a) The Chief Executive Officer shall transmit the complete application and all supporting materials to the chairperson of each department in which the applicant seeks clinical privileges. Each chairperson shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested.

(b) The department chairperson shall be available to the Credentials Committee, the Executive Committee or the Board to answer any questions that may be raised with respect to that chairperson's report and findings.

3.A.5. Credentials Committee Procedure:

(a) The Credentials Committee may use the expertise of the department chairperson, or any member of the department, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(b) The Credentials Committee may also require the applicant to undergo a physical and/or mental examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease.

(c) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). The Credentials Committee may also recommend that appointment be granted for a period of less than one year in order to permit closer monitoring of an individual's compliance with any conditions.

(d) If the recommendation of the Credentials Committee is delayed longer than 90 days after the date on which the completed application was received, the Chairperson of the Credentials Committee shall send a letter to the applicant, with a copy to the Executive Committee and the Chief Executive Officer, explaining the reasons for the delay.

(e) The Credentials Committee shall send its recommendation and written findings in support thereof to the Executive Committee. Each recommendation shall state one of the following:

(1) that the applicant be appointed to the Medical Staff;

(2) that the applicant's application be deferred for further consideration; or

(3) that the applicant be rejected for Medical Staff appointment.

3.A.6. Executive Committee Procedure:

(a) At its next regular meeting after receipt of the complete application and the written findings and recommendation of the Credentials Committee, the Executive Committee shall:

(1) adopt the findings and recommendation of the Credentials Committee as its own; or

(2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Executive Committee prior to its final recommendation; or

(3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.

(b) The Executive Committee shall determine whether to recommend to the Board that the applicant be appointed to the Medical Staff, that the application be deferred for further consideration, or that the application for staff appointment or clinical privileges be denied.

(c) If the recommendation of the Executive Committee is to appoint, the recommendation shall be forwarded to the Board and the Chief Executive Officer.

(d) If the recommendation of the Executive Committee is to defer the application for further consideration, it must be followed up within 15 days with a subsequent written recommendation to the Board (or its committee) and the Chief Executive Officer for appointment to the Medical Staff with specified clinical privileges, or for denial of the application for staff appointment.

(e) If the recommendation of the Executive Committee would entitle the applicant to request a hearing, the Executive Committee shall forward its recommendation to the Chief Executive Officer, who shall promptly send special notice to the applicant. The Chief Executive Officer shall then hold the application until after the applicant has completed or waived a hearing and appeal.

Chairperson of the Credentials Committee. If the Board's determination remains unfavorable to the applicant, the Chief Executive Officer shall promptly send special notice to the applicant that the applicant is entitled to request a hearing.

(f) Any final decision by the Board to grant, deny, revise or revoke appointment and/or clinical privileges is disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.A.8. Time Periods for Processing:

Once an application is deemed complete and provided to the Credentials Committee, it shall be processed by the Credentials Committee within 90 days, unless it becomes incomplete during processing. After review and recommendation by the Executive Committee, the Board shall then act on the application within 60 days of its receipt of the recommendation. These time periods are intended to be a guideline only and shall not create any right for the applicant to have the application processed within these precise time periods. However, if the Credentials Committee does not process a complete application within 90 days of its receipt, the applicant may request mediation, which shall be conducted within a reasonable period of time.

3.B. PROVISIONAL PERIOD

3.B.1. Duration of Provisional Period:

(a) All initial appointments to the Medical Staff (regardless of the category of the staff) and all initial grants of clinical privileges, whether at the time of initial appointment, reappointment, or during the term of an appointment, shall be provisional for a period of 12 months or longer, up to a maximum of 24 months, if recommended by the Credentials Committee and the Executive Committee. The purpose of the provisional period is to confirm, through actual experience with the individual, the appropriateness of the decision to grant appointment and/or clinical privileges.

(b) As part of the provisional period, the individual's exercise of relevant clinical privileges will be subject to a focused professional practice evaluation. The evaluation process is set forth in the Peer Review Policy.

(c) Also as part of the provisional period, the individual's fulfillment of Medical Staff responsibilities shall be assessed.

(d) Clinical privileges shall be adjusted to reflect clinical competence at the end of the provisional period, or sooner if warranted.

(e) Appointment and clinical privileges after the provisional period shall be conditioned on an evaluation of the factors to be considered for reappointment.

3.B.2. Duties During Provisional Period:

(a) During the provisional period, a member must arrange, or cooperate in the arrangement of, any required numbers and types of cases to be evaluated.

(b) A new member's Medical Staff appointment and clinical privileges shall be automatically relinquished if the member fails, during the provisional period, to:

(1) participate in any required number of cases;

(2) cooperate with the monitoring and observation conditions; or

(3) fulfill all requirements of appointment, including but not limited to meeting attendance, completion of medical records, and/or emergency service call responsibilities.

In such case, the member may not reapply for initial appointment or clinical privileges for two years.

(c) If a member of the Medical Staff who has been granted additional clinical privileges fails, during the provisional period, to participate in any required number of cases or fails to cooperate with the evaluation process, the additional clinical privileges shall be automatically relinquished at the end of the provisional period. The individual may not reapply for the privileges in question for two years.

(d) When, based on the evaluation performed during the provisional period, clinical privileges are terminated, revoked, or restricted for reasons related to clinical competence and/or professional conduct, the individual shall be entitled to a hearing and appeal.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a) Appointment or reappointment alone shall not confer any clinical privileges or right to practice at the Medical Center.

(b) Each individual who has been appointed to the Medical Staff is entitled to exercise only those clinical privileges specifically granted by the Board.

(c) The granting of clinical privileges includes responsibility for emergency department call established to fulfill the Medical Center's responsibilities under the Emergency Medical Treatment and Active Labor Act and/or other applicable requirements or standards.

(d) Clinical privileges may be voluntarily relinquished only in a manner that provides for the orderly transfer of applicable obligations.

(e) In order for a request for privileges to be processed, the applicant must satisfy any applicable eligibility criteria.

(f) Requests for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with applicable contracts.

(g) The clinical privileges recommended to the Board shall be based upon consideration of the following:

(1) the applicant's education, relevant training, experience, demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families and other members of the health care team and peer evaluations relating to the same;

(2) utilization patterns;

(3) ability to perform the privileges requested competently and safely;

(4) information resulting from ongoing and focused professional practice evaluation, performance improvement and other peer review activities, if applicable;

(5) availability of qualified staff members to provide coverage in case of the applicant's illness or unavailability;

(6) adequate professional liability insurance coverage for the clinical privileges requested;

(7) the Medical Center's available resources and personnel;

(8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

(9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;

(10) practitioner-specific data as compared to aggregate data, when available;

(11) morbidity and mortality data, when available; and

(12) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.

(h) The applicant has the burden of establishing qualifications and current competence for all clinical privileges requested.

(i) The report of the chairperson of the clinical department in which privileges are sought shall be forwarded to the Credentials Committee and processed as a part of the initial application for staff appointment.

(j) During the term of appointment, a member may request increased privileges by applying in writing to the Credentials Committee. The request shall state the specific additional clinical privileges requested and information sufficient to establish eligibility, as specified in applicable criteria. If the individual is eligible and the application is complete, it shall be processed in the same manner as an application for initial clinical privileges.

4.A.2. Clinical Privileges for New Procedures:

(a) Requests for clinical privileges to perform a significant procedure or service not currently being performed at the Medical Center (or a significant new technique to perform an existing procedure ("new procedure")) will not be processed until

(1) a determination has been made that the procedure will be offered by the Medical Center and (2) criteria to be eligible to request those clinical privileges have been established.

(b) The Credentials Committee and the Executive Committee shall make a preliminary recommendation as to whether the new procedure should be offered to the community. Factors to be considered by the Credentials Committee and the Executive Committee include, but are not limited to, whether there is empirical evidence of improved patient outcomes and/or other clinical benefits to patients, whether the new procedure is being performed at other similar hospitals and the experiences of those institutions, and whether the Medical Center has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

(c) If it is recommended that the new procedure be offered, the Credentials Committee shall conduct research and consult with experts, including those on the Medical Staff and those outside the Medical Center, and develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the new procedure, and (2) the extent of monitoring and supervision that should occur if the privileges are granted. The Credentials Committee may also develop criteria and/or indications for when the new procedure is appropriate. The Credentials Committee shall forward its recommendations to the Executive Committee, which shall review the matter and forward its recommendations to the Board for final action.

4.A.3. Clinical Privileges That Cross Specialty Lines:

(a) Requests for clinical privileges that traditionally at the Medical Center have been exercised only by individuals from another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.

(b) The Credentials Committee shall conduct research and consult with experts, including those on the Medical Staff (e.g., department chairpersons, individuals

on the Medical Staff with special interest and/or expertise) and those outside the Medical Center (e.g., other hospitals, residency training programs, specialty societies).

(c) The Credentials Committee shall develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the clinical privileges in question, and (2) the extent of monitoring and supervision that should occur. These recommendations may or may not permit individuals from different specialties to request the privileges at issue. The Credentials Committee shall forward its recommendations to the Executive Committee, which shall review the matter and forward its recommendations to the Board for final action.

4.A.4. Clinical Privileges for Dentists and Oral and Maxillofacial Surgeons:

(a) The scope and extent of surgical procedures that a dentist or an oral and maxillofacial surgeon may perform in the Medical Center shall be delineated and recommended in the same manner as other clinical privileges.

(b) Surgical procedures performed by dentists or oral and maxillofacial surgeons shall be under the overall supervision of the Chairperson of the Department of Surgery. A medical history and physical examination of the patient shall be made and recorded by a physician who is a member of the Medical Staff before dental surgery shall be performed (with the exception of (c) below), and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

(c) Oral and maxillofacial surgeons who admit patients without significant health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Credentials Committee.

(d) The dentist or oral and maxillofacial surgeon shall be responsible for the dental care of the patient, including the dental history and dental physical examination, as well as all appropriate elements of the patient's record. Dentists and oral and maxillofacial surgeons may write orders within the scope of their license and

consistent with the Medical Staff Rules and Regulations and in compliance with the Medical Center and Medical Staff Bylaws and this Policy.

4.A.5. Clinical Privileges for Podiatrists:

(a) The scope and extent of surgical procedures that a podiatrist may perform in the Medical Center shall be delineated and recommended in accordance with the provisions of the policies governing such practitioners as may be adopted by the Board and in the same manner as other clinical privileges.

(b) Surgical procedures performed by podiatrists shall be under the overall supervision of the Chairperson of the Department of Surgery. A medical history and physical examination of each patient shall be made and recorded by a physician who is a member of the Medical Staff before podiatric surgery shall be performed, and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

(c) The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination, as well as all appropriate elements of the patient's record. Podiatrists may write orders which are within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the Medical Center and Medical Staff Bylaws and this Policy.

4.A.6. Physicians in Training:

(a) Participants registered in professional graduate medical education programs at the Medical Center will not hold appointments to the Medical Staff and will not be granted specific privileges. The program director, clinical faculty and/or attending staff members will be responsible for the direction and supervision of the on-site and day-to-day patient care activities of each participant, who will be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements and/or training protocols approved by the Executive Committee, the Graduate Medical Education Committee and the Chief Executive Officer.

(b) The scope of clinical activities granted to participants in professional graduate medical education programs will be limited to the specialty and duration of the individual's training program and will be subject to supervision at all times as specified by residency manuals and policies and the applicable accreditation guidelines.

(c) The applicable program director will be responsible for verifying and evaluating the qualifications of each participant in training.

(d) Members of the Medical Staff who supervise or oversee the training of these participants will be provided with a written description of the role, responsibilities and patient care activities of the participants in the training programs. These descriptions will include identification of the mechanisms by which the supervising staff member and training program director make decisions about each participant's progressive involvement and independence in specific patient care activities.

4.B. TEMPORARY CLINICAL PRIVILEGES

4.B.1. Eligibility to Request Temporary Clinical Privileges:

(a) Temporary privileges may be granted by the Chief Executive Officer to meet an important patient care need that requires immediate authorization to practice. Specifically, temporary privileges may be granted for: (i) the care of a specific patient or (ii) an individual serving as a locum tenens for a member of the Medical Staff. Prior to a grant of temporary privileges in these situations, current licensure and current competence shall be verified and the Data Bank will be queried.

(b) Temporary privileges may be granted by the Chief Executive Officer, after consultation with the department chairperson, the Chairperson of the Credentials Committee or the Chairperson of the Executive Committee, when an applicant for initial appointment has submitted a completed application and the application is pending review by the Executive Committee and Board. Prior to a grant of temporary privileges in this situation, the credentialing process must be complete, including verification of current licensure, DEA registration, Texas Department

of Public Safety Controlled Substance Registration Certificate, relevant training or experience, current competence, and ability to exercise the privileges requested; compliance with privileges criteria; and consideration of information from the Data Bank. In order to be eligible for temporary privileges, an individual must demonstrate that there are no current or previously successful challenges to his or her licensure or registration and that he or she has not been subject to involuntary termination of medical staff membership, or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility.

(c) Prior to temporary privileges being granted, the individual must agree in writing to be bound by the Bylaws, Rules and Regulations, policies, procedures and protocols of the Medical Staff and the Medical Center.

(d) Temporary privileges shall be granted for a specific period of time, as warranted by the situation. In no situation should the initial grant of temporary privileges be for a period exceeding 120 days.

(e) Temporary privileges shall expire at the end of the time period for which they are granted.

4.B.2. Supervision Requirements:

In exercising temporary privileges, the individual shall act under the supervision of the department chairperson. Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges. Temporary appointment and clinical privileges shall be immediately terminated by the Chief Executive Officer upon notice of any failure by the individual to comply with such special conditions.

4.B.3. Termination of Temporary Clinical Privileges:

(a) The Chief Executive Officer may, at any time after consulting with the President of the Medical Staff, the Chairperson of the Credentials Committee, or the department chairperson, terminate temporary admitting privileges. Clinical privileges shall be terminated when the individual's inpatients are discharged.

(b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the Chief Executive Officer, the department chairperson, or the President of the Medical Staff may immediately terminate all temporary privileges. The department chairperson or the President of the Medical Staff shall assign to another member of the Medical Staff responsibility for the care of such individual's patients until they are discharged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.

(c) The granting of temporary privileges is a courtesy and may be terminated for any reason.

(d) Neither the denial nor termination of temporary privileges shall entitle the individual to a hearing or appeal.

(e) Temporary appointment and clinical privileges shall be automatically terminated at such time as the Executive Committee recommends unfavorably with respect to the applicant's appointment to the staff. At the Executive Committee's discretion, temporary clinical privileges shall be modified to conform to the recommendation of the Executive Committee that the applicant be granted different permanent privileges from the temporary privileges.

4.C. EMERGENCY SITUATIONS

(1) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.

(2) In an emergency situation, a member of the Medical Staff may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges. Similarly, in an emergency situation, any practitioner who is not currently appointed to the Medical Staff may administer treatment to the extent permitted by his or her license.

(3) When the emergency situation no longer exists, the patient shall be assigned by the department chairperson or the President of the Medical Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES

(1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the Chief Executive Officer or the President of the Medical Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.

(2) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.

(a) A volunteer's identity may be verified through a valid government-issued photo identification (i.e., driver's license or passport).

(b) A volunteer's license may be verified in any of the following ways: (i) current Medical Center picture ID card that clearly identifies the individual's professional designation; (ii) current license to practice; (iii) primary source verification of the license; (iv) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (v) identification by a current Medical Center or Medical Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

(3) Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide services at the Medical Center.

(4) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame;

(b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

(5) The Medical Staff will oversee the professional practice and performance of volunteer licensed independent practitioners, as appropriate and available, through direct observation, mentoring or clinical record review.

(6) The Medical Center will make a decision, based on information obtained regarding the professional practice of the volunteer, within 72 hours relating to the continuation of the disaster privileges initially granted.

4.E. TELEMEDICINE PRIVILEGES

(1) Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of improving patient care, treatment, and services. The Board shall determine the clinical services to be provided through telemedicine after considering the recommendations of the appropriate department chairperson(s), the Credentials Committee, and the Executive Committee.

(2) Individuals applying for telemedicine privileges must meet the qualifications for medical staff appointment outlined in this Policy, except for those requirements relating to geographic residency

(3) Qualified applicants may be granted telemedicine privileges but shall not be appointed to the Medical Staff. Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

(4) Applications for telemedicine privileges shall be processed in accordance with the provisions of this Policy in the same manner as for any other applicant. However, the Medical Center may use credentialing verification services provided by the distant hospital or telemedicine entity (as those terms are defined by Medicare) through which the applicant practices, as long as the Medical Center enters into a

contract with the distant hospital or telemedicine entity that satisfies any applicable legal and accreditation requirements.

(5) Telemedicine privileges, if granted, shall be for a period of not more than two years. Individuals seeking to renew telemedicine privileges will be required to complete an application and, upon request, provide the Medical Center with evidence of current clinical competence. This information may include, but not be limited to, a copy of the individual's quality profile from his or her primary practice affiliation and evaluation form(s) from qualified supervisor(s). If all requested information is not received by dates established by the Medical Center, the individual's telemedicine privileges will expire at the end of the current term. Once all information is received and verified, an application to renew telemedicine privileges will be processed as set forth above.

(6) Individuals granted telemedicine privileges shall be subject to the Medical Center's performance improvement and professional and peer review activities.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment.

5.A.1. Eligibility for Reappointment:

To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous appointment term:

(a) completed all medical records;

(b) completed all continuing medical education requirements;

(c) satisfied all Medical Staff responsibilities, including payment of dues and assessments, if applicable;

(d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested; and

(e) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Medical Center must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from his/her private office practice and/or a quality profile from a managed care organization), before the application will be considered complete and processed further.

5.A.2. Factors for Evaluation:

In considering an individual's application for reappointment, the factors listed in Section 2.A.3 of this Policy will be considered. Additionally, the following factors will be evaluated as part of the reappointment process:

(a) compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Medical Center;

(b) participation in Medical Staff duties, including committee assignments and emergency call;

(c) the results of the Medical Center's performance improvement, ongoing professional practice evaluations, and other peer review activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty, provided that other practitioners shall not be identified;

(d) any focused professional practice evaluations;

(e) verified complaints received from patients and/or staff; and

(f) other reasonable indicators of continuing qualifications.

5.A.3. Reappointment Application:

(a) An application for reappointment shall be furnished to members at least five months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Office within 30 days.

(b) Failure to submit an application at least three months prior to the expiration of the member's current term shall result in automatic expiration of appointment and clinical privileges at the end of the then current term of appointment, and the individual may not practice until an application is processed.

(c) Reappointment, if granted, shall be for a period of not more than two years.

(d) In the event the applicant for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

(e) The application will be reviewed by the Chief Executive Officer to determine that all questions have been answered and that the individual satisfies all eligibility criteria for reappointment and for the clinical privileges requested.

(f) The Chief Executive Officer shall oversee the process of gathering and verifying relevant information. The Chief Executive Officer shall also be responsible for confirming that all relevant information has been received.

5.A.4. Processing Applications for Reappointment:

(a) The Chief Executive Officer shall forward the application to the relevant department chairperson and the application for reappointment shall be processed in a manner consistent with applications for initial appointment. Applications for reappointment and renewal of clinical privileges shall be processed through the Credentials Committee and the Executive Committee.

(b) If it becomes apparent to the Credentials Committee or the Executive Committee that it is considering a recommendation to deny reappointment or a requested change in staff category, or to reduce clinical privileges, the chairperson of the committee may notify the individual of the general tenor of the possible recommendation and invite the individual to meet prior to any final recommendation being made. At the meeting, the individual should be informed of the general nature of the information supporting the recommendation contemplated and shall be invited to discuss, explain or refute it. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The committee shall indicate as part of its report whether such a meeting occurred and shall include a summary of the meeting with its minutes.

5.A.5. Time Periods for Processing:

Once an application is deemed complete and is provided to the Credentials Committee, it shall be processed by the Credentials Committee within 90 days of its receipt, unless it becomes incomplete during processing. After review and recommendation by the Executive Committee, the Board shall then act on the application within 60 days of its receipt of the recommendation. These time periods are intended to be a guideline only and shall not create any right for the applicant to have the application processed within these precise time periods. However, if the Credentials Committee does not process a complete application within 90 days of its receipt, the applicant may request mediation, which shall be conducted within a reasonable period of time.

ARTICLE 6

QUESTIONS INVOLVING MEDICAL STAFF MEMBERS

6.A. COLLEGIAL INTERVENTION

(1) This Policy encourages the use of progressive steps by Medical Staff leaders and Medical Center administration, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

(2) Collegial intervention is a part of ongoing and focused professional practice evaluation, performance improvement, and peer review.

(3) Collegial intervention efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of staff members and pursuing counseling, education, and related steps, such as the following:

(a) advising colleagues of all applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

(b) proctoring, monitoring, consultation, and letters of guidance; and

(c) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.

(4) The relevant Medical Staff leader shall determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential file. If documentation of collegial efforts is included in an individual's file, the individual will have an opportunity to review it and respond in writing. The response shall be maintained in that individual's file along with the original documentation.

(5) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and Medical Center Administration.

(6) The President of the Medical Staff, in conjunction with the Credentials Committee or Chief Executive Officer, shall determine whether to direct that a matter be handled in accordance with another Policy, such as the Policy on Physician Health Issues or the Medical Staff Code of Conduct Policy, or to direct it to the Executive Committee for further determination.

6.B. INVESTIGATIONS

6.B.1. Initial Review:

(a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue, regarding:

(1) the clinical competence or clinical practice of any member of the Medical Staff, including the care, treatment or management of a patient or patients;

(2) the known or suspected violation by any member of the Medical Staff of applicable ethical standards or the Bylaws, policies, Rules and Regulations of the Medical Center or the Medical Staff, including, but not limited to, the Medical Center's performance improvement, risk management, and utilization management programs; and/or

(3) conduct by any member of the Medical Staff that is considered lower than the standards of the Medical Center or disruptive to the orderly operation of the Medical Center or its Medical Staff, including the inability of the member to work harmoniously with others, the matter may be referred to the President of the Medical Staff, the chairperson of the department, the chairperson or a majority of a standing committee, the Chief Executive Officer, or the Chairperson of the Board.

(b) The person, or committee, to whom the matter is referred shall make sufficient inquiry to satisfy himself or herself that the question raised is credible and, if so, shall forward it in writing to the Executive Committee.

(c) No action taken pursuant to this Section shall constitute an investigation.

6.B.2. Initiation of Investigation:

(a) When a question involving clinical competence or professional conduct is referred to, or raised by, the Executive Committee, the Executive Committee shall review the matter and determine whether to conduct an investigation or to direct the matter to be handled pursuant to the Policy on Physician Health Issues or the Code of Conduct Policy. In making this determination, the Executive Committee may discuss the matter with the individual. An investigation shall begin only after a formal determination by the Executive Committee to do so.

(b) The Executive Committee shall inform the individual that an investigation has begun. Notification may be delayed if, in the Executive Committee's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Medical Center or Medical Staff.

(c) The Board may also determine to commence an investigation and may delegate the investigation to the Executive Committee, a subcommittee of the Board, or an ad hoc committee.

(d) The President of the Medical Staff shall keep the Chief Executive Officer fully informed of all action taken in connection with an investigation.

6.B.3. Investigative Procedure:

(a) Once a determination has been made to begin an investigation, the Executive Committee shall either investigate the matter itself, appoint a subcommittee to do so, request that the Credentials Committee conduct the investigation, or appoint an individual or ad hoc committee to conduct the investigation. Any ad hoc committee shall not include partners, associates, or relatives of the individual being investigated, but may include individuals not on the Medical Staff. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., physician, dentist, or podiatrist).

(b) The committee conducting the investigation ("investigating committee") shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the

Medical Center, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the Medical Center and investigating committee that

(1) the clinical expertise needed to conduct the review is not available on the Medical Staff; or

(2) the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff; or

(3) the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.

(c) The investigating committee may require a physical and mental examination of the individual by health care professional(s) acceptable to it. The results of such examination shall be made available for consideration by the investigating committee.

(d) The individual shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview shall be made by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual being investigated shall not have the right to be represented by legal counsel at this meeting.

(e) The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review, and within a total of 90-120 days of the commencement of the investigation. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the

investigating committee is unable to complete the investigation and issue its report within these time frames, it shall inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.

(f) At the conclusion of the investigation, the investigating committee shall prepare a report with its findings, conclusions and recommendations.

(g) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Medical Center, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:

(1) relevant literature and clinical practice guidelines, as appropriate;

(2) all of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s); and

(3) any information or explanations provided by the individual under review.

6.B.4. Recommendation:

(a) The Executive Committee may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the Executive Committee may:

(1) determine that no action is justified;

(2) issue a letter of guidance, warning, or reprimand;

(3) impose conditions for continued appointment;

(4) impose a requirement for monitoring or consultation;

(5) recommend additional training or education;

(6) recommend reduction of clinical privileges;

(7) recommend suspension of clinical privileges for a term;

(8) recommend revocation of appointment and/or clinical privileges; or

(9) make any other recommendation that it deems necessary or appropriate.

(b) A recommendation by the Executive Committee that would entitle the individual to request a hearing shall be forwarded to the Chief Executive Officer, who shall

promptly inform the individual by special notice. The Chief Executive Officer shall hold the recommendation until after the individual has completed or waived a hearing and appeal.

(c) If the Executive Committee makes a recommendation that does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board.

(d) In the event the Board considers a modification to the recommendation of the Executive Committee that would entitle the individual to request a hearing, the Chief Executive Officer shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.

(e) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by Medical Staff leaders on an ongoing basis through the Medical Center's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

6.C. PRECAUTIONARY SUSPENSION OF CLINICAL PRIVILEGES

6.C.1. Grounds for Precautionary Suspension or Restriction:

(a) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the President of the Medical Staff, the chairperson of the relevant clinical department, the Chairperson of the Credentials Committee, the Chief Executive Officer or the Board Chairperson is authorized to (1) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation; and (2) suspend or restrict all or any portion of an individual's clinical privileges pending an investigation.

(b) A precautionary suspension can be imposed at any time including after a specific event, a pattern of events, or a recommendation by the Executive Committee that would entitle the individual to request a hearing. When possible, prior to the imposition of a precautionary suspension, the person(s) considering the suspension will meet with the individual and review the concerns that support the suspension and afford the individual an opportunity to respond.

(c) Precautionary suspension is an interim step in the professional review activity and does not imply any final finding regarding the concerns supporting the suspension.

(d) A precautionary suspension is effective immediately and will be promptly reported to the Chief Executive Officer, the President of the Medical Staff and the Chairperson of the Credentials Committee. A precautionary suspension will remain in effect unless it is modified by the Chief Executive Officer or the Board.

(e) Within three days of the imposition of the suspension, a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any), will be provided to the individual.

6.C.2. Executive Committee Procedure:

(a) Within a reasonable time, not to exceed 30 days of the imposition of the suspension, the Executive Committee will review the reasons for the suspension.

(b) As part of this review, the individual will be invited to meet with the Executive Committee. In advance of the meeting, the individual may submit a written statement and other information to the Executive Committee.

(c) At the meeting, the individual may provide information to the Executive Committee and should respond to questions that may be raised by committee members. The individual may also propose ways, other than precautionary suspension, to protect patients, employees or others while an investigation is conducted.

(d) After considering the reasons for the suspension and the individual's response, if any, the Executive Committee will determine whether the precautionary suspension should be continued, modified, or lifted. The Executive Committee will also determine whether to begin an investigation.

(e) If the Executive Committee decides to continue the suspension, it will send the individual written notice of its decision, including the basis for it and that suspensions lasting longer than 30 days must be reported to the National Practitioner Data Bank.

(f) There is no right to a hearing based on the imposition or continuation of a precautionary suspension. The procedures outlined above are deemed to be fair under the circumstances.

(g) Upon the imposition of a precautionary suspension, the appropriate department chairperson, or, if unavailable, the President of the Medical Staff will assign responsibility for the care of any hospitalized patients to another individual with appropriate clinical privileges. Whenever possible, consideration will be given to the wishes of the patient in the selection of a covering physician.

6.D. AUTOMATIC RELINQUISHMENT

6.D.1. Failure to Complete Medical Records:

Failure to complete medical records shall result in automatic relinquishment of all clinical privileges, after notification by the medical records department of delinquency. Relinquishment shall continue until all delinquent records are completed and reinstatement accomplished in accordance with applicable Rules and Regulations. Failure to complete the medical records that caused relinquishment within six months from the relinquishment of privileges or the failure to make arrangements for emergency call coverage shall result in automatic resignation from the Medical Staff.

6.D.2. Action by Government Agency or Insurer:

(a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below, or failure to satisfy any of the threshold eligibility criteria, must be promptly reported to the Chief Executive Officer.

(b) An individual's clinical privileges shall be automatically relinquished if any of the following occur, unless the predicate act is a restriction in which case the Medical Executive Committee may recommend to the Board a restriction of privileges in lieu of a relinquishment:

(1) Licensure: Revocation, expiration, suspension or the placement of conditions or restrictions on an individual's license.

(2) Controlled Substance Authorization: Revocation, expiration, suspension or the placement of conditions or restrictions on an individual's DEA or state controlled substance authorization.

(3) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage or other action causing the coverage to fall below the minimum required by the Medical Center or to cease to be in effect, in whole or in part.

(4) Medicare and Medicaid Participation: Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.

(5) Criminal Activity: Indictment, conviction, or a plea of guilty or *nolo contendere* pertaining to any felony, or any misdemeanor involving (i) controlled substances; (ii) illegal drugs; or (iii) violence against another.

(c) An individual's appointment and clinical privileges will be automatically relinquished, without entitlement to a hearing and appeal, if the individual fails to satisfy any of the threshold eligibility criteria or his or her responsibilities during the provisional period.

(d) Automatic relinquishment or restriction shall take effect immediately and continue until the matter is resolved, if applicable, and a request for reinstatement of privileges has been acted upon by the Credentials Committee, the Executive Committee, and the Board.

6.D.3. Failure to Provide Requested Information:

Failure to provide information pertaining to an individual's qualifications for appointment or clinical privileges, in response to a written request from the Credentials Committee, the Executive Committee, the Chief Executive Officer, or any other committee authorized to request such information, shall result in automatic relinquishment of all clinical privileges until the information is provided.

6.D.4. Failure to Attend Special Conference:

(a) Whenever there is an apparent or suspected deviation from standard clinical practice involving any individual, the department chairperson or the President of the Medical Staff may require the individual to attend a special conference with Medical Staff leaders and/or with a standing or ad hoc committee of the Medical Staff.

(b) The notice to the individual regarding this conference shall be given by special notice at least three days prior to the conference and shall inform the individual that attendance at the conference is mandatory.

(c) Failure of the individual to attend the conference shall be reported to the Executive Committee. Unless excused by the Executive Committee upon a showing of good cause, such failure shall result in automatic relinquishment of all or such portion of the individual's clinical privileges as the Executive Committee may direct. Such relinquishment shall remain in effect until the matter is resolved.

6.D.5. Failure to Attend Meetings or to Satisfy Continuing Education Requirements:

(a) Failure to attend required meetings or failure to complete mandated continuing education requirements shall be sufficient grounds for refusing to reappoint the individual concerned. Such failures shall be documented and specifically considered by the Credentials Committee and the Executive Committee when making recommendations for reappointment and by the Board when making its final decisions.

(b) Any appointee whose reappointment has been refused for failure to attend meetings or to satisfy continuing education requirements shall be entitled to meet with a committee to be designated by the Board before final action is taken. This meeting with the Board committee shall not be conducted under the procedural rules provided in this policy.

(c) If reappointment is refused by the Board for failure to attend meetings or failure to satisfy continuing education requirements, the individual shall be eligible to

apply again for staff appointment, and the application shall be processed in the same manner as if it were an initial application.

6.E. LEAVES OF ABSENCE

(1) An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the President of the Medical Staff, the Chief Executive Officer or to the chairperson of the department in which the individual holds clinical privileges, who transmits the request together with a recommendation to the CEO for action by the Board. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave. Any absence from Medical Staff and/or from patient care responsibilities for longer than 60 days shall require an individual to request a leave of absence.

(2) The Chief Executive Officer will determine whether a request for a leave of absence shall be granted. In determining whether to grant a request, the Chief Executive Officer shall consult with the President of the Medical Staff and the relevant department chairperson.

(3) During the leave of absence, the individual shall not exercise any clinical privileges. In addition, the individual shall be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) during this period.

(4) No later than 30 days prior to the conclusion of the leave of absence, the individual shall request reinstatement by providing to the Chief Executive Officer a written summary of professional activities during the leave of absence. The Chief Executive Officer shall refer the matter to the Executive Committee for a recommendation. The individual bears the burden of providing information sufficient to demonstrate current competence and all other applicable qualifications.

(5) If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the

individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.

(6) The Chief Executive Officer shall consider the recommendations of the Executive Committee and may approve reinstatement to the same or a different staff category and may limit or modify the individual's clinical privileges. In the event the Chief Executive Officer determines to take action that would entitle the individual to request a hearing, the individual shall be given special notice.

(7) Absence for longer than one year shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the Chief Executive Officer. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Medical Center.

(8) If an individual's current appointment is due to expire during the leave, the individual must apply for reappointment, or appointment and clinical privileges shall lapse at the end of the appointment period.

(9) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

ARTICLE 7

HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

(a) An individual is entitled to request a hearing whenever the Executive Committee makes one of the following recommendations:

(1) denial of initial appointment to the Medical Staff;

(2) denial of reappointment to the Medical Staff;

(3) revocation of appointment to the Medical Staff;

(4) denial of requested clinical privileges;

(5) revocation of clinical privileges;

(6) suspension of clinical privileges for more than 30 days; or

(7) mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance).

(b) No other recommendations shall entitle the individual to a hearing.

(c) The hearing shall be conducted in as informal a manner as possible.

(d) The individual may request a hearing before the Board takes final action, if the Board makes any of these recommendations without a prior Executive Committee recommendation. In this instance all references in this Article to the Executive Committee shall mean the Board.

7.A.2. Actions Not Grounds for Hearing:

None of the following actions shall constitute grounds for a hearing, and they shall take effect without hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into his or her file:

(a) issuance of a letter of guidance, warning, or reprimand;

(b) imposition of conditions, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);

(c) termination of temporary privileges;

(d) automatic relinquishment of appointment or privileges;

(e) imposition of a requirement for additional training or continuing education;

(f) precautionary suspension;

(g) denial of a request for leave of absence, or for an extension of a leave;

(h) determination that an application is incomplete;

(i) determination that an application will not be processed due to a misstatement or omission; or

(j) determination of ineligibility based on a failure to meet threshold criteria, a lack of need or resources, or because of an exclusive contract.

7.B. THE HEARING

7.B.1. Notice of Recommendation:

The Chief Executive Officer shall promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:

(a) a statement of the recommendation and the general reasons for it;

(b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and

(c) a copy of this Article.

7.B.2. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing. The request shall be in writing to the Chief Executive Officer and shall include the name, address and telephone number of the individual's counsel, if any. Failure to request a hearing shall constitute waiver of the right to a hearing, and the recommendation shall be transmitted to the Board for final action.

7.B.3. Notice of Hearing and Statement of Reasons:

(a) The Chief Executive Officer shall schedule the hearing and provide, by special notice, the following:

(1) the time, place, and date of the hearing;

(2) a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;

(3) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and

(4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity, up to 30 days, to review and rebut the additional information.

(b) The hearing shall begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

7.B.4. Witness List:

(a) At least 15 days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

(b) The witness list shall include a brief summary of the anticipated testimony.

(c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

7.B.5. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

(1) The Chief Executive Officer, after consulting with the President of the Medical Staff, shall appoint a Hearing Panel composed of not less than three members, one of whom shall be designated as chairperson. The Hearing Panel shall be composed of members the Medical Staff who did not actively participate in the matter at any previous level, physicians or

laypersons not connected with the Medical Center, or a combination thereof. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel. Employment by, or a contract with, the Medical Center or an affiliate shall not preclude any individual from serving on the Hearing Panel.

(2) The Hearing Panel shall not include anyone who is in direct economic competition with, professionally associated with or related to, or involved in a significant referral relationship with, the individual requesting the hearing.

(b) Presiding Officer:

(1) In lieu of a Hearing Panel Chairperson, the Chief Executive Officer may appoint a Presiding Officer who may be legal counsel to the Medical Center. The Presiding Officer shall not act as a prosecuting officer or as an advocate for either side at the hearing.

(2) If no Presiding Officer has been appointed, the Chairperson of the Hearing Panel shall serve as the Presiding Officer and shall be entitled to one vote.

(3) The Presiding Officer shall:

(i) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

(ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;

(iii) maintain decorum throughout the hearing;

(iv) determine the order of procedure;

(v) rule on all matters of procedure and the admissibility of evidence;

(vi) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present; and

(vii) act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual

requesting the hearing is considered by the Hearing Panel in formulating its recommendations.

(4) The Presiding Officer may be advised by legal counsel to the Medical Center with regard to the hearing procedure.

(5) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.

(c) Hearing Officer:

(1) As an alternative to a Hearing Panel, the Chief Executive Officer, after consulting with the President of the Medical Staff, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing.

(2) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" shall be deemed to refer to the Hearing Officer.

(d) Objections:

Any objection to any member of the Hearing Panel, or the Hearing Officer or Presiding Officer, shall be made in writing within 10 days of receipt of notice to the Chief Executive Officer, who shall resolve the objection.

7.C. PRE-HEARING AND HEARING PROCEDURE

7.C.1. Provision of Relevant Information:

(a) The individual requesting the hearing is entitled to the following, subject to the condition that all documents and information be maintained as confidential and not disclosed or used for any purpose outside of the hearing:

(1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;

(2) reports of experts relied upon by the Executive Committee;

(3) redacted copies of relevant minutes; and

(4) copies of any other documents relied upon by the Executive Committee.

The provision of this information is not intended to waive any privilege under the state peer review protection statute.

(b) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners.

(c) Prior to the hearing, on dates set by the Presiding Officer or agreed upon by both sides, each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, shall be submitted in writing in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(d) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.

(e) Neither the individual, nor his or her attorney, nor any other person acting on behalf of the individual, shall contact Medical Center employees appearing on the Executive Committee's witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

7.C.2. Pre-Hearing Conference:

The Presiding Officer shall require a representative (who may be counsel) for the individual and for the Executive Committee to participate in a pre-hearing conference. At the pre-hearing conference the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and the time to be allotted to each witness's testimony and cross-examination.

7.C.3. Failure to Appear:

Failure, without good cause, to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be transmitted to the Board for final action.

7.C.4. Record of Hearing:

A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the Medical Center. Copies of the transcript shall be available at the individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

7.C.5. Rights of Both Sides and the Hearing Panel at the Hearing:

(a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:

(1) to call and examine witnesses, to the extent they are available and willing to testify;

(2) to introduce exhibits;

(3) to cross-examine any witness on any matter relevant to the issues;

(4) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case. Both sides shall notify the other of the name of that counsel at least ten days prior to the date of the hearing; and

(5) to submit a written statement at the close of the hearing.

(b) If the individual who requested the hearing does not testify, he or she may be called and questioned.

(c) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

7.C.6. Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Evidence shall not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The guiding principle shall be that the record contain information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

7.C.7. Post-Hearing Statement:

Each party shall have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

7.C.8. Persons to be Present:

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

7.C.9. Official Notice:

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

7.C.10. Postponements and Extensions:

Postponements and extensions of time may be requested by anyone, but shall be permitted only by the Presiding Officer or the Chief Executive Officer on a showing of good cause.

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

7.D.1. Order of Presentation:

The Executive Committee shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

7.D.2. Basis of Hearing Panel Recommendation:

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel shall recommend in favor of the Executive Committee unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by substantial evidence.

7.D.3. Deliberations and Recommendation of the Hearing Panel:

Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel shall render a recommendation, accompanied by a report, which shall contain a concise statement of the basis for its recommendation.

7.D.4. Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report to the Chief Executive Officer. The Chief Executive Officer shall send by special notice a copy of the report to the individual who requested the hearing. The Chief Executive Officer shall also provide a copy of the report to the Executive Committee.

7.E. APPEAL PROCEDURE

7.E.1. Time for Appeal:

Within 10 days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the Chief Executive Officer either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If an appeal is not requested within 10 days, an appeal is deemed to be

waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

7.E.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

(a) there was substantial failure to comply with this Policy and/or the Bylaws of the Medical Center or Medical Staff during or prior to the hearing, so as to deny a fair hearing; and/or

(b) the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by substantial evidence.

7.E.3. Time, Place and Notice:

Whenever an appeal is requested as set forth in the preceding Sections, the Chairperson of the Board shall, within ten days after receipt of such request, schedule and arrange for an appeal. The individual shall be given special notice of the time, place, and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.E.4. Nature of Appellate Review:

(a) The Chairperson of the Board shall appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Medical Center, to consider the record upon which the recommendation before it was made, or the Board may consider the appeal as a whole body.

(b) Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the Review Panel (or Board) may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

(c) The Review Panel (or Board) may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation

provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied, and then only at the discretion of the Review Panel (or Board).

(d) The Review Panel shall recommend final action to the Board.

7.E.5. Final Decision of the Board:

Within 30 days after receipt of the Review Panel's recommendation, the Board shall render a final decision in writing, including specific reasons, and shall send special notice thereof to the individual. The Board may affirm, modify, or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and clinical privileges. A copy shall also be provided to the Executive Committee for its information.

7.E.6. Further Review:

Except where the matter is referred for further action and recommendation, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

7.E.7. Right to One Hearing and One Appeal Only:

No applicant or member of the Medical Staff shall be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment to the Medical Staff or reappointment or revokes the appointment and/or clinical privileges of a current member of the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of five years unless the Board provides otherwise.

ARTICLE 8

CONFIDENTIALITY AND PEER REVIEW PROTECTION

8.A. CONFIDENTIALITY

Actions taken and recommendations made pursuant to this Policy shall be strictly confidential. Individuals participating in peer review activities shall make no disclosures of any such information (discussions or documentation) outside of peer review committee meetings, except:

(1) when the disclosures are to another authorized member of the Medical Staff or authorized Medical Center employee and are for the purpose of conducting legitimate peer review activities; or

(2) when the disclosures are authorized, in writing, by the Chief Executive Officer or by legal counsel to the Medical Center.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action.

8.B. PEER REVIEW COMMITTEE

(1) All peer review activities pursuant to this Policy and related Medical Staff documents shall be performed by medical peer review committees in accordance with Texas law. Medical peer review committees include, but are not limited to:

(a) all committees;

(b) all departments and sections;

(c) the Board and its committees; and

(d) any individual acting for or on behalf of any such entity, including but not limited to department chairpersons, section chiefs, committee chairpersons and members, officers of the Medical Staff, and experts or consultants retained to assist in peer review activities.

All reports, recommendations, actions, and minutes made or taken by medical peer review committees are confidential and covered by the provisions of applicable state law.

(2) All medical peer review committees shall also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 *et seq.*

ARTICLE 9
AMENDMENTS

(a) This Policy may be amended by a majority vote of the members of the Executive Committee present and voting at any meeting of that committee where a quorum exists, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Executive Committee. Notice of all proposed amendments shall be posted on the Medical Staff bulletin board at least 14 days prior to the Executive Committee meeting, and any member of the Medical Staff may submit written comments to the Executive Committee.

(b) No amendment shall be effective unless and until it has been approved by the Board.

ARTICLE 10

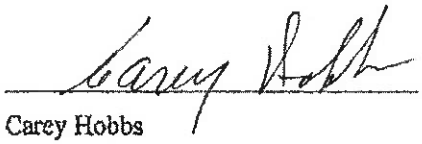
ADOPTION

This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, rules and regulations of the Medical Staff or Medical Center policies pertaining to the subject matter thereof.

Adopted by the Medical Staff:

Henry J. Boehm, III, M.D.,
President, Medical Staff Date: April 12, 2018

Approved by the Board:



Carey Hobbs
Chairman, HBMC Board of Directors Date: April 18, 2018

ARTICLE 10
ADOPTION

This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, rules and regulations of the Medical Staff or Medical Center policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: April 12, 2018

Approved by the Board: April 18, 2018