OUR CHILDREN'S HOUSE

MEDICAL STAFF

BYLAWS

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PREAMBLE

Whereas, the Physicians and other providers as may be qualified pursuant to these Bylaws who are appointed to the Medical Staff at Our Children's House will be organized to provide leadership for the Medical Staff and be accountable to the Hospital's Board of Directors ("Board of Directors") as required by legal and accreditation requirements;

Therefore, these Medical Staff Bylaws set out:

- the organization and structure, rights, and obligations of the Medical Staff of Our Children's House and its members, and the relationship of the Medical Staff and its Board of Directors;

- the Medical Staff's responsibility for the oversight, review, and appraisal of the quality of the professional services provided by Members of the Medical Staff and others with Clinical Privileges;

- the mechanism by which Medical Staff membership and Clinical Privileges are granted, limited, and terminated; and the Medical Staff's accountability to the Board of Directors.

Our Children's House along with each member of the Medical Staff, and other health care providers granted clinical privileges, shall be considered members of, and shall participate in, the hospital's Organized Health Care Arrangement ("OHCA") formed for the purpose of implementing and complying with the federal privacy and security regulations of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") for the protection of individually identifiable health information. An OHCA is a clinically integrated care setting in which individuals typically receive health care from more than one healthcare provider. An OHCA allows the hospital to share protected health information with the Medical Staff and other health care providers granted clinical privileges and their offices for purposes of treatment, payment and practice operations. The patient will receive one Notice of Privacy Practices during the hospital's registration or admissions process, which shall include information about the OHCA with the Medical Staff and other health care providers granted clinical privileges. Each Medical Staff member agrees to comply with the hospital's policies as adopted regarding the use and disclosure of individually identifiable health information and protected health information, as those terms are defined by HIPAA or as any similar terms are defined by more stringent state law.

ARTICLE I. DEFINITIONS

"Advanced Practice Professional" (APP) is defined as an individual licensed, certified, registered, or otherwise authorized in the State of Texas, who is not a member of the Medical Staff, who has advanced training as an Advanced Practice Registered Nurse, Physician Assistant, Certified Registered Nurse Anesthetist, Psychologist or a Certified Anesthesiologist Assistant. APPs are trained in some aspect of the evaluation or treatment of human illness to perform specified services to patients at Our Children's House under the responsibility of a Medical Staff member as outlined in the Medical Staff policies and procedures.

"Adverse Action" or "Adverse Recommendation" means a recommendation or action by the Medical Executive Committee (or by the Board of Directors following a recommendation by the Medical Executive Committee that was not an Adverse Action) that adversely affects a Practitioner's clinical privileges and that is listed in Article XIII under the definition of Adverse Action. An Adverse Action entitles a Practitioner to the procedural rights of review in Article XIII.

"Allied Health Professional" (AHP) is defined as an individual licensed, certified, registered, or otherwise qualified in the State of Texas, who is not a member of the Medical Staff and not an APP, who is granted permission to perform specified patient care related services at Our Children's House under the responsibility and supervision of a Medical Staff member as outlined in the Medical Staff policies and procedures.

"Board of Directors" is defined as the oversight governing board of Our Children's House, and in that capacity has the responsibility for and the authority over, the operation of Our Children's House, including but not limited to the Hospital's organization and management. The Board of Directors duties and responsibilities are more fully set forth in its Charter.

"Chief Medical Officer at Our Children's House" (Chief Medical Officer OCH) is the individual who has been appointed by the JPE Chief Medical Officer to provide oversight of clinical operations at Our Children's House.

"Children's Health System of Texas" (CHST) is defined as the not for profit corporation that is the corporate parent of OCH Holdings.

"Clinical Privileges" is defined as the scope of clinical authority to provide patient care services granted by the Board of Directors to members of the Medical Staff.

"Community Physician" is defined as a physician who is a member of Hospital's Medical staff who is not a full-time faculty member at UT Southwestern.

"Corrective Action" is defined as an action taken in accordance with the procedures in Article XII.

"Ex-officio" is defined as a member of a body by virtue of an office or position held with or without voting rights as defined in these Bylaws.

"Fellow" is defined as a physician who is receiving additional training and or experience in a medical specialty following completion of a primary residency.

"FPPE" is defined as focused professional practice evaluation of a member of the Medical Staff or APP, as referenced in Article VII and as further outlined in the Medical Staff credentialing policies.

"Hospital Administrator or Administrator" is defined as the individual appointed by the Board of Directors to act on its behalf in the overall day-to-day management of Our Children's House.

The term "Investigation" means an investigation for purposes of mandatory reporting pursuant to the federal Health Care Quality Improvement Act and/or state law, and is limited to:

a. An investigation initiated by the Medical Executive Committee following receipt of a request for Corrective Action as set forth in Article XII based on professional competence or conduct;

b. That period of time following issuance of an Adverse Action based on professional competence or conduct in the course of appointment, reappointment, clinical privileges, or corrective action pursuant to these Bylaws; or

c. That period of time following imposition of a summary suspension or restriction pursuant to these Bylaws.

An Investigation continues until issuance of a final decision by the Board of Directors, acceptance of a resignation from the Practitioner by the Board of Directors, or withdrawal of the application from processing. Any other use of the term "investigation" in these Bylaws, the Rules and Regulations, or policies of the Medical Staff does not constitute an Investigation for purposes of mandatory reporting.

"JPE Chief Medical Officer" is the individual who has been appointed by the joint pediatric enterprise, of which Our Children's House is a part, to provide overall medical direction and clinical care.

"Legal Counsel" is defined as the attorney(s) providing legal advice to the Hospital, either by employment or independent contractor arrangement.

"Medical Staff" or "Staff" is defined as all Practitioners who currently hold an appointment to the Medical Staff granted in accordance with these Bylaws.

"Medical Staff Year" is defined as January 1 through December 31 of each year.

"Medical Executive Committee" (MEC) is defined as the administrative and executive body of the Medical Staff.

"Member" is defined as a physician, dentist, or podiatrist appointed to any category of the Medical Staff in accordance with these Bylaws.

"Member in Good Standing" is defined as a Member whose Medical Staff membership and Clinical Privileges are not currently subject to any limitation or restriction, or automatic action (excluding any automatic suspension for failure to complete medical records), and who is not currently subject to Corrective Action, or under Investigation. For purposes of a former Member of the Medical Staff, the Member is considered in good standing if these criteria were met on the date of termination of appointment from the Medical Staff.

"NPDB" is defined as the National Practitioner Data Bank established by the federal Health Care Quality Improvement Act (42 U.S.C. Sec. 11101-11151).

"OCH Holdings" is defined as the not for profit corporation that owns and operates Our Children's House.

"OPPE" is defined as ongoing professional practice evaluation of a member of the Medical Staff or APP, as referenced in Article VII, and as further outlined in the Medical Staff credentialing policies.

Our Children's House or "Hospital" is defined as the facility of that name licensed by the state of Texas, and accredited and certified as applicable, to provide pediatric related services at its campus and its provider based locations.

"Patient Contacts" is defined as patient care activities in the Hospital, carried out by the Member (or APP/AHP as detailed below) pursuant to a Member's Clinical Privileges, defined as:

a. The admission of a patient either as an inpatient or outpatient with appropriate documentation ("admitting provider");

b. Holding primary responsibility for an inpatient or outpatient with ongoing appropriate documentation throughout the patient's stay ("attending provider");

c. Consulting on a patient with the entry of a written report in the medical record, in any venue of the Hospital whether inpatient or outpatient ("consultant");

d. Performing patient rounds with entry of a progress note in the medical record, including when providing coverage for a partner or under a call-sharing arrangement (the patient contact is credited only to the actual Member that rounded on the patient);

e. Performing any procedure on a patient that requires a History and Physical examination (H&P), whether that H&P was done by the Member or not (e.g., endoscopy, etc.);

f. Interpretation of any diagnostic test with entry of a report of that interpretation in the medical record, either as a separate entry or as part of a more comprehensive note; and

g. Any of the above activities when carried out by an AHP/APP under the direct or indirect supervision of the Member, which will be attributed to the Member.

   Multiple Patient Contacts by a Member (or AHP/APP under the direct or indirect supervision of a Member) as listed above during a single inpatient admission or outpatient stay will constitute a single patient contact by that Member for purposes of this definition.

"Peer Review" is defined as a medical peer review and professional review activity as those terms are defined in the Texas Medical Practice Act and the federal Health Care Quality Improvement Act, and as further detailed in Article XII.

"Practitioner" is defined as any physician, dentist or podiatrist who is either applying to the Medical Staff or who has been granted clinical privileges and/or staff membership on the Medical Staff.

"Presiding Officer" is defined as the individual appointed pursuant to Article XIII, to preside over a hearing and serve as counsel to the Hearing Committee.

"Psychologist" is defined as an individual licensed by the Texas State Board of Examiners of Psychologists for the independent practice of psychology, and who is not a member of the Medical Staff.

"Resident" is defined as a medical school graduate who is receiving additional training and/or experience in a medical specialty in a program accredited by the Accreditation Counsel for Graduate Medical Education or such other applicable accreditation body.

"Rules and Regulations" is defined as the Rules and Regulations of the Medical Staff adopted as set out in Article X.

"Service" is defined as a major clinical service area of the Medical Staff, grouping members in accordance with their specialty or major practice interest.

"Service Chief" as defined in Article VI.

"Special Notice" is defined as written notice: (1) sent by certified or registered mail, return receipt requested, which shall be deemed to have been delivered on the date indicated on the receipt of delivery (or the date delivery was refused); or (2) hand delivered which shall be deemed to have been delivered on the date indicated on the receipt of delivery (or on the date delivery is refused and so noted on the receipt of delivery). If delivery of notice is made by a combination of the means specified in this definition, delivery shall be deemed to have occurred on the earliest date made. Special Notice to a Practitioner shall be effective if delivered to the Practitioner's office or administrative staff or if delivered to the Practitioner or an individual at the Practitioner's home address, using the addresses currently on file with Medical Staff Services.

* To the extent permitted by law and accreditation rules, any action provided for in these Bylaws by the Hospital Administrator or another member of Hospital administration, a Medical Staff Officer, Service Chief, or a committee chair may be taken by that individual's designee pursuant to an appropriate delegation.

** Any reference to "day" or "days" means calendar days including weekends or holidays, unless otherwise provided.

*** Whenever the word "he", or any other form of masculine pronoun, appears in these Bylaws, it shall be deemed to include the word "she" or other appropriate form of feminine pronoun and "they" or other appropriate form of gender neutral pronoun.

ARTICLE II. MEDICAL STAFF MEMBERSHIP

Section A. Medical Staff Appointment

Appointment to the Medical Staff at Our Children's House is a privilege which may be granted by the Hospital to competent physicians and podiatrists who meet the qualifications, standards, and

requirements set forth in these Bylaws, the Rules and Regulations, and associated policies and procedures of the Medical Staff of Our Children's House, and who help advance the mission of Our Children's House.

Section B. Qualifications for Membership and/or Clinical Privileges

Qualifications include the following and information as required in Section II.E below:

1. Eligible Disciplines. Only physicians with Doctor of Medicine or Doctor of Osteopathy degree or equivalent (e.g. M.B.B.S. degree), dentists with Doctor of Dental Medicine or Doctor of Dental Surgery degrees or equivalent (e.g. B.D.S degree), or podiatrists with a Doctor of Podiatric Medicine degree, and holding a license or permit to practice in the State of Texas, are qualified for application for or membership on the Medical Staff of Our Children's House. No Practitioner is entitled to membership on the Medical Staff or to the exercise of particular clinical privileges at Our Children's House merely by virtue of licensure to practice in this or any other state, membership in any professional organization, or privileges at any other hospital.

2. Burden on Practitioner. The Practitioner has the burden of providing documentation to establish his or her qualifications for Medical Staff Membership and any requested Clinical Privileges at the time of application, reappointment, on any request for Clinical Privileges, and in between terms of appointment as requested by a Medical Staff Committee.

3. Professional Licensure. Each Practitioner must hold a current, valid, unrestricted license issued by the Texas professional licensing agency to practice medicine or podiatry, as applicable. The Practitioner must disclose (a) any current or past professional license in any other state; (b)any current or past licensure revocation, suspension, relinquishment or lapse; and (c) any current or past investigation, proceeding or other action by any State medical board or other licensing agency.

4. Controlled Substances Registration. Each Practitioner must hold a current registration to prescribe controlled substances issued by the federal Drug Enforcement Administration (DEA) unless the registration requirement has been waived by the Medical Executive Committee, with the approval of the Board of Directors, because the Practitioner does not prescribe.

5. Residency Training and Board Certification. Documentation of experience and training including completion of an accredited residency and fellowship, if applicable, is required. Board certification in the Practitioner's applicable specialty or subspecialty area is required. Accepted Boards include American Board of Medical Specialties (ABMS), American Osteopathic Association, Royal College of Physicians and Surgeons in Canada and the United Kingdom, and the Australian Medical Council. Any Medical Staff applicant boarded by another board or another country's certifying body (other than those listed above) must submit documentation to deem the certification equivalent to the ABMS requirements and the request shall be reviewed on a case by case basis by the Credentials Committee.

   a. All new applicants to Our Children's House Medical Staff who have completed their post-graduate training within the past two (2) years shall be required to obtain board certification within six (6) years of completing their most recent training (i.e.,

residency or fellowship). The director of the applicant's most recent training program will designate the completion date of training.

b. All new applicants to Our Children's House Medical Staff who completed their post-graduate training more than two (2) years prior to their application for Medical Staff Membership must be Board eligible (i.e. tracking toward certification) through the applicable certifying board and shall be required to obtain board certification within four (4) years of their initial appointment to the Medical Staff and granting of Clinical Privileges.

c. Current Members of the Medical Staff who complete additional post-graduate training and/or qualify for and request new privileges in a separate sub-specialty area must be Board eligible through the applicable certifying board and shall be required to obtain board certification within four (4) years of their initial approval of the new Clinical Privileges.

d. Current Members of the Medical Staff who fail to maintain their applicable board certification or applicable sub-board certification shall be allotted two (2) years from date of expiration to renew (or re-obtain) their board certification. Failure to renew within the two (2) year period will result in non-renewal of Medical Staff membership and Clinical Privileges. Staff whose membership and/or Clinical Privileges are not renewed, or allowed to expire, due to failure to maintain board certification will not be eligible to reapply until such time that certification is obtained.

e. Exceptions to the above (Section B.5.a-d) must be requested by the appropriate Service Chief in consultation with the Credentials Committee. The board certification requirement may be waived for Practitioners who have been practitioners in their specialty field for a significant number of years and/or hold national or international prominence, or serve a specific need of patients at Our Children's House. These Practitioners will be admitted only upon the approval of the Credentials Committee, MEC, and the Board of Directors.

6. Professional Liability Insurance. Each Practitioner must maintain professional liability insurance coverage in the form and amounts not less than $200,000 per occurrence and $600,000 in aggregate as required by the Board of Directors, as applicable to the Practitioner's practice in the Hospital, including the use of any AHP, APP, or other health care providers not employed by the Hospital. Evidence of coverage must be submitted: (i) at the time of application to the Medical Staff; (ii) no later than the last day of coverage for the policy currently in effect; and (iii) within five days of a request from Medical Staff Services. Involvement in any professional liability action including final judgments and claims settled must be reported at initial appointment, at each reappointment, or as specified on the application for Medical Staff Membership.

7. Lack of Exclusion. Each Practitioner must not be, and never have been, excluded from participation in the Medicare, Medicaid or any other federal or state governmental health care program or convicted (or pled guilty or nolo contendere to) of actions (e.g. violations of the

federal ant kickback law; submission of false claims) constituting fraud and/or abuse under the Medicare, Medicaid or other federal or state governmental or private payer health care programs.

8. Current Competencies, Experience and Clinical Judgment. Each Practitioner must demonstrate the areas of general competencies, experience and clinical judgment to include: patient care, medical/clinical knowledge, practice-based learning and improvement, professionalism, and systems-based practice and interpersonal and communication skills such that the Practitioner has the demonstrated ability to effectively communicate with patients and colleagues and to appropriately document.

9. Health Status and Ability. Each Practitioner must possess the necessary health status and ability to perform the essential functions of Medical Staff Membership and to exercise the Clinical Privileges requested in accordance with accepted professional standards and without posing a direct threat to patients.

a. Documentation of health status and ability shall be provided at the time of application to the Medical Staff and at any time thereafter on request if there are concerns regarding impairment. A request to provide documentation of necessary health status and ability may include, without limitation, submitting to examination, evaluation and/or testing in accordance with written Policy and cooperating with a physician health and rehabilitation committee or the appropriate Medical Staff committee to which such matters are delegated by the MEC (PHRC).

b. Requests for documentation may be made by the Medical Executive Committee or Medical Staff President, Hospital Administrator, the PHRC or its Chair, or the Practitioner's Service Chief pursuant to written Policy.

c. A Practitioner must be impairment free which is defined as being free of or having under adequate control any impairment that interferes with, or presents a reasonable probability of interfering with, the Practitioner's ability to satisfy any of the general qualifications and performance of the essential functions of staff membership, and exercising all or any of the Clinical Privileges requested or granted safely and competently.

10. Character, Ethics and Ability to Work with Others. Each Practitioner must provide evidence of good character and judgment and adherence to the ethics of their profession including but not limited to, a good reputation, integrity, acceptable interpersonal skills and the ability to work effectively and professionally with other Medical Staff Members, the Board of Directors and others in the delivery of patient care to promote the mission of Our Children's House.

11. Proximity. The MEC, in its discretion, may require each Practitioner with Clinical Privileges to document that he or she resides and practices within sufficient proximity to the Hospital, as determined by the MEC, to permit timely response to emergencies, including requirements for physical presence.

12. Lack of Criminal History. Each Practitioner may not have been convicted of, pled guilty or pled nolo contendere to any felony, or to any non-felony offense reasonably related to the provision or billing of healthcare services as well Practitioner's qualifications, competence, functions, or duties as a medical professional or involving an act of violence, child abuse, or a sexual offense, or have been court-martialed for such actions.

13. Lack of Corrective Action. A Practitioner who is currently subject to corrective action investigation by another hospital or health care entity or subject to investigation by the Texas professional licensing agency is not eligible for consideration for initial appointment until the investigation has been completed and any resulting action is final.

14. Coverage. The Practitioner must demonstrate written arrangements for alternative medical coverage for patients for whom the Practitioner is or will become responsible by submitting written verification from an appropriately privileged Member who has agreed and is available to stand in the place of the Practitioner should the Practitioner be unavailable.

15. Lack of Eligibility. Lack of eligibility for consideration for Medical Staff appointment or processing of an application due to failure to document compliance with objective criteria set out above is not an Adverse Recommendation or Action and does not entitle the Practitioner to any procedural rights of review under these Bylaws or otherwise.

Section C. Nondiscrimination

Our Children's House shall not discriminate in granting staff appointment and/or Clinical Privileges on the basis of age, gender, race, sexual orientation, creed, physical disability, color, nationality, religion or any other basis prohibited by law.

Section D. Conditions and Duration of Appointment and Granting of Clinical Privileges

Appointments to the Medical Staff and clinical privileges shall not exceed two (2) years. The MEC may recommend membership and/or Clinical Privileges for a term of less than two (2) years as deemed appropriate by the MEC and as approved by the Board of Directors.

a. Membership and Clinical Privileges are not exclusively interconnected and may be granted independent of one another as further outlined in the Medical Staff credentialing policies.

b. All members or providers granted clinical privileges must continuously meet the competency and activity requirements as established through the Medical Staff credentialing policies and procedures and otherwise exhibit a continuous interest and involvement in the welfare and clinical affairs of OCH as noted in Article III.

c. Providers shall request only those privileges that he or she intends to utilize at OCH during the appointment period. Providers who fail to exercise their clinical privileges at OCH during the reappointment cycle will no longer be deemed eligible for continuous granting of said privileges (with the exception of approved consult services as outlined in the Medical Staff credentialing policies). Should this occur, the provider

shall have the following options as further defined in the Medical Staff credentialing policies:

- Modify his or her request to more appropriately reflect the clinical privileges that he or she exercises at OCH (i.e. refer and follow);

- Withdraw his or her request to maintain clinical privileges and request to maintain Medical Staff membership only (if membership criteria was met at the time of reappointment);

- If the provider intends to increase his or her utilization over the next six (6) months, the Service Chief and Credentials Committee have the option to recommend a focused practice professional evaluation as outlined in the Focused Practice Professional Evaluation Policy.

Section E. Process for Appointment

1. Application. As part of Medical Peer Review, a separate credentials file shall be maintained for each Practitioner applying for Medical Staff appointment. Each application for appointment and reappointment to the Medical Staff shall be in writing, submitted on a form approved by the MEC and the Hospital Administrator, and signed by the Practitioner. The Practitioner applying for initial appointment shall be provided with a copy of or access to these Bylaws, the Rules and Regulations, and applicable policies. The application form shall require accurate and complete disclosure of the information required by Section II.B above and the following:

   a. Documentation of all current and prior professional licenses in any state, federal and state controlled substances registrations, and any investigations and actions on same;

   b. Documentation of current and past professional liability insurance and all claims, judgments, settlements, and dismissals and any lapses or non-renewals of coverage;

   c. Documentation of all current and prior health care entity affiliations, any actions on medical staff membership and/or clinical privileges, and information about investigations and professional practice evaluations at any health care entity;

   d. Documentation of at least two (2) peer references or clinical evaluations in the same professional discipline who have worked with the Practitioner, have personal knowledge of the Practitioner's ability, and who can provide truthful references as to the Practitioner's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism, and other qualifications;

   e. Statement of necessary health status and ability as required by Section B.9.;

   f. Identifying information, including name, social security number, an official government issued picture ID, addresses of all offices and residences, Medicare Provider UPIN and National Provider Number NPI and contact information including email addresses, and all phone numbers for residences, offices and mobile phone;

g. Specialty board certification, including the names of the board(s) and dates of certification;

h. Any conviction, guilty plea or deferred adjudications, or *nolo contendere* plea or filing of formal charges for a felony or misdemeanor (including DUI or PI) other than minor traffic violations;

i. Commitment to comply with the duties and obligations of Medical Staff membership as set out in Section B above if appointment is granted; and

j. Attestation as to the elements in Section E.2. below.

2. Representations. On submission of an application for appointment to the Medical Staff and/or Clinical Privileges, each Practitioner represents the following which shall remain effective during the term of Medical Staff appointment and any exercise of Clinical Privileges:

a. Signifies the Practitioner will abide by the Medical Staff Bylaws, Rules and Regulations, and policies, as well as Hospital policies;

b. Certifies that all information submitted in connection with the application is true, correct and complete, and agrees to provide any new or updated information pertinent to the Practitioner's qualifications or the information on the application to Medical Staff Services within ten (10) business days of receipt of notice of the information;

c. Agrees that any misstatements, omissions or misrepresentations considered material by Hospital in connection with the application, whether intentional or not, may be grounds to withdraw the application from further processing, deny appointment or reappointment and/or Clinical Privileges, or take Corrective Action;

d. Authorizes the Hospital and Medical Staff and representatives to consult with other health care entities, medical staffs, and any other individuals and entities regarding the Practitioner's professional qualifications and any other information related to his application for appointment and/or Clinical Privileges, and agrees to appear for an interview if requested;

e. Authorizes the release of information by the Hospital, any Medical Staff committees, and by third parties, including without limitation medical records regarding any of the Practitioner's patients and the Practitioner and Medical Peer Review data, relating to the Practitioner's professional qualifications, any Adverse Recommendation or Action, any corrective action, FPPE or OPPE, complaints, and/or any other information related to an application for appointment and/or clinical privileges at another health care entity, provided such information is provided in good faith and without malice;

f. Releases from liability and agrees to hold harmless all third parties, as defined in Article X, who provide information to the Hospital and the Medical Staff relating to the Practitioner;

g. Releases from liability and agrees to hold harmless the Hospital, its affiliates and their successors, assigns, and transferees, and their representatives, the Medical Staff, Board of

Directors, directors, officers, members of the Medical Staff committees and Services, and any other individuals for any acts, communications, reports, records, statements, documents, recommendations, or disclosures made in good faith and without malice concerning any matter that might directly or indirectly affect the Practitioner's exercise of Clinical Privileges or relating to the Practitioner's qualifications for appointment or reappointment to the Medical Staff;

h. Acknowledges and agrees to the immunity provisions as set forth in Article X and to execute all requested authorizations and releases to give effect to the provisions in these Bylaws; and

i. Acknowledges that the agreements, authorizations, and releases in these Bylaws and on the applications for appointment, reappointment and/or Clinical Privileges are express conditions to the Practitioner's appointment, continuation of appointment and reappointment, and to the Practitioner's exercise of Clinical Privileges in the Hospital.

3. Complete Application Required. An application must be a Complete Application to be submitted for consideration and the Practitioner is responsible to ensure that the application is a Complete Application.

   a. A Complete Application means:

      i. The application form has been completely filled out and signed by the applicant;

      ii. All questions on the application form have been answered truthful and to the satisfaction of the involved Medical Staff committees and all supplemental information as requested has been provided (e.g., malpractice claims, copies of licenses, DEA certificate, etc.);

      iii. All reference requests**,** required documentation, and requests for additional information/clarification forwarded to the applicant and/or other parties**,** and any other documents/verifications solicited by the Hospital, the Service Chief, and the applicable Medical Staff committees have been received;

      iv. If an interview or meeting has been requested, the applicant has participated and provided the requested information to the satisfaction of the interviewing individual or committee;

      v. Any questions or issues raised during the processing of an application by the Hospital, the Service Chief, and/or the applicable Medical Staff committees have been resolved; and

      vi. The applicant has facilitated any responses from outside sources when reasonably requested by the Hospital when the Hospital's internal OPPE reports do not provide sufficient information at reappointment to verify competence and acceptable performance.

An application can be a Complete Application, but then become incomplete due to a subsequent request for information.

b. If an application is not a Complete Application, Medical Staff personnel will provide the Practitioner with Special Notice of:

   i. What information is needed and from whom;

   ii. The time period within which the information must be received;

   iii. The fact that the application will be withdrawn from further processing if the information is not received within that time period; and

   iv. That withdrawal of an application from further processing is not a denial of the application or an Adverse Recommendation or Action and does not entitle the Practitioner to any procedural rights under these Bylaws or otherwise.

c. Once an application has been withdrawn from processing due to not being a Complete Application as provided in this section, the Practitioner may not submit a new application for a period of at least one year from the date the application was withdrawn.

4. Review by Service Chief.

   a. Once an application is a Complete Application, Medical Staff Services will forward the application and any supporting documentation to the Service Chief appropriate to the Practitioner's specialty. The Service Chief shall have 30 days from receipt to review the application and may conduct a personal interview with the Practitioner. Should the Service Chief not complete this action within 30 days, the Credentials Committee may initiate its review.

   b. The Service Chief shall issue a written recommendation to the Credentials Committee as to whether Medical Staff membership should be granted and, if so, what Staff category and Clinical Privileges are appropriate and any conditions or limitations on that category or Clinical Privileges. If appointment or Clinical Privileges are not recommended or any conditions or limitations are recommended, a statement of the reasons for such shall be included.

5. Review by Medical Executive Committee.

   a. The MEC shall also act as the Credentials Committee and will review the application and make recommendation to the Board of Directors within 30 days of receipt. The MEC may conduct a personal interview with the Practitioner.

   b. The MEC shall issue a written recommendation to the Board of Directors as to whether Medical Staff membership should be granted and, if so, what Staff category and Clinical Privileges are appropriate and any conditions or limitations on that category or Clinical Privileges. If appointment or Clinical Privileges are not recommended or any conditions or limitations are recommended, a statement of the reasons for such shall be included.

c. If the recommendation of the MEC is an Adverse Recommendation or Action, the Hospital Administrator shall provide the Practitioner with Special Notice of the recommendation as provided in Article XIII and all further procedures shall be as set forth in that Article.

d. If the recommendation of the MEC is not an Adverse Recommendation of Action, it shall be forwarded with any supporting documentation to the Board of Directors for review under Section E.7. below.

6. Review by Board of Directors.

a. At its next regular meeting, but in no event more than 60 days from its receipt of a Complete Application and a recommendation from the MEC that is not an Adverse Recommendation or Action, the Board of Directors, or a delegated Committee of the Board of Directors, shall review the application and recommendation and issue its own determination.

b. The Board of Directors written determination shall indicate whether Medical Staff membership should be granted and, if so, what Staff category and Clinical Privileges are appropriate, and any conditions or limitations on that category or Clinical Privileges. If appointment or Clinical Privileges are not granted or any conditions or limitations are imposed, a statement of the reasons for such shall be included in the determination.

c. If the determination of the Board of Directors is an Adverse Recommendation or Action, the Hospital Administrator shall provide the Practitioner with Special Notice of the determination as provided in Article XIII and all further procedures shall be as set forth in that Article.

d. If the determination of the Board of Directors is not an Adverse Recommendation or Action, it shall be the final decision of the Board of Directors. The Hospital Administrator shall notify the Practitioner in writing within 20 days of the decision.

7. Deferral. Any committee may defer action on an application for the purpose of obtaining additional information. The committee must follow up within 30 days of deferral with a recommendation.

Section F. Staff Dues or Application Fees

Annual Medical Staff dues or application fees shall be set by the MEC and may be modified from time to time in the MEC's discretion.

Section G. Responsibilities of Membership

Each Medical Staff Member shall:

1. Direct the care of patient(s) in a manner consistent with generally accepted standards of care and the standards of the Medical Staff, including evidence-based protocols.

2. Abide by these Bylaws, Medical Staff Rules and Regulations and policies, and Our Children's House policies and procedures .

3. Supervise the work of any Residents, Fellows, or APPs or AHPs under the Member's supervision, as applicable.

4. Assist Our Children's House in fulfilling its responsibilities for providing emergency and charitable care to the extent determined by the MEC with approval by the Board of Directors for each Service and or Staff category.

5. Seek consultation when indicated and provide consulting services in the care of patients requiring those services on request within the Member's specialty, capability and capacity, without regard to the patient's ability to pay.

6. Comply with the ethical standards and professional guidelines of the Member's profession.

7. Treat employees, patients, visitors, and Members in a dignified and courteous manner; cooperate with other Members, staff and hospital employees and administration in a respectful and professional manner so as to promote the delivery of quality patient care and the orderly operation of the Hospital.

8. Cooperate with the committees of the Medical Staff and Our Children's House, as appropriate including carrying out the assignments associated with Membership and Hospital and Medical Staff committee assignments and participating in medical peer review and maintaining in strict confidence the records and proceedings of medical peer review and all involved committees.

9. Prepare and complete in a timely manner as required by Medical Staff Rules & Regulations and Hospital policy, accurate, legible and clinically pertinent medical records for all patients to whom the Member provides care in the Hospital, including utilization of electronic medical records system(s) and completion of any associated training, and maintain the confidentiality of those records, to include accessing only those records for which the Member has a legitimate reason and maintaining proper controls on access by the Member's employees, APPs and AHPs;

10. Maintain continued compliance with all criteria and qualifications of Medical Staff Membership and notify Medical Staff Services as soon as possible and no later than ten (10) business days, and no later than one (1) day with regard to 10.a-c below, after receiving notice of any of the following:

    a. Suspension, termination, restriction, or denial, in whole or in part, of the Member's professional licensure to practice medicine or podiatry in any state or controlled substances registration either federal or any state;

    b. Loss, cancellation, reduction, or other modification of professional liability insurance;

    c. Exclusion from participation in Medicare, Medicaid or any other governmental programs;

    d. Initiation of an investigation or implementation of an agreed order, remedial plan, or any other action by any professional licensing agency or a professional certification board;

e. Imposition of: (i) any disciplinary or corrective action (including probation), (ii) initiation of an investigation for purposes of possible corrective action, (iii) suspension, reduction or loss of clinical privileges, (iv) proctoring, monitoring or review for any reason other than FPPE applicable to new Practitioners or the exercise of newly granted clinical privileges, or (v) denial of appointment, reappointment or renewal of Medical Staff Membership or clinical privileges at any other hospital or health care entity, but not including automatic action for delinquent medical records;

f. Resignation of Clinical Privileges or Medical Staff Membership at Hospital or any other hospitals;

g. Leave of absence, whether voluntary or involuntary, from another hospital or health care entity;

h. Filing of any report concerning the Member with the National Practitioner Data Bank and any of the following:

   i. Pending investigations, formal or informal actions, or sanctions, whether criminal or civil, by the Texas Medical Foundation, Medicare, Medicaid, or any other state or federal governmental program;

   ii. Filing of, or notice of claim, for any civil or administrative action alleging professional incompetence, professional negligence, or improper professional conduct or professional misconduct;

   iii. Judgment, settlement or dismissal of any claim for any civil or administrative actions alleging professional incompetence, professional negligence, or improper professional conduct or professional misconduct;

   iv. Voluntary or involuntary challenge, denial, limitation, suspension, revocation or relinquishment of Membership in any medical/professional society or initiation of any action that would affect Membership in such a society organization;

   v. Any change in health status or ability, including a failure to comply with recommended treatment that might affect the Member's ability to fulfill the essential functions of Medical Staff Membership and/or exercise Clinical Privileges in accordance with accepted professional standards and without posing a direct threat to patients.

   vi. Any conviction, guilty plea or deferred adjudication, or *nolo contendere* plea or filing of formal charges for a felony or misdemeanor (including DUI or PI) other than minor traffic violations.

11. Maintain accurate and current contact information with Medical Staff Services, including email address, all office addresses and home address, office, home and mobile telephone numbers.

Section H. Leave of Absence

Members of the Medical Staff may be granted a leave of absence as set forth in the policies and procedures of the Medical Staff.

ARTICLE III. CLINICAL PRIVILEGES

Section A. General

A Practitioner providing patient care services at the Hospital may exercise only those Clinical Privileges requested and specifically granted by the Board of Directors. Clinical Privileges must be Hospital specific, within the scope of the Practitioner's license authorizing such practice in this state and limited by any conditions or restrictions imposed by the Board of Directors. The exercise of Clinical Privileges shall be subject to these Bylaws, the Rules and Regulations and Hospital policies and carried out in accordance with accepted professional standards and the standards of the Medical Staff, as well as legal and accreditation standards.

Section B. Delineation of Clinical Privileges.

1. Development. The Medical Staff, through the MEC and consultation with the appropriate Service Chief(s), shall be responsible to develop and recommend to the Board of Directors for approval a listing of Clinical Privileges that will be available and offered at the Hospital. The list of Clinical Privileges shall take into consideration the needs of the community and the Members of the Medical Staff, and the adequacy of resources, equipment and personnel of the Hospital to support the Clinical Privileges.

2. Criteria. The MEC, in consultation with the appropriate Service Chief(s) shall also develop and approve criteria for the granting of the approved list of Clinical Privileges, which shall also be subject to the approval of the Board of Directors.

Section C. Process for Granting and Renewal.

1. Application.

    a. A request for the specific Clinical Privileges desired by a Practitioner shall be indicated on the prescribed form and must accompany each application for appointment or reappointment. A request by a Member for a modification of Clinical Privileges may be made at any time.

    b. All such requests must be supported by documentation, in the application, of required qualifications. Failure to document satisfaction of minimum threshold criteria established for the requested Clinical Privilege shall result in lack of processing of the request as to that Clinical Privilege.

2. Criteria. The determination of whether to grant Clinical Privileges shall be based on:

a. The Practitioner's education, training, experience, current competence, clinical judgment, health status and ability to perform the requested Clinical Privileges, peer recommendations or clinical evaluations when required, and other relevant information;

b. Information regarding previously successful or currently pending challenges to or restrictions on any licensure or registration or the voluntary relinquishment of such licensure or registration;

c. Information regarding voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction or loss of Clinical Privileges at another health care entity;

d. Information regarding professional liability claims and suits either pending or closed, regardless of the outcome; and

e. The Practitioner's documentation of compliance with any minimum threshold criteria or other requirements established by the Board of Directors, following consultation with the MEC, for those Clinical Privileges.

3. Process.

a. The process for consideration and granting of Clinical Privileges, both initially and on renewal shall be the same as that used for appointment and reappointment in Article II, Section E above, and may include expedited processing.

b. The renewal process shall include any information relevant to the Practitioner's competence and professional conduct, including without limitation, consideration of information generated pursuant to Medical Peer Review, relevant Practitioner-specific data as compared to aggregate data and morbidity and mortality data when available, and, if needed, information from other health care entities.

c. This same process shall be used for requests for changes in Clinical Privileges between reappointment times which may be subject to FPPE.

4. Term.

a. Clinical Privileges may be granted for a period of up to two (2) years and may be for a period of less than two (2) years. A term of less than two (2) years is not an Adverse Recommendation or Action and does not entitle the Practitioner to any procedural rights of review under these Bylaws or otherwise.

b. Any initial grant of Clinical Privileges shall be subject to FPPE as set out in written Policy. The term of the initial FPPE may be extended, not to exceed a total of two (2) years, unless a special exception is approved by the MEC.

Section D. Exclusive Professional Service Arrangements

1. Requirement to Process. If the exercise of Clinical Privileges is subject to an exclusive contract or other arrangement approved by the Board of Directors, an application for Clinical Privileges shall be processed only if the requesting Practitioner or Member is subject to the arrangement, unless otherwise provided by the Board of Directors.

2. Effect on Current Members. If the Hospital, with the approval of the Board of Directors, enters into an exclusive arrangement as to the exercise of certain Clinical Privileges in accordance with this Section and Article VI, only those Members subject to that arrangement may continue to exercise the Clinical Privileges addressed by the arrangement, unless otherwise provided by the Board of Directors. Those Members who are not subject to the exclusive arrangement shall be considered to have automatically relinquished those Clinical Privileges addressed by the arrangement and shall not be entitled to procedural rights of review under these Bylaws or otherwise.

Section E. Temporary Clinical Privileges

1. Criteria. Temporary Clinical Privileges may be granted only to Practitioners with a pending application for initial appointment or to fulfill an important patient care, treatment, and service need, as detailed below. In granting temporary Clinical Privileges, special requirements may be imposed in order to monitor and assess the quality of care rendered by the Practitioner exercising such privileges. Temporary privileges may be recommended by the Medical Staff President or his/her designee which may include the appropriate Service Chief or Chief Medical Officer OCH, or the Credentials Committee Chair. Temporary privileges may be granted by the President or the Hospital Administrator.

2. Clean Application. After receipt of a Complete Application for Medical Staff appointment, including a request for specific temporary Clinical Privileges and in accordance with the conditions specified below, a Practitioner may be granted temporary Clinical Privileges for a period not to exceed 120 days while awaiting MEC and Board of Directors approval. The credentialing process must include primary source verification of the applicant's current state professional licensure(s), current professional liability coverage, relevant training and current competence at time of granting privileges, ability to perform the privileges requested, a query and evaluation of the NPDB information, no current or previously successful challenge to licensure or controlled substances registration, no record of involuntary termination of medical staff membership at another health care entity, and no record of involuntary limitation, reduction, denial or loss of clinical privileges at another health care entity.

3. Important Patient Need.

    a. After receipt of a written request and other required documentation, a Practitioner who is not an applicant for Medical Staff appointment may be granted temporary Clinical Privileges for the care of one or more specific patients for purposes of an important patient care, treatment or service need as designated in the request.

    b. All such patients shall be attended by a Member of the Active Staff with the Practitioner with temporary Clinical Privileges providing appropriate consultation.

c. Such Clinical Privileges shall be restricted to the 120 day period by any Practitioner, after which such Practitioner shall be required to apply for appointment to the Medical Staff before being allowed to attend additional patients.

4. Authority of Service Chief. Practitioners with temporary Clinical Privileges shall be subject to the authority of the Service Chief to which the Practitioner is assigned and special requirements of consultation and reporting may be imposed by that Chief.

5. Subject to Bylaws. Before temporary Clinical Privileges are granted, the Practitioner must acknowledge in writing that the Practitioner has received or been given access to and agrees to be bound by the terms of the Medical Staff Bylaws, Rules and Regulations, and relevant Hospital policies, including all releases.

6. Termination of Temporary Clinical Privileges. The Hospital Administrator may, after consultation with the Medical Staff President or appropriate Service Chief, terminate any or all of a Practitioner's temporary Clinical Privileges. Temporary Clinical Privileges shall automatically terminate on issuance of an Adverse Recommendation or Action. They shall be automatically terminated on issuance of an unfavorable recommendation by the Credentials Committee or automatically modified to conform to a recommendation by the Credentials Committee that the Practitioner be granted Clinical Privileges which are different from the temporary Clinical Privileges. In the event of termination, the Practitioner's hospitalized patients shall be assisted to select another Practitioner by the Service Chief.

7. No Procedural Rights of Review. The granting of temporary Clinical Privileges is a courtesy on the part of the Hospital. A Practitioner is not entitled to any procedural rights afforded by these Bylaws or otherwise as a result of granting temporary Clinical Privileges, a failure to grant temporary Clinical Privileges or because of any termination or suspension of temporary Clinical Privileges.

Section F. Care in an Emergency

1. Authorization. During an emergency, any qualified Member, to the degree permitted by the Member's professional license, shall be permitted and assisted to do everything appropriate in an effort to save the life of a patient or prevent serious harm, using every facility of the Hospital necessary, including the calling of any consultation necessary or desirable, even though some of the actions may be taken outside the scope of the Member's Clinical Privileges or Staff category. The Member shall promptly provide the Medical Executive Committee with a written statement setting out the circumstances giving rise to the care in an emergency under this Section.

2. Emergency Defined. For purposes of this Section, an emergency is defined as a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

Section G. Privileges to Perform H&P

1. General. Clinical Privileges for performing a medical history and physical examination shall be delineated. A history and physical examination must be completed and documented

by a physician member of the Medical Staff with clinical privileges, or by a licensed individual approved for such privilege based on demonstrated competence. The pre-hospitalization medical history and physical examination must be performed by a Physician Member of the Medical Staff.

2. Time Requirements.

   a. A history and physical must be completed and documented in the medical record of all inpatients within twenty-four (24) hours of admission.

   b. A new history and physical must be completed if the original history and physical was performed and completed greater than thirty (30) days prior to admission, registration or a procedure. If the original history and physical was performed and completed within the past thirty (30) days (prior to admission, registration or a procedure), there must be evidence of an updated examination of the patient, including any changes in the patient's condition. This is called an interval note.

3. Podiatrists.

   a. Members who are Podiatrists are responsible for that part of their patients' histories and physical examinations that relate to podiatry.

   b. Podiatrists are responsible to secure a Physician Member to manage and coordinate their patients' medical condition during hospitalization and meet any requirements in the Rules and Regulations.

4. Residents and Other Approved Practitioners. When the history and physical examination is recorded by a resident, intern, or other approved practitioner, the supervising physician shall review such history and physical, make a separate entry, and countersign or authenticate it, according to Our Children's House policy, to indicate his/her approval and agreement with the contents.

The Medical Staff Rules and Regulations as well as the health information management policies and procedures outline specific requirements related to the content and other requirements for completion of histories and physicals.

Section H. Telemedicine Clinical Privileges

1. General. Practitioners who wish to provide telemedicine services in prescribing, rendering a diagnosis or otherwise providing clinical treatment to a Hospital patient shall be required to apply for and, except as provided below, be granted Clinical Privileges for these services as provided in these Bylaws and as required by Texas law.

2. Reliance on Distant Site Credentialing. The Board of Directors, following consultation with the MEC, may authorize a written agreement with a distant site hospital or other entity, which agreement allows reliance on the credentialing and privileging decisions of that distant site; provided that, the process meets the applicable requirements of The Joint Commission and the

Medicare Conditions of Participation and the criteria in these Bylaws for the applicable Telemedicine Clinical Privileges.

3. Scope of Telemedicine Services. Only those clinical services that are appropriately delivered through a telemedicine medium, according to commonly accepted quality standards, shall be recommended to the Board of Directors by the MEC as appropriate for Telemedicine Clinical Privileges. This limited scope shall be documented in writing in Hospital policy. Consideration of appropriate utilization of telemedicine equipment by the Telemedicine Practitioner shall be encompassed in the Clinical Privileges delineation which is reviewed by the appropriate Service Chief and the recommendation is sent to the Credentials Committee, MEC, and the Board for final approval.

Section I. Temporary Disaster Privileges

1. Authority. If the Hospital's Emergency Medical Plan has been activated, any Member or other health care provider with Clinical Privileges, to the degree permitted by his license, shall be permitted to and be assisted by Hospital personnel in doing everything possible to save the life of a patient or to save the patient from serious harm. Additionally, temporary disaster privileges may be granted to Practitioners and other health care providers who are not Members of the Staff by the Hospital President or Medical Staff President, or their designees, as provided in Hospital policy.

2. Process. The process for granting temporary disaster privileges shall include the basic steps of photo identification and direct observation, mentoring, and clinical record review of volunteer staff in accordance with legal and accreditation requirements.

3. Termination. Once the immediate situation has passed and such determination has been made consistent with the Hospital's Emergency Medical Plan, all temporary disaster privileges shall automatically terminate immediately. Any person identified in the Emergency Medical Plan or Hospital policy with the authority to grant temporary disaster privileges shall also have the authority to terminate such privileges. Such authority may be exercised in the sole discretion of the Hospital and will not give rise to any procedural rights of review under these Bylaws or otherwise.

Section J. Advanced Practice and Allied Health Professionals (APPs/AHPs)

1. General. Certain individuals may be granted Clinical Privileges to provide health care in the Hospital as APPs or AHPs. The process for reviewing applicants and granting Clinical Privileges to an APP or AHP shall be set out in Hospital policy. Any grant of Clinical Privileges shall be in accordance with the Medical Staff credentialing and privileging process, and shall be subject to any required Practitioner delegation, direction and/or supervision as set out in Hospital policy following consultation and recommendation by the Medical Executive Committee. APPs and AHPs are not eligible for Medical Staff membership or any of the procedural rights of review afforded to Practitioners under these Bylaws or otherwise. Any review rights shall be limited to those set out in the Hospital policy.

2. Supervising Practitioner. Except for those employed by the Hospital or APPs/AHPs that the Board of Directors determine do not require a Supervising Practitioner, each APP/AHP must

be engaged by a Member either as an employee or independent contractor of the Member or the Member's practice group. One Member shall be designated as the primary supervising Practitioner, and required to submit attestations as to the competence of the APP/AHP and the obligations of the supervising Practitioner as set forth in these Bylaws, Hospital and Medical Staff Policy and the Rules and Regulations on use of the APP/AHP. All other Members utilizing the services of the APP/AHP are considered alternate supervising Practitioners and subject to the same obligations. All supervising Practitioners are responsible to provide the required delegation, direction and/or supervision as set forth in Hospital policy and the APP/AHP's delineation of Clinical Privileges when using the services of the APP/AHP. Each supervising Practitioner retains full responsibility for the performance and care provided by the APP/AHP in the Hospital.

3. Improper Use. Use by a Practitioner of an APP/AHP, other health care provider authorized to provide health care in the Hospital, or Hospital employee in a manner not permitted by the individual's Clinical Privileges or other authorization may be grounds for Corrective Action against the Practitioner.

ARTICLE IV. CATEGORIES OF THE MEDICAL STAFF

The categories of Medical Staff membership are Active, Consulting and Courtesy. Each Member of the Medical Staff must be assigned to a specific Staff category as well as a Service.

Section A: Active Staff

1. *Qualifications*. A member of the Medical Staff is eligible for the category of Active staff by maintaining a minimum of twelve (12) or more Patient Contacts per appointment period or being appointed through the appropriate process as defined in the Bylaws or Medical Staff policies as the JPE Chief Medical Officer, Chief Medical Officer OCH, Service Chief, Medical or Surgical Director or Training Program Director. In the event a member up for reappointment to the Active Staff category has six (6) or fewer contacts during the preceding appointment period, such member shall be eligible for the Active category if the member had significant involvement, as determined by the MEC in its sole discretion, in issues of quality of care either through Medical Staff, service, or service leadership or Medical Staff committee involvement.

2. *Prerogatives*. A member of the Active staff may:

   a. Admit patients without limitation, subject to these Bylaws, the Rules and Regulations, and applicable Medical Staff, Hospital and service policies and procedures.

   b. Exercise such clinical privileges as granted pursuant to these Bylaws.

   c. Vote on all matters presented to the general Medical Staff and of the service and committees of which he is a member.

   d. Hold any office that is voted on by all members of the Medical Staff and in the service and committees of which he is a member.

3. *Responsibilities.* A member of the Active staff shall:

   b. Actively participate in the quality evaluation and monitoring activities required of Medical Staff members.

   c. Discharge the responsibilities set forth in these Bylaws, Medical Staff Policies, Procedures, Rules and Regulations, and applicable Hospital and service policies and procedures.

   d. Retain responsibility within his area of professional competence for the continuous care and supervision of each patient for whom he is responsible for providing services in the Hospital, or arrange a suitable alternative as applicable in accordance with these Bylaws, Medical Staff Policies, Procedures, Rules and Regulations, and applicable Hospital and service policies and procedures.

   e. Have procedures in place to provide care to or assist in the provision of care to such staff member's patients who come or are brought to the Hospital's emergency room.

   f. Discharge such other staff functions as may be required from time to time by the MEC or the Service Chief in which the member is assigned.

Section B: Courtesy Staff

1. *Qualifications*.

   a. A member of the Medical Staff is eligible for the category of Courtesy Staff as follows: Maintain at least one (1) and up to a maximum of eleven (11) contacts per appointment period. This maximum number shall not include Patient Contacts that occur when the Courtesy Staff member is providing call coverage for an Active staff member. The MEC may accept evidence of satisfactory patient care activity at another health care facility in lieu of the one (1) contact requirement in special circumstances to best meet the needs of the Medical Staff or Hospital. In the event a member of the Courtesy Staff does not meet the minimum number of contacts during an appointment period, such member may be reappointed by the MEC in its sole discretion, but such reappointment may only be for one (1) year. Only a single one (1) year reappointment shall be granted in the event the member does not meet the contact requirement.

   b. A Courtesy Staff member will not be required to become an Active staff member because of call-coverage contacts alone.

   c. A Courtesy Staff member is a member of the active staff of another accredited facility where he actively participates in quality review, evaluation, and monitoring activities similar to those required of the Active staff at this Hospital.

2. *Prerogatives*. A Courtesy Staff member may:

a. Admit patients to the Hospital subject to these Bylaws, within the limitations provided in the Rules and Regulations and applicable Hospital, Medical Staff, and service policies and procedures and under the same conditions as specified for Active staff members.

b. Exercise such clinical privileges as granted pursuant to these Bylaws.

c. Within the sole discretion of the MEC, hold office in the service and committees of which he is a member.

d. Not hold any office that is voted on by all members of the Medical Staff.

3. *Responsibilities*. A member of the Courtesy Staff shall:

a. Actively participate in the quality evaluation and monitoring activities required of Medical Staff members;

b. Discharge the basic responsibilities set forth in these Bylaws and Medical Staff Policies, Procedures, Rules and Regulations and applicable Hospital and service policies and procedures;

c. Retain responsibility within his area of professional competence for the continuous care and supervision of each patient for whom he is responsible for providing services in the Hospital, or arrange a suitable alternative as applicable in accordance with these Bylaws, Medical Staff Policies, Procedures, Rules and Regulations, and applicable Hospital and service policies and procedures;

d. Have procedures in place to provide care to or assist in the provision of care to such staff member's patients who come or are brought to the Hospital's emergency room;

e. Discharge such other staff functions as may be required from time to time by the MEC or the Service Chief in which the member is assigned.

Section C. Consulting Staff

The Consulting Category shall consist of Medical Staff members who are persons whose specialty/services are infrequently required (as determined by the MEC) for patients at the Hospital and whose practice in the Medical Center is limited to consultation. These members shall be expected to respond to call for consultation by members of the Medical Staff.

1. *Qualifications*. A member of the Medical Staff is eligible for the category of Consulting Staff as follows:

a. Receives recognition for outstanding attainments in medicine or podiatry; and

b. Is a member of the active staff of another medical or podiatric facility where he actively participates in quality review, evaluation, and monitoring activities similar to those required of the Active staff of this Hospital.

2. *Prerogatives.* A Consulting Staff member may:

   a. Not have admitting privileges;

   b. Not hold any office that is voted on by all members of the Medical Staff;

   c. Exercise such clinical privileges as granted pursuant to these Bylaws;

   d. Hold office in the service or committees of which he is a member;

   e. Provide consultation as requested by any member of the Medical Staff at the Hospital and subject to these Bylaws, Medical Staff Policies, Procedures, Rules and Regulations, and applicable Hospital and service policies and procedures; and

   f. Participate in quality review, evaluation, and monitoring activities similar to those required of the Active-Clinical staff of this Hospital.

3. *Responsibilities*. A member of the Consulting Staff shall:

   a. Discharge the basic responsibilities set forth in these Bylaws, Medical Staff Policies, Procedures, Rules and Regulations, and applicable Hospital and service policies and procedures;

   b. Discharge such other staff functions as may be required from time to time by the MEC or the Service Chief to which he is assigned.

Section D. Changes in Staff Category

Any request to change a Member's Staff category will be processed only if the Member documents compliance with the above qualifications. Processing will be handled using the procedures for appointment in Article II. At reappointment, a Member who does not meet the threshold eligibility requirements for continuing in the same Staff category may be reassigned to the appropriate category if the Member meets the threshold eligibility requirements for such category. Reassignment is not an Adverse Recommendation or Action and does not entitle the Member to procedural rights of review under these Bylaws or otherwise.

ARTICLE V. OFFICERS AND COMPOSITION OF THE MEDICAL STAFF

Section A. Officers of the Medical Staff and Duties

The responsibility for the organization and conduct of the business of the Medical Staff shall rest with a Physician Member who shall serve as the Medical Staff President and Chair of the MEC .

It is expected that any elected officer serve as a role model for all staff and his/her behavior represents Our Children's House and the care provided by Our Children's House in a positive light at all times; this includes but is not limited to:

- Behave in a professional and ethical manner

- Maintain a positive relationship with staff, patients and families
- Represent Our Children's House in a positive manner
- Adhere to Medical Staff Bylaws and Rules and Regulations and policies
- Comply with all hospital policies and the Code of Ethical Conduct
- Be a role model to all staff and leading by example

1. The Medical Staff shall have an elected President:

   a. Medical Staff President. The duties and responsibilities of the Medical Staff President shall include the following:

      i. Represent and act as a spokesperson for the Medical Staff to Hospital management, the Board of Directors and the community;

      ii. Serve as a voting member of and Chair the MEC;

      iii. Serve as an ex-officio member of the Board of Directors;

      iv. Serve as an ex-officio, non-voting member of all other standing committees of the Medical Staff, the Services and any Service committees, and all special and ad hoc committees or task forces of the Medical Staff or a Service;

      v. Call, preside at, and be responsible for the agenda of all regular and special meetings of the Medical Staff;

      vi. Enforce the Medical Staff Bylaws, Rules and Regulations and policies, and Hospital policies applicable to Practitioners and other health care providers with Clinical Privileges, consistent with the procedural rights set forth therein;

      vii. Implement and interpret the policies of the Board of Directors to the Medical Staff and report to the Board of Directors regarding patient care, Medical Peer Review and other activities affecting the Medical Staff;

      viii. Interact with the Hospital Administrator, JPE Chief Medical Officer, Chief Medical Officer OCH, other members of Hospital administration, and the Board of Directors on matters of mutual concern affecting the Hospital;

      ix. Appoint Members to all Medical Staff committees and task forces, unless otherwise specified in these Bylaws;

      x. Perform those duties specifically listed in these Bylaws or as may be delegated by the MEC or the Board of Directors;

xi. Act in coordination and cooperation with all Medical Staff leaders and administrative leaders at Our Children's House on an as needed basis on issues that affect the practice of the Medical Staff at Our Children's House;

xii. Participate in the quality and credentialing processes of the Medical Staff; and

xiii. Serve as the Chair of the Nominating Committee.

Section B. Qualifications of Medical Staff Leadership

1. The Medical/Staff President, Representatives-at-Large, Chief Medical Officer OCH, any other appointed Medical Staff leadership, as well as the MEC must:

   a. be members in good standing of the Active Staff and remain in good standing on the Active Staff during their term in office;

   b. be actively involved in patient care at Our Children's House;

   c. not have been subject to Corrective Action at this Hospital at any time;

   d. not hold a similar position or a position on the Board of Directors at another health care entity during their service in these positions;

   e. have demonstrated an ability to work well with others; and

   f. be in compliance with the professional conduct policies of Our Children's House.

2. The Nominating Committee, a subcommittee of the MEC chaired by the Medical Staff President will have discretion to determine if a staff member wishing to run for office meets the qualifying criteria.

Section C. Nomination and Election of Officers

1. A Nominating Committee shall be appointed yearly by the MEC as set out in Article VII and chaired by the Medical Staff President. This committee shall offer one or more nominees for Medical Staff President and Representatives-at-Large.

2. Nominations for Medical Staff President may also be made by a petition signed by at least ten percent (10%) of the members of the Active Medical Staff. Such a petition must be submitted to the Nominating Committee no later than the first day of October.

3. Only Active members of the Medical Staff shall be eligible to vote for officers. All candidates who have accepted the nominations shall be placed on a ballot. The ballot will be distributed to all Active Staff members and they shall have fourteen (14) calendar days to vote. The candidate for each office receiving the most votes cast shall be elected, subject to approval and confirmation by the Board of Directors.

4. If the results of the election should end in a tie for any position, a runoff election will be initiated. The runoff ballot will be distributed to all Active Staff and they shall have fourteen

(14) calendar days to vote. The candidate receiving the most votes cast shall be elected, subject to approval and confirmation by the Board of Directors.

Section D. Nomination and Election of Representatives-at-Large

1. The candidates for Representatives-at-Large to the MEC may be nominated by members of the Active Medical Staff. To appear on the ballot, a candidate must receive at least ten (10) signed nominations. If no candidate for one of the offices has received ten (10) nominations by the date requested by the Nominating Committee, the duty to nominate for that office shall revert to the Nominating Committee.

2. Each Representative-at-Large member shall be elected for a two (2) year term. The candidates for the Representative-at-Large positions receiving the most votes cast shall be elected, subject to approval and confirmation by the Board.

Section E. Terms of Office and Stipend

1. The Medical Staff President and all Representatives-at-Large to the MEC shall take office on the first day of the calendar year.

2. The term of the Medical Staff President shall be for two (2) years with a maximum of two (2) consecutive terms being served.

3. The Medical Staff President may, in each year of the term, receive an annual stipend established and approved by the Board of Directors. Such stipend, if any, and associated documentation shall be made in accordance with Medical Staff policies and procedures and applicable law.

Section F. Vacancies in Office

Vacancies in the office of the Medical Staff President and Representatives-at-Large shall be filled by a specially called election of the Medical Staff.

Section G. Removal of the Medical Staff President or Representative-at-Large

1. The Board of Directors may remove the Medical Staff President or Representative-at-Large if he or she meets one or more of the criteria outlined below for removal, but only after a consultation with representatives of the MEC. The affected individual will not participate in this consultation.

2. The Medical Staff may remove the Medical Staff President Representative-at-Large by petition of twenty-five percent (25%) of the Active Medical Staff and a subsequent two-thirds (2/3) vote by ballot of the Active Medical Staff, if he or she meets one or more of the criteria outlined below for removal.

3. Each of the following conditions, in itself, may constitute grounds for removal of the Medical Staff President or Representative-at-Large from office by the MEC or if requested through one of the above processes:

a. Revocation of professional license by the authorizing state agency;

b. Suspension or resignation from the Medical Staff;

c. Failure to maintain professional liability insurance;

d. Failure to adhere to professional ethics;

e. Failure to comply with or support enforcement of the policies and procedures of Our Children's House and with the Bylaws, the Rules and Regulations, and the policies and procedures of the Medical Staff;

f. Failure to perform the required duties of the office; or

g. Failure to maintain Active Staff status.

This is not an all-inclusive list and other actions by the Medical Staff President or Representative-at-Large such as those involving moral turpitude may give rise to removal from office. Removal of the Medical Staff President or Representative-at-Large shall not be grounds for a hearing or appeal as set forth in Article XIII.

ARTICLE VI. ORGANIZATION OF MEDICAL STAFF BY CLINICAL SERVICES

Section A. Clinical Services

1. Services. The Medical Staff shall be organized into Clinical Services categorized by specialty or sub-specialty. The Services of the Medical Staff are: Pulmonology, Pediatrics/Hospital Medicine, and Physical Medicine and Rehabilitation (PMR).

2. Service Chief. Each Service shall have a Service Chief who shall be appointed by the Board of Directors, initially or in the event of a vacancy, upon the nomination by the Chief Medical Officer OCH with the concurrence of the Hospital Administrator and the MEC. After the initial appointment, the Service Chief will be appointed annually thereafter by the Board of Directors. Each Service Chief shall have the appropriate board certification in his/her specialty or comparable competence affirmatively established in the credentialing process as described in Article III. The Service Chiefs will have overall responsibility for the supervision and satisfactory discharge of functions and identified roles and responsibilities which are set out in these Bylaws, shall report directly to the Medical Staff President, and will be responsible to the Board of Directors, through the MEC. No Service Chief shall serve in excess of ten (10) consecutive years, unless specifically approved by the Board of Directors upon the recommendation of the MEC.

Section B. Medical Directors

The Service Chiefs may submit a request to appoint Medical Directors to oversee specific programs or clinical areas within their Clinical Services. The request to appoint a Medical Director, as well as the specific roles and responsibilities for the position, shall be reviewed and approved by the Hospital Administrator or Chief Medical Officer OCH, whichever is

appropriate. In the absence of a Service Chief, the Chief Medical Officer OCH may independently appoint and approve a Medical Director in collaboration and with approval of the Hospital Administrator. The Chief Medical Officer OCH shall approve positions as applicable and as outlined in the Medical/Dental Staff Policies.

Section C. Changes to Clinical Services

1. Additional Clinical Services may be established or re-organized by the MEC with approval by the Board of Directors. Any requests for new or reorganization of existing Clinical Services shall be made in writing with justification to the MEC. The JPE Chief Medical Officer, in collaboration and with approval of the Chief Medical Officer OCH and Hospital Administrator, may recommend the addition or reorganization of Clinical Services to the MEC. The MEC shall recommend the addition or reorganization of Clinical Services along with justification to the Board of Directors for approval.

2. In the interests of efficiency, management, quality of patient care, education, and/or financial stewardship, the Board of Directors may in its sole discretion determine that certain medical Services, or subspecialties within a Service that are not otherwise exclusive or closed, shall be provided on an exclusive basis.

3. An individual whose application, reapplication, or request for extension of privileges is declined or not granted due to such exclusivity is not entitled to the hearing and appeal procedures as outlined in Article XIII.

Section D. Meetings, Activities and Functions

1. Meetings. Service Chiefs may require attendance at Service meeting and Morbidity and Mortality conferences. Attendance requirements must be approved by the MEC. Specially called meetings must be preceded by prior written notification of at least fourteen (14) calendar days for all of those expected to attend.

2. Activities and Functions. Each Service, among other activities, shall perform the following:

   a. Implement and conduct Medical Peer Review of the delivery of patient care in the Service;

   b. Monitor the competence and professional conduct of Members and others with Clinical Privileges assigned to the Service;

   c. Consult with the MEC and Credentials Committee to establish criteria for Clinical Privileges in the Service, subject to approval of the Board of Directors and subject to the applicable provisions of these Bylaws, the Rules and Regulations, and Hospital policies;

   d. Monitor and report quality improvement activities including taking appropriate action to improve the quality and efficiency of the delivery of patient care in the Service;

   e. Discuss and develop policies and procedures for the Service subject to applicable approvals;

f. Review specific issues at the request of the Medical Staff President, Chief Medical Officer OCH, or the MEC and develop recommendations for consideration by Medical Staff President, the Chief Medical Officer OCH or the MEC; and

g. These functions shall be delegated to the Service Chief who shall have the right to call Service meetings as needed to accomplish these functions, if necessary.

Section E. Service Committees

1. Authority to Appoint. The Service Chief has the authority to appoint committees of the Service, whether standing or ad hoc, to accomplish the activities and functions of the Service. Any committee appointed, and its responsibilities and authorities shall be subject to the approval of the MEC.

2. Procedures. Each Service committee shall have a chair who must be a voting Member of the Service. Any action by the committee must be approved by the Service Chief.

Section F. Qualifications and Tenure of Service Chiefs

1. Each Service Chief shall be a Member of the Active Medical Staff, whose primary practice is at the Hospital, who is willing and able to fulfil the Roles and Responsibilities as set out in Section F below.

2. Each Service Chief shall be appointed by the Board of Directors for a one (1) year term.

3. Any Service Chief may be removed by the Board of Directors following the Board of Directors consultation with the Medical Staff President, Chief Medical Officer OCH, the MEC and the Hospital Administrator. The removal of a Service Chief from office shall not be grounds for a hearing and appeal as outlined in Article XIII.

4. If in the event the Service Chief is out of town or otherwise unavailable, he shall assign the administrative responsibilities (recommending privileges, call schedules, reviewing incident or quality reports, etc.) to a qualified designee in his Service, who has been approved by the Chief Medical Officer OCH.

Section G. Service Chief Roles and Responsibilities

1. Each Service Chief shall be responsible for the following:

   a. All clinically related activities of the Service, subject to the direction of the Medical Staff President, the Chief Medical Officer OCH and the Hospital Administrator;

   b. All administratively related activities of the Service, unless otherwise provided for by the Hospital;

   c. The continuing oversight of the professional performance of all individuals in the Service who have delineated clinical privileges;

d. The recommendation to the Medical Staff of the criteria for clinical privileges that are relevant to the care provided in the Service;

e. The recommendation of clinical privileges for each Medical Staff Member of the Service;

f. The assessment and recommendation to Our Children's House administration of off-site sources for necessary patient care, treatment, and services not provided by the Service or the organization;

g. The integration of the Service into the primary functions of the Medical Staff and the Hospital;

h. The development and implementation of policies and procedures to guide and support the provision of care, treatment, and services;

i. The recommendation of a sufficient number of qualified and competent persons to the Medical Staff as needed to provide care, treatment, and service to patients served by or through the Service;

j. The determination of the qualifications and competence of individuals assigned to the Service who are not licensed independent physicians but who provide patient care, treatment and services;

k. The continuous assessment and improvement of the quality and safety of care, treatment and service provided, including peer review and the analysis of aggregate data and performance improvement data, at all times including at each Member's reappointment.

l. The maintenance of quality control programs, as appropriate;

m. The orientation and continuing education of all physicians in the Service; and

n. Recommendations for space and other resources needed by the Service.

2. Service Chiefs are responsible for quality and Medical Peer Review matters in their Service and will see that such matters are conducted in accordance with and completed within the time frame outlined in these Medical Bylaws and Medical Staff Rules and Regulations and Policies. This includes, but is not limited to, Service Morbidity and Mortality case reviews, individual practice evaluations, ongoing professional practice evaluations, focused professional practice evaluations and any quality matters, incident reports or educational needs brought to the Service Chief's attention.

3. Service Chiefs are responsible for distributing communication to Members within their Service regarding policy revisions that may affect the Service or an individual practice. This includes, but is not limited to, ensuring that all staff is educated on regulatory requirements with which they must comply while providing services at Our Children's House.

4. Service Chiefs will represent Members and/or concerns within their Service at Medical Staff leadership meetings and partner with the appropriate administrative leaders in efforts to resolve any conflicts which may arise.

Section H. Assignment to Clinical Services

Each credentialed Medical Staff Member and other Practitioner and APP/AHP with Clinical Privileges will be assigned to the appropriate Clinical Service by the Board of Directors upon the recommendation of the MEC and be accountable to the Chief of that Clinical Service, as well as to the MEC.

ARTICLE VII. COMMITTEES OF THE MEDICAL STAFF

Section A. General

Committees of the Medical Staff shall include the following standing committees, as well as any subcommittees, ad hoc committees or any other additional committees, which may be established in accordance with these Bylaws:

Medical Executive Committee (MEC)

Nominating Committee

Section B. Medical Executive Committee (MEC)

General. The MEC shall serve as the executive committee of the Medical Staff. By approval of these Bylaws, the Medical Staff delegates and authorizes the MEC to represent and act on its behalf on all matters and in between meetings of the Medical Staff, subject to any limitations imposed by these Bylaws and in a manner consistent with these Bylaws. The MEC, whose composition and duties are set forth below, shall facilitate communication between all levels of governance of Our Children's House, including the Board of Directors, the Clinical Services, and the members of the Medical Staff.

1. Composition.

   a. The voting members of the MEC shall include:

      i. Medical Staff President

      ii. Chief Medical Officer OCH

      iii. Service Chiefs

      iv. Two (2) Representatives-at-Large from the Medical Staff

   b. Ex-officio, voting members of the MEC shall include:

      i. JPE Chief Medical Officer

Should any individual hold more than one (1) of these positions simultaneously, that individual shall be entitled to one (1) vote.

c. Ex-officio, non-voting members of the MEC shall include:

i. Hospital Administrator

ii. System Chief Nursing Executive

iii. Associate Chief Nursing Officer OCH

iv. Vice President, Medical Staff Affairs

v. OCH Quality Medical Director

vi. Vice President of Quality and Safety

vii. Associate General Counsel

d. In the event there is a need for an executive session of the MEC, the following ex-officio, non-voting members will be permitted to attend in addition to the voting members listed above:

- Hospital Administrator
- System Chief Nursing Executive
- Vice President, Medical Staff Affairs
- Associate General Counsel

e. A member who serves on the MEC by virtue of his/her Hospital position will be removed from the MEC if he or she is removed by virtue of his or her Hospital position as outlined in Article V and XII. Members who are elected to the MEC can be removed based on vacating their existing position within the organization or by two-thirds (2/3) vote of the MEC with the approval of the Board of Directors.

2. The Medical Staff President shall be the Chair of the MEC.

3. Duties. MEC serves as the primary group accountable to the Board of Directors for ensuring fulfillment of Medical Staff functions of governance, leadership and performance improvement, as well as supporting the activities of quality, safety, and disease management around patients who seek care across the Hospital continuum. The MEC is also accountable for activities relating to the growth and financial performance of the Hospital. Specific duties of the MEC shall include, but not be limited to:

a. To represent and act on behalf of the Medical Staff between meetings of the organized Medical Staff. This authority is delegated to the MEC by approval of these Bylaws by the

Active Staff and can be removed via the processes for Bylaws revisions as outlined in Article X.

b. To be accountable on behalf of the Medical Staff to the Board of Directors for the medical and surgical care of patients at Our Children's House and to make suggestions to the Board of Directors on matters of hospital management and planning;

c. To act as a liaison between the Medical Staff and the Hospital Administrator and to recommend action to the Hospital Administrator on medical administrative matters;

d. To recommend to the Board of Directors a set of Bylaws, a set of Medical Staff Rules and Regulations, and a set of policies and procedures as outlined in these Bylaws; to maintain compliance of the Medical Staff with these documents; and to periodically review and propose revision or amendment of the documents as it deems necessary or upon request by an individual member or committee of the Medical Staff;

e. To recommend to the Board of Directors a Corrective Action and Due Process Procedure as outlined in Article XII of these Bylaws and to participate in the processes;

f. To implement and coordinate the activities and general policies of the Medical Staff, as set forth in these Medical Staff Bylaws, Rules and Regulations, and associated policies and procedures.

g. To designate committees to conduct the business of the Medical Staff and to receive and act upon committee reports;

h. To recommend to the Board of Directors a mechanism for reviewing the credentials of applicants for Medical Staff membership and for delineating individual clinical privileges and to periodically review and propose revisions to this process as necessary;

i. To review the report of the Credentials Committee on all applicants and to make recommendations to the Board of Directors for staff membership, including staff category, Service assignment, and delineation of Clinical Privileges;

j. To take all reasonable steps to maintain and enforce professionally ethical conduct and competent clinical performance by all members of the Medical Staff, participants in graduate or post graduate medical education training programs, APPs and AHPs;

k. To recommend to the Board of Directors a mechanism by which Medical Staff membership and/or clinical privileges may be terminated;

l. To provide consultation to the Board of Directors concerning removal of Officers or Representatives-at-Large of the Medical Staff, or Service Chiefs;

m. To review and approve Service policies and procedures as necessary and to provide a liaison between the Service Chiefs and the members of the Medical Staff;

n. To review and approve the requirements set by Service Chiefs for emergency services call and for coverage of clinical services, as applicable;

o. To provide a designee who will meet upon request with any practitioner on the Medical Staff regarding an impending issue of importance not included in Article XII. Corrective Action and Due Process, and to resolve conflicts related to this issue;

p. To provide recommendations to the Medical Staff concerning membership dues or application fees;

q. To schedule special meetings of the Medical Staff when presented with a valid petition from members of the Active Medical Staff that requires a discussion and/or a vote by the Medical Staff;

r. To establish a mechanism to organize, conduct, evaluate and revise the performance-improvement activities of the Medical Staff; and to ensure the participation of the Medical Staff in the performance-improvement activities of the greater hospital organization;

s. To coordinate activities related to the accreditation program of Our Children's House and to keep the Medical Staff informed of the requirements of the program and the accreditation status of Our Children's House;

t. To provide assistance and support to the Medical Staff, APPs and AHPs on health issues, and coordinate the evaluation and intervention if indicated by reports of impairment;

u. To perform duties in the Policies on Peer Review including FPPE and OPPE;

v. To conduct such other functions as are necessary for the effective operation of the Medical Staff; and

w. To report on the activities of the MEC and its subsidiary bodies and representatives at each meeting of the Medical Staff.

x. To oversee Professional Conduct to include evaluating reports of unprofessional conduct of a Member of the Medical Staff or other provider with Clinical Privileges and/or noncompliance in connection with the Medical Staff Bylaws, Rules and Regulations and policies and procedures and determining the appropriate disposition of any unprofessional conduct or noncompliance in accordance with the Medical Staff's Bylaws and policies.

y. Bylaws.

   i. To maintain the Medical Staff Bylaws, Rules and Regulations and Policies on an ongoing basis to reflect the current Medical Staff organization and function and compliance with regulatory and accrediting requirements;

   ii. To conduct a review of the Medical Staff Bylaws, Rules and Regulations and Policies at least yearly or more frequently as deemed necessary;

iii. To maintain current knowledge of legal and regulatory requirements pertinent to the Bylaws and other governance documents, and referring questions to Hospital legal counsel; and

iv. To draft revisions to the Medical Staff Bylaws and governance documents as necessary in accordance with the procedures in Article X.

z. Credentials

i. To coordinate the credentialing and privileging process for Practitioners in accordance with the Bylaws;

ii. To review the recommendations of the Service Chiefs regarding appointment, reappointment and/or Clinical Privileges;

iii. To make recommendations regarding appointment, reappointment and/or Clinical Privileges, including Staff category and Service assignment; and

iv. To make recommendations for criteria for Clinical Privileges, after consultation with the Service Chiefs

4. Meetings

a. Frequency – The MEC shall meet as often as necessary to fulfill its responsibility, but not less than quarterly. It shall maintain a permanent record of its proceedings and actions. Special meetings of the MEC may be called at any time by the Medical Staff President. Such special meetings must be preceded by prior written notification of at least seven (7) calendar days for all of those expected to attend.

b. Quorum – The quorum requirement for the MEC shall be fifty percent (50%) of the voting members of the Committee.

c. Attendance Requirements – Members of the MEC shall be required to attend at least seventy-five percent (75%) of the meetings in each calendar year. Failure to meet Attendance Requirements may result in removal from MEC membership.

Section C. Nominating Committee

1. Duties. The Nominating Committee shall solicit qualified and interested Members of the Medical staff as candidates for elected office, and review and document their qualifications and experience. If acceptable, the Nominating Committee shall nominate those Members for election as provided in the Bylaws.

2. Composition. The Nominating Committee shall be composed of the Medical Staff President as the Chair, Chief Medical Officer OCH and at least one other member as appointed by the Medical Executive Committee.

3. Meetings. The Nominating Committee shall meet as necessary to accomplish its duties.

Section D. Additional Committees and Responsibilities

1. Standing. Other standing committees of the Medical Staff or of the Medical Executive Committee may be established in writing by the Medical Executive Committee, subject to the approval of the Board of Directors, and shall not require amendment of these Bylaws.

2. Special and Ad Hoc. The Medical Executive Committee and/or its Chair have the authority to form special or ad hoc committees and task forces, including without limitation, a Joint Conference Committee as provided in Articles VII and X, to assist in the performance of authorized functions. Any such formation shall be reflected in writing with a statement of the purpose of the committee or task force and its duration and lines of reporting.

3. Reporting. Standing, special, and ad hoc committees shall report to the MEC unless otherwise provided in these Bylaws.

4. Attendance by the Hospital Administrator and Chief Medical Officer OCH. The Hospital Administrator and Chief Medical Officer OCH may attend any MEC or other Medical Staff committee meeting, whether standing, ad hoc, or special, including a meeting in executive session.

ARTICLE VIII. MEDICAL STAFF MEETINGS

Section A. Meetings of the full Medical Staff

1. Regular. Regular Medical Staff meetings shall be held on call of the MEC, with at least one meeting held before the end of the Medical Staff Year to allow for the election of Medical Staff officers in accordance with Article V and reports from retiring officers and standing Medical Staff committee chairs. At least 20 days prior written notice of the date, time and place of any regular Medical Staff meeting shall be sent to the voting Members of the Medical Staff**.** The agenda for the meeting shall be determined by the Medical Staff President, subject to any requirements in these Bylaws.

2. Special. Special called meetings of the Medical Staff shall be convened at the date, time and place designated by the MEC. Special called meetings shall also be convened within 20 calendar days of the request of the Medical Staff President or the Hospital Administrator or the written request of 25% of the voting Members of the Medical Staff. At least 7 days prior written notice of a special called meeting shall be given to the voting Members of the Medical Staff Members. The Medical Staff President shall preside at the meeting and the only business conducted at a special meeting is that stated in the notice for the meeting.

3. Committees

   Standing committees of the Medical Staff shall meet on a quarterly basis unless otherwise provided in Article VII. Ad hoc or special committees and task forces shall meet on call of the chair of the committee.

4. Attendance Requirements

a. Medical Staff. There shall be no attendance requirements for regular or special called Medical Staff meetings. However, Members are encouraged to attend at least 50% of the meetings. Pertinent information discussed at the Medical Staff meetings will be distributed to all Members via memorandum, newsletter, electronic transmission, or equivalent written format.

b. Committee. Active Staff Members are required to attend 50% of the meetings of committees of which they are a voting member.

5. Notice of Meetings

Notice of regular or special meetings shall be deemed delivered to the Practitioner on: (i) deposit with the U.S. mail, (ii) on facsimile, or (iii) on electronic transmission of the notice to the most current address on file with Medical Staff Services.

6. Quorum and Voting

a. Quorum. Unless these Bylaws provide otherwise, the personal presence of at least 25% of the voting Members shall constitute a quorum for all Service or Committee meetings.

b. Affirmative Vote. The affirmative vote of a majority of the Members present and voting at a meeting at which a quorum is present shall be required to take action, except as provided elsewhere in these Bylaws. Each Member present and eligible to vote shall be entitled to cast only one vote.

c. No Proxy or Absentee Ballots. If a Member is unable to attend a meeting, the Member may not send another person to attend and vote in the Member's place, nor may the Member vote by proxy. Absentee ballots are not permitted.

7. Mail/Electronic Ballots

a. General. Unless otherwise provided by the MEC or these Bylaws, any business of the Medical Staff, a Service, or a committee may be conducted by mail or electronic ballot. The mail/electronic ballot setting out the issue or matter requiring action shall be presented to the voting Members of the Medical Staff, Service, or committee as provided below.

b. Delivery. The mail/electronic ballot shall be deemed delivered on: (i) deposit in the U.S. mail, (ii) on facsimile, or (iii) on electronic transmission to the most current address on file with Medical Staff Services. Different forms of transmission may be used for the same mail/electronic ballot (i.e., some ballots sent by mail, some by electronic transmission).

c. Return. Mail/electronic ballots shall allow at least 20 days from the date of delivery for return. Affirmative action shall require the majority vote of those ballots returned. Return may be by mail, facsimile, electronic transmission, or hand delivery by the required date. Unless otherwise provided in these Bylaws, a mail/electronic ballot vote requires voting by at least 50% of the Members who are sent a ballot.

Section B. Minutes

Minutes of each regular or special meeting of the Medical Staff or a committee or Clinical Service shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. All Service and committee minutes are privileged and confidential Medical Peer Review Committees.

ARTICLE IX. MEDICAL STAFF MEMBER RIGHTS

Section A. Right to Meet with the MEC

Each practitioner on the Medical Staff shall have the right to meet with the MEC or its designee regarding an impending issue of importance that cannot be resolved at the appropriate Service level. In this circumstance, the practitioner may, upon presentation of a written request, meet with the MEC or its designee to review the issue and to refer the issue to the MEC for resolution. This section does not pertain to issues involving disciplinary action, denial of a request for appointment or clinical privileges, or any other matter relating to individual "credentialing" actions. Article XII Professional Evaluation and Corrective Action and Article XIII Procedural Rights of Review provide recourse in such matters.

Section B. Right to Initiate a Recall Election of a Medical Staff Officer or Representative-at-Large

Any practitioner on the Active Medical Staff shall have the right to initiate, by petition, a recall election of a Medical Staff Officer. Upon presentation to the Chair of the MEC of a valid petition signed by at least twenty-five percent (25%) of the members of the Active Medical Staff, the MEC shall schedule a special Medical Staff meeting for purposes of discussing the issue and holding a recall election.

Section C. Right to Initiate the Scheduling of a Meeting of the Medical Staff

Any practitioner on the Active Medical Staff shall have the right to initiate, by petition, the scheduling of a meeting of the Medical Staff. Upon presentation to the MEC of a valid petition signed by at least twenty-five percent (25%) of the members of the Active Medical Staff, the MEC shall schedule a meeting of the Medical Staff for the specific purpose addressed by the petition. No business other than that in the petition may be transacted.

Section D. Right to Due Process

Any practitioner on or applying for membership on the Medical Staff shall have the rights as set out in these Bylaws to a hearing, appeal and mediation as outlined in Article XIII of these Bylaws.

ARTICLE X. REVIEW, REVISION, ADOPTION, AND AMENDMENT OF THE MEDICAL STAFF BYLAWS, RULES AND REGULATIONS AND ASSOCIATED POLICIES

Section A. Medical Staff Responsibility

1. The Medical Staff shall have the responsibility to formulate, review at least biennially, and recommend to the Board of Directors, any amendments to these Bylaws. The Bylaws and any amendments thereto shall become effective when approved by the Board of Directors. The Medical Staff must exercise this responsibility regarding Bylaws by direct vote of its Active Staff members. Neither the Medical Staff nor the Board of Directors may unilaterally amend these Bylaws.

2. The Medical Staff may exercise its responsibility to formulate, review at least biennially, and recommend to the Board of Directors the Rules and Regulations, any associated policies and procedures, and any amendments thereto, through the MEC. The MEC will exercise this responsibility in good faith and in a reasonable, responsible, and timely manner.

Section B. Methods of Adoption and Amendment

1. Technical Amendments. Amendments that are strictly limited to correcting typographical or inadvertent errors or updating references in the Medical Staff Bylaws, such as titles of positions or names of policies, that do not involve a substantive change may be made by Medical Staff Services, with the approval of the Medical Staff President and the Hospital Administrator, without the necessity of compliance with the procedures in this Article.

2. Substantive Amendments.

    a. Proposed amendments to the Medical Staff Bylaws may be originated by the MEC on its own initiative or by a petition signed by twenty-five percent (25%) of the voting members of the Medical Staff. When are proposed by the MEC, there will be communication to the organized Medical Staff and the amendments shall be submitted to the Active Staff for vote via the process outlined in Section E below before they are voted upon by the MEC.-When revisions are proposed via a petition signed by twenty-five percent (25%) of the voting members of the Medical Staff, there will be communication of the proposed amendment to the MEC before they are voted upon by the voting members of the Medical Staff. If no amendments are proposed in any biennial period, the MEC shall certify to the Board of Directors that neither it, nor the Medical Staff have proposed any such amendments during such period.

    b. Proposed amendments to the Medical Staff Rules and Regulations may be originated by the MEC or by a petition signed by twenty-five percent (25%) of the voting members of the Medical Staff.

    c. When amendments to the Rules and Regulations are proposed by the MEC, they will be communicated to the Medical Staff before they are voted upon by the MEC. If there are no concerns or conflicts expressed by the voting members of the Medical Staff within fourteen (14) calendar days following the communication, the proposed amendments will

be presented to the Board of Directors for final approval. If there are conflicts or concerns expressed regarding the proposed amendments by the voting members of the Medical Staff during this period, the conflict resolution process outlined in this Article will be carried out. In cases of a documented need for an urgent amendment to the Rules and Regulations necessary to comply with law or regulation, the amendment process outlined in Section C below shall be applied.

d. When amendments to these Rules and Regulations are proposed by twenty-five percent (25%) of the voting members of the Medical Staff, they will be communicated to the MEC before they are presented to the Board of Directors for final approval. The MEC shall review the proposed amendments at their next regularly scheduled meeting and consider the proposal. If there are conflicts or concerns expressed by the MEC the conflict resolution process outlined in this Article will be carried out.

e. Any proposed amendments to these Bylaws, Rules and Regulations that are submitted to the voting members of the Medical Staff shall be distributed in writing, and voting members shall have a minimum of fourteen (14) calendar days to respond. Those who fail to respond are presumed to have cast an affirmative vote. At least 50% affirmative vote from the voting members of the Medical Staff is required before a proposal can be presented to the Board of Directors for final approval.

f. Acceptance of the amendment by the voting members of the Medical Staff shall constitute a recommendation of the amendment to the Board of Directors. The amendment shall become effective when approved by the Board of Directors and all proposed amendments to the Bylaws, Rules and Regulations and associated policies and procedures shall be communicated to all members of the Medical Staff.

3. Urgent Amendments.

a. In the event that the Hospital becomes aware of the need to amend the Bylaws and Rules and Regulations in order to comply with law or regulation, as delegated by the voting members to do so, the MEC shall have the authority to provisionally adopt, and the Board of Directors may provisionally approve the urgent amendments without prior communication to the Medical Staff.

b. In such case, the MEC shall immediately notify the Medical Staff of such amendment.

c. The voting members of the Medical Staff shall have a minimum of fourteen (14) days to retrospectively review and comment on the provisional amendment.

d. If there is no conflict between the voting members of the Medical staff and the MEC, the provisional amendment will remain in effect. If there is conflict regarding the provisional amendment, the process for resolving conflict as outlined in this Article will be applied.

Section C. Conflict Management

A conflict management process will be initiated to address any disagreement or conflict between the Board of Directors and the MEC or between the Medical Staff and the MEC relating to Medical

Staff governing documents or functions, including, but not limited to, a proposal to adopt or amend the Medical Staff Bylaws, Rules and Regulations, and/or policies, or a proposal to remove some authority delegated to the Medical Executive Committee by the Medical Staff under these Bylaws (by amending the Bylaws) using the mechanisms noted below:

1. A member of the Medical Staff that is eligible to vote may express concerns regarding a bylaw, rule or policy established by the MEC or the authority delegated to the MEC through the following process:

   a. Submission of a written notification or inquiry to the President of the Medical Staff of the concern including any recommended changes to the bylaws, rule, policy or delegated authority.

   b. The concern shall be reviewed and discussed at the next regularly scheduled MEC meeting to determine if any changes will be made to the bylaw, rule, policy or delegated authority. The MEC has the option to appoint an ad hoc committee if needed to review the inquiry and recommend options to address the concerns.

   c. The Medical Staff member submitting the concern may be asked by the MEC or the appointed ad-hoc committee to appear before the committee and/or submit additional written statements for consideration.

   d. If revisions are made based on the concerns, the revision will be communicated back to the Medical Staff member who submitted the inquiry and he or she will have until the next regularly scheduled MEC meeting to respond to the proposed revisions.

   e. Once the MEC has taken final action in response to the inquiry, the communication and adoption process as outlined in Article X. – Section B above, will be followed.

   Not Applicable to Individual Peer Review. This provision shall <u>not</u> apply to Medical Peer Review decisions regarding individual Practitioners, including but not limited to those pertaining to appointment, reappointment, Clinical Privileges, or Corrective Action.

2. If twenty-five percent (25%) of the voting members of the Medical Staff recommend directly to the Board of Directors an amendment to the Bylaws, Rules and Regulations, or associated policies and procedures or a change to the authority delegated to the MEC that is different from what has been recommended by the MEC, the following conflict resolution process shall be followed:

   a. The MEC shall have the option of appointing an ad hoc committee to review the differing recommendations of the MEC and the voting members of the Medical Staff and recommend language or a change to the authority delegated to the MEC that is agreeable to both the voting members of the Medical Staff and the MEC.

   b. Whether or not the MEC adopts modified language, the voting members of the Medical Staff shall still have the opportunity to recommend alternative language directly to the Board of Directors.

c. If the Board of Directors receives differing recommended proposals from the MEC and the voting members of the Medical Staff, the Board of Directors will have the option of appointing a task force of the Board of Directors and/or using external resources to study the basis of the differing recommendations and to recommend appropriate Board of Directors action.

d. The Board of Directors has the final authority to resolve the differences between the Medical Staff and the MEC, subject to the requirement that both the Board of Directors and the Medical Staff must approve any amendments to these Bylaws.

Section D. Medical Staff Governance Documents

1. Authority; Medical Staff Bylaws Control.

   a. General. The Medical Staff shall adopt, using the procedures below, Rules and Regulations and Policies as may be necessary to implement the processes and requirements set out in these Bylaws. The Rules and Regulations and Policies shall be reviewed periodically to ensure compliance with legal and accreditation requirements and current Medical Staff practice.

   b. Bylaws Control. Any documents adopted pursuant to this Article shall be subject to and governed by these Bylaws. The definitions in these Bylaws shall be applicable to the Rules and Regulations, and Policies although such documents may include additional definitions. In the event of a conflict between the Rules and Regulations and/or Policies and the Medical Staff Bylaws, these Bylaws shall control.

2. Adoption and Amendment of Medical Staff Policies.

   a. Adoption or amendment of a Medical Staff Policy may be accomplished:

      i. On the affirmative vote of a majority of the members of the MEC at a regular or special meeting of the MEC at which a quorum is present; or

      ii. By the Medical Staff using the procedures in Section B above.

   b. On approval or adoption of a Policy by the MEC, notice of the Policy shall be provided to the Medical Staff. The conflict management process in Section E shall be implemented on submission of a written petition, disagreeing with the policy, signed by at least 25% of the voting Members of the Medical Staff within 10 days of the provision of notice of the Policy to the Medical Staff.

3. Approval by Board of Directors.

   The Rules and Regulations and any amendments thereto, shall be effective only on approval by the Board of Directors. Policies shall be effective on approval by the Medical Staff or the MEC in accordance with the procedures in Section B; provided that, Policies dealing with Medical Peer Review activities shall require approval by the Board of Directors and not be effective until so approved.

4. Notices to Medical Staff. Any notices to the Medical Staff required by this Article X shall be deemed delivered to the Practitioner on: (i) deposit with the U.S. mail, (ii) on facsimile, or (iii) on electronic transmission of the notice to the most current address on file with Medical Staff Services.

5. Prohibition on Unilateral Amendment. Except as noted under Section B for certain Medical Staff Policies, neither the Medical Staff, the Medical Executive Committee, nor the Board of Directors may unilaterally adopt or amend the Rules and Regulations.

6. Adoption and Effective Date.

These Bylaws and any amendments pursuant to this Article shall become effective only upon the date of approval by the Board of Directors. The Bylaws and any amendments shall replace and supersede all previous Medical Staff bylaws and be upheld by the Board of Directors. The Medical Staff, individual Members of the Medical Staff, and applicants for Medical Staff membership and/or Clinical Privileges shall comply with and enforce the Medical Staff Bylaws, which shall be distributed to or made available to Members and applicants.

ARTICLE XI. CONFIDENTIALITY AND MEDICAL PEER REVIEW, IMMUNITY AND CONFLICT OF INTEREST

1. Confidentiality and Medical Peer Review.

   a. Authorization. Each committee (whether Medical Staff, Service, standing, special, subcommittee, or joint) and each Service, as well as the Medical Staff when meeting as a whole, shall be established and operate as a "medical peer review committee," "medical committee," and "professional review body," as such terms are defined by state and federal law, and is authorized by the Board of Directors through these bylaws to engage in medical peer review. Specific policies and procedures for the accomplishment of its charge may be developed and established by a committee or Service, subject to the approval of the MEC and the Board of Directors.

   b. Privilege and Confidentiality. All records and proceedings of the Medical Staff, the MEC, the Services, and any committees (whether standing, special, ad hoc, subcommittees, joint committees, or task forces, including a Hearing Committee or Appellate Review Panel under Articles VII and/or XII) thereof, and the Board of Directors, including but not limited to any minutes of meetings, disclosures, discussion, statements, actions, or recommendations in the course of medical peer review, shall be privileged and confidential. They shall be subject to disclosure only in accordance with written Hospital policies, unless otherwise required by Texas and/or federal law, and shall be privileged to the fullest extent permitted by Texas and federal law.

   c. Obligation to Maintain Confidentiality. All Staff Members and other providers holding Clinical Privileges, as well as those applying for such status, and all other individuals participating in, providing information to, or attending meetings of a medical peer review committee are required to maintain the records and proceedings related to any medical peer review activities as confidential, subject to disclosure only in accordance with Hospital policies, unless otherwise required by Texas and/or federal law.

d. Waiver. Waiver of the privilege of confidentiality as to the records and proceedings of those listed in this Article shall require the written consent of the Chair of the committee, Service, or Medical Staff President and the Hospital Administrator.

e. Minutes. Minutes of all meetings of those listed in this Article, except for the Board of Directors, shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer of the meeting and forwarded to the MEC.

f. Maintenance and Access. All minutes subject to this Article will be maintained by the Hospital as records and proceedings of a "medical peer review committee," "medical committee," and "professional review body," as such terms are defined under Texas and/or federal law, in a confidential manner to provide maximum protection under the law. They are the property of the Hospital and, except for Board of Directors minutes, are maintained by Medical Staff Services.

   i. They will be available for inspection by the MEC, the Hospital Administrator, the JPE Chief Medical Officer, the Chief Medical Officer OCH, the Board of Directors, and any employees and agents of the Hospital whose authorized functions necessitate access.

   ii. A Service Chief, and committee members, may also inspect the records and proceedings of their committee, which were generated during their service as members, as long as the member is currently a Member of the Medical Staff.

   iii. Access is also permitted pursuant to Hospital policy and as required by Texas and/or federal law, accreditation requirements, or third party contract of the Hospital.

   iv. Access of a Practitioner to records and proceedings shall be only as required by law, written Policy, or as approved by the Hospital Administrator.

2. Immunity from Liability.

a. Immunity. The Medical Staff and its Members, the Board of Directors, the Hospital, and any committees, representatives, agents, employees, or members thereof, and third parties as defined below, will have immunity to the fullest extent permitted by Texas and/or federal law and shall include any immunity for any permissive and mandatory reporting provided for by Texas and/or federal law.

b. Third Parties. The reference above to third parties shall mean all individuals and entities, including without limitation their representatives, Medical Staff, directors, officers, and employees, who provide information, whether orally or in writing, to the Hospital and/or the Medical Staff, concerning any matter that might directly or indirectly affect a Member, Practitioner or provider's exercise of Clinical Privileges or Medical Staff membership, or relating to the Member, Practitioner or provider's qualifications for appointment or reappointment to the Medical Staff or practice at the Hospital.

c. Authorization and Release of Liability. All applicants for appointment to the Medical Staff, reappointment, and/or Clinical Privileges shall execute a release of liability consistent with the immunity and release of liability provisions in these Bylaws and an authorization for the Hospital, the Medical Staff, and third parties to disclose confidential information as necessary for Medical Peer Review in the course of application and at all times thereafter. The effectiveness of the immunity provisions of these Bylaws, however, is not contingent on execution of these authorizations and releases. The immunity provisions in these Bylaws and any releases of liability shall be in addition to and not in limitation of any immunity afforded by Texas and/or federal law.

3. Mandatory Reporting and Investigation.

Duty. The Hospital Administrator, in consultation with the Medical Staff President and the Chief Medical Officer OCH, shall be responsible to comply with any mandatory reporting requirements of the Hospital under Texas and/or federal law pertaining to Medical Staff membership and/or Clinical Privileges, and under Articles III and XIII of the Bylaws. Nothing in this section or the other provisions of the Bylaws shall prevent an individual Member or member of the Board of Directors from making any other report to Texas and/or federal agencies as permitted or required by law.

4. Conflict of Interest.

a. Disclosure. Whenever a Practitioner is participating in Medical Peer Review and/or performing a function for the Medical Staff, the MEC or a Service, or a committee thereof, or the Hospital, and the Practitioner's personal or professional interests could be reasonably interpreted as being in conflict with the interests of the Medical Staff, MEC, Service, or other committee, Hospital, or individual under review, the Practitioner shall disclose those interests and the potential for conflict to the appropriate decision makers prior to such participation. The Service Chief or applicable committee Chair may require the Practitioner to refrain from any participation in decisions that may be affected by or affect the Practitioner's interests.

b. Individual Peer Review. A Practitioner shall not be eligible to participate in, or be present during, any meeting, discussion, or deliberation of the MEC, a Service, or committee or task force of which he is a member regarding his Clinical Privileges or Medical Staff membership or any other Medical Peer Review activity involving the Practitioner, except to the extent specifically provided for in these Bylaws, Rules and Regulations, or Policy, or when invited by the Service Chief or applicable committee Chair.

c. Involvement of Family or Business Partners. Any family members or business partners of a Practitioner shall not be eligible to participate in, or be present during, any meeting, discussion, or deliberation of the MEC, a Service, or committee or task force regarding the Practitioner's Clinical Privileges or Medical Staff membership or any other medical peer review activity involving the Practitioner. "Family member" shall mean a Practitioner's: (i) parents or stepparents, including spouses of the same, (ii) ancestors, (iii) spouse, (iv) child or stepchild, grandchild, or great grandchildren, (v) siblings, whether related by whole

or half blood, or (vi) the spouse of an individual described in clause (iv) or clause (v), and shall include adoptive relationships of the above.

d. Hospital. These provisions shall be in addition to any requirements of the Hospital's conflict of interest policies.

ARTICLE XII. PROFESSIONAL PRACTICE EVALUATION AND CORRECTIVE ACTION

Section A. Professional Practice Evaluation

1. Professional practice evaluation, as a part of Peer Review, specifically to include but not be limited to medical peer review and professional review activity, is conducted on an ongoing basis in accordance with written Medical Staff policy, with primary responsibility for implementation of Our Children's House quality and patient safety program and plan pertinent to the Medical Staff and others with clinical privileges placed on the MEC, Service Chiefs, and appropriate Medical Staff Committees. In addition to ongoing professional practice evaluation (OPPE), verification of competence for initially granted clinical privileges and reported concerns regarding the professional competence or conduct of a Practitioner are evaluated through focused professional practice evaluation (FPPE) in accordance written Medical Staff policy.

2. Focused professional practice evaluation and performance improvement programs for an individual Practitioner with existing clinical privileges are intended to be implemented on a voluntary and collegial basis to the fullest extent possible. If necessary changes cannot be implemented on a voluntary and collegial basis, matters may be referred for corrective action as set forth below.

3. Information generated pursuant to the ongoing and focused professional practice evaluation processes is also used in the reappointment process.

Section B. Corrective Action

1. Grounds – Initiation: Whenever a Practitioner's action or failure to act: (i) is in violation of accepted standards of professional practice, (ii) is disruptive or unprofessional, (iii) is in violation of these Bylaws, the Rules and Regulations, or policies of the Medical Staff or the Hospital, or (iv) is in any manner disruptive to the Hospital or to the care of patients, any Member of the Medical Staff, the Hospital Administrator, or the chairman of the Board of Directors may request corrective action. All requests for corrective action shall be in writing, submitted to the MEC and shall specify the conduct constituting the basis for the request.

2. Investigation:

   a. Within thirty (30) calendar days of receipt of a request for corrective action, the MEC shall determine whether to: (i) initiate a corrective action investigation, (ii) refer the request for handling in another manner, or (iii) dismiss the request. If the MEC decides to conduct a corrective action investigation, it shall be so noted in the MEC minutes. The MEC may conduct the investigation itself or through an ad hoc committee or subcommittee of the

MEC, or delegate this responsibility to an appropriate standing committee, as it deems necessary ("Investigating Committee").

b. The investigation may include interviews with the requester, the affected Practitioner, or other persons. Such review may include, at the Investigating Committee's discretion, a review of pertinent medical records, policies and procedures, Peer Review records, clinical literature and practice guidelines, or any other documents. If it deems necessary, the Investigating Committee may, subject to the approval of the Hospital Administrator, utilize individuals not employed by or on the Medical Staff to assist in the investigation including, but not limited to, an external consultant. The Investigating Committee may also require the Practitioner under review to undergo a physical and/or mental examination, to the extent permitted by law, and may require access to the results of such exams to assist in its deliberation.

c. During an investigation, the Practitioner under review shall be granted the opportunity to meet with the Investigating Committee. The Investigating Committee shall determine the date(s), frequency, and duration of any such meeting(s).

d. If the request for corrective action is the result of a review of essentially the same acts or omissions by a standing committee, which review afforded the Practitioner an opportunity to meet with the committee and address the issues, the MEC may decide that the results of the review may be used as the investigation under this section and that no further investigation is required.

e. Neither the investigation nor any other activities of the Investigating Committee, including any meeting(s) with the affected Practitioner or any other person, in acting upon a request for corrective action, shall constitute a hearing and none of the procedural rights of review in this Article shall apply.

f. If the investigation is delegated to a committee other than the MEC, such committee shall proceed with the investigation in a prompt manner and shall forward a written report of its findings, conclusions, and recommendations to the MEC as soon as possible.

g. The Practitioner under review shall be notified, in writing by hand delivery or certified mail, return receipt requested by the MEC, that an investigation for purposes of possible corrective action has been initiated within five (5) calendar days of such action, and shall be given an opportunity to provide information in a manner and upon such terms as the Investigating Committee deems appropriate. The Practitioner shall not have the right to be represented by legal counsel before the Investigating Committee nor to compel the Medical Staff to engage external consultation.

h. Despite the status of any investigation, at all times the MEC shall retain authority and discretion to take whatever action may be warranted by the circumstances, and permitted under these Bylaws, including suspension, termination of the investigative process, or other action.

3. Time for Taking Action – Notice: Within thirty (30) calendar days of completion of the investigation, or within such reasonable additional time as the MEC deems necessary, the MEC

shall take action upon the request for Corrective Action. Within five (5) calendar days after taking such action, the MEC shall give written notice to the affected Practitioner stating the actions the MEC has taken or recommended.

4. Possible Actions: The action of the MEC on a request for corrective action may be to reject the request, recommend a voluntary performance improvement plan or other collegial intervention, or recommend any of the following corrective actions:

   a. A letter of warning or reprimand;

   b. Additional education or training;

   c. Probation;

   d. Proctoring, including observation, use of a physician first assistant, co-admitting requirements, or consultation;

   e. Reduction, suspension, or revocation of clinical privileges;

   f. Termination, modification or affirmation of an already imposed summary suspension or restriction of clinical privileges;

   g. Suspension or revocation of the Practitioner's Medical Staff membership; or

   h. Other corrective actions deemed appropriate by the MEC.

5. If the action of the MEC is an Adverse Action, all further procedures shall be as set forth in Article XIII, Procedural Rights of Review. In no event shall a Practitioner be entitled to the procedural rights of review in Article XIII unless the action taken by the MEC is an action defined as a ground for mediation or hearing under Article XIII. Any MEC recommendation or action that does not give the Practitioner procedural rights of review under Article XIII may be implemented by the MEC and shall be effective as of the date and time determined by the MEC. The MEC's recommendation or action will be forwarded to the Board of Directors for review at its next regularly scheduled meeting.

   a. If the Board of Directors affirms the action or recommendation of the MEC, it shall be the final decision and the Hospital Administrator shall provide the Practitioner with notice of the final decision, including a statement of the basis for the decision, within twenty (20) days of the decision. The notice shall be in writing and sent by hand delivery or certified mail, return receipt requested.

   b. If the Board of Directors modifies or reverses the MEC's recommendation or action which results in an Adverse Action, the Practitioner shall be entitled to the procedural rights of review under Article XIII, and any further procedures shall be as set forth in Article XIII.

6. The affected Practitioner may submit a written response to any action taken by the MEC in addition to any procedural rights to which the Practitioner may be entitled under Article XIII, which response shall be maintained in the Practitioner's file.

7. Notice to the Hospital Administrator: The Chair of the MEC shall immediately notify the Hospital Administrator in writing of each request for corrective action and shall keep him fully informed of all actions in connection with each request.

Section C. Summary Suspension or Restriction

1. Grounds – Authority. All or any portion of a Practitioner's clinical privileges may be summarily suspended or restricted if failure to take such an action may result in an imminent danger to the health and/or safety of any individual. Each of the following persons have the authority to summarily suspend or restrict a Practitioner's clinical privileges:

   a. Medical Staff President

   b. Chief Medical Officer OCH

   c. Hospital Administrator

2. Summary action pursuant to this Section shall be reported immediately to the MEC and shall be temporary and effective only until further action is taken by the MEC. The individual imposing the summary action shall promptly give oral notice of action taken, including the reason for the action, to the affected Practitioner, and each of the other individuals listed under Article XII. The Hospital Administrator shall give the Practitioner written notice of the summary action, with a statement of the reason for the action, within twenty-four (24) hours of imposition, by Special Notice.

3. The MEC, before taking further action, shall conduct such investigation as it deems necessary or delegate this responsibility to an appropriate standing or ad hoc committee, which may include an interview with the suspending party. The affected Practitioner shall be afforded an opportunity to meet with the MEC or committee conducting the investigation. Such investigation may include chart reviews, if applicable, and interviews with other reports from other persons or relevant services or committees. Neither the investigation nor any other activities of the MEC in taking its further action shall constitute a hearing, nor shall the procedural rights of review provided in Article XIII and process with respect to hearings, appeals and mediation apply.

4. The MEC must review the summary action and the results of any investigation within ten (10) calendar days of imposition of the summary action and recommend modification, continuance, or termination of the terms of the summary action. If, as a result of such investigation, the MEC does not recommend the termination of the summary action and the action is an Adverse Action under Section B of Article XIII, the Practitioner shall be entitled to the procedural rights of review in accordance with Article XIII and all further procedures shall be as set forth in Article XIII. Additionally, the terms of the summary action as sustained or as modified by the MEC shall remain in effect pending a final decision thereon by the Board of Directors. For purposes of mandatory reporting under the federal Health Care Quality Improvement Act, a summary action, although taken in the course of Peer Review, is considered a "professional review action" when affirmed by the MEC.

5. Immediately upon the imposition of a summary action, the Chair of the MEC or the appropriate Service Chief shall have authority to assist the Practitioner's patients in the hospital at the time of the summary action to secure alternative medical coverage.

Section D. Temporary Suspension or Restriction

1. The same individuals who are authorized to impose a summary action under Section C above may impose a temporary suspension or restriction of a Practitioner's clinical privileges for a period not to exceed fourteen (14) calendar days, during which an investigation is being conducted to determine the need for corrective action.

2. Temporary action pursuant to this Section shall be reported immediately to the MEC and shall be temporary and effective only until further action is taken by the MEC or expiration of the fourteen (14) calendar days, whichever occurs first. The individual imposing the temporary action shall promptly give oral notice of the action taken to the affected Practitioner, and each of the other individuals authorized to take the action. The Hospital Administrator shall give the Practitioner written notice of the temporary action, with a statement of the reason for the action, within twenty-four (24) hours of imposition by hand delivery or certified mail, return receipt requested.

3. Temporary action under this Section is taken in the course of Peer Review but is not considered corrective action and does not entitle the Practitioner to any procedural rights of review under Article XIII, the Bylaws or otherwise.

Section E. Voluntary Agreement

A Practitioner may voluntarily agree not to exercise any or all of his clinical privileges at Our Children's House, or to a condition on those privileges, for a specified or unlimited period of time pending a review, an investigation, or the exercise of procedural rights of review under Article XIII. While taken in the course of Peer Review, a voluntary agreement shall not constitute a surrender of clinical privileges or corrective action. The agreement shall be in writing and shall allow the Practitioner to terminate the agreement on written prior notice to the Hospital Administrator under the terms set out in the agreement.

Section F. Automatic Action

1. No Hearing. Automatic Action imposed under this Section, while taken in the course of medical peer review and professional review activity, is not considered corrective action and does not entitle the Practitioner to the procedural rights of review under Article XIII.

2. Grounds. Appointment to the Medical Staff and/or all clinical privileges shall be automatically suspended, terminated or relinquished, as outlined specifically within each section below, upon the occurrence of any of the following events:
   a. Licensure. Upon receipt by Our Children's House of notice that a Practitioner's license to practice in Texas is revoked, not renewed, restricted, suspended, or voluntarily relinquished to the licensing agency, the Practitioner's Staff membership and clinical privileges at Our Children's House shall automatically terminate. If a Practitioner's license to practice in Texas is made subject to probationary terms by the licensing agency, the Practitioner's

Staff membership and clinical privileges shall automatically become subject to the terms of probation.

b. Drugs/Medication. An automatic suspension of a Practitioner's privileges to prescribe, administer, or obtain controlled substances and/or other medications at or through Our Children's House shall be immediately imposed upon receipt by Our Children's House of notice that such Practitioner's right or license to prescribe or obtain controlled substances or medications has been suspended, revoked, or otherwise restricted by the applicable governmental agency. Such automatic suspension shall include only those controlled substances or medications suspended or revoked by the governmental agency and shall be effective until the governmental agency reinstates the Practitioner's right or license in question. If a Practitioner's right or license to prescribe or obtain controlled substances or medications is subject to an order of probation, the Practitioner's privileges to prescribe or obtain controlled substances or other medications at or through Our Children's House shall automatically become subject to the terms of the probation effective upon and for at least the term of the probation. A Practitioner shall not be permitted to prescribe medications under Our Children's House DEA number.

c. Loss of Professional Liability Insurance. If a Practitioner fails to maintain professional liability insurance coverage in an amount not less than $200,000 per occurrence and $600,000 in aggregate as required by the Bylaws or fails to provide evidence of such coverage, the Practitioner's Staff membership and clinical privileges, shall be automatically suspended and shall remain so until the Practitioner provides evidence to the Medical Staff Office that he/she has secured the required professional liability coverage**,** to include coverage for any period of lapse in coverage. Failure to provide such evidence within ninety (90) calendar days after the date the automatic suspension became effective shall be deemed a voluntary relinquishment of Medical Staff membership and clinical privileges.

d. Immunizations. A Practitioner who fails to submit the required immunization documentation within the time frame set forth in the Medical Staff credentialing policies shall have his/her clinical privileges automatically suspended. With the exception of seasonal influenza vaccinations, failure to submit the required immunization documentation within ninety (90) calendar days after the date the automatic suspension became effective shall be deemed a voluntary relinquishment of Medical Staff membership and clinical privileges.

e. Medical Records. A Practitioner who is delinquent in completing medical records shall have his/her clinical privileges automatically suspended, until the deficiency is cured. Such suspension shall be in accordance with the Rules and Regulations of the Medical Staff. Failure to complete delinquent records within ninety (90) calendar days after the date the automatic suspension became effective shall be deemed a voluntary relinquishment of Medical Staff membership and clinical privileges.

f. Required Education Documentation. When an educational training requirement is implemented as a requirement for all Medical Staff members or all members in a certain specialty or subspecialty, Practitioners who fail to comply after the expiration of the time

specified in the written notice shall have their clinical privileges automatically suspended on expiration of the time period. Failure to provide documentation of compliance with the requirement within ninety (90) calendar days after the date the automatic suspension became effective shall be deemed a voluntary relinquishment of Medical Staff membership and clinical privileges.

g. Omission, Misstatement or Misrepresentation on Application. Failure to provide accurate and complete information on an application or documentation supporting an application for Medical Staff membership and/or clinical privileges, resulting in a material omission, misstatement or misrepresentation the Practitioner, including but not limited to credentialing documentation, or other hospital related communications, will result in the Practitioner's Medical Staff membership and clinical privileges being automatically terminated or, if the application is pending, automatic withdrawal from further processing.

3. The imposition of automatic action does not preclude the imposition of corrective action on the same or similar grounds.

ARTICLE XIII. Procedural Rights of Review

Section A. General

A Practitioner is entitled to the procedural rights of review as set out in this Article whenever the MEC takes an Adverse Action or the Board of Directors takes an Adverse Action following a recommendation by the MEC that was not an Adverse Action.

Section B. Adverse Action Defined and Notice to Practitioner

1. Adverse Action. Only the following actions or recommendations, when taken by the MEC, or by the Board of Directors following a recommendation by the MEC that was not an Adverse Action, constitute an Adverse Action and entitle a Practitioner to the procedural rights of review in this Article:

   a. Denial of Medical Staff appointment or reappointment;

   b. Revocation or termination of Medical Staff appointment;

   c. Denial of requested Clinical Privileges;

   d. Revocation or termination of Clinical Privileges;

   e. Requirement and assignment of a proctor or supervisor based on an assessment of the Practitioner's professional competence or conduct in which the proctor's or supervisor's approval is required for the Practitioner to exercise clinical privileges;

   f. Suspension of Medical Staff appointment or clinical privileges, other than a temporary action pursuant to Article XII;

   g. Requirement to have a concurring consultation prior to exercising clinical privileges; or

h. Requirement to obtain education, training, or counseling prior to exercising clinical privileges.

i. Any other restriction or limitation of Clinical Privileges based on competence or professional conduct if such action, when final, would be reportable to the National Practitioner Data Bank.

2. Not Grounds for Procedural Rights of Review. The following are not considered an Adverse Action, nor any other actions or recommendations so specified in these Bylaws, and do not entitle the Practitioner to the procedural rights of review set forth in these Bylaws:

a. Issuance of a letter of guidance, warning, or reprimand, placement under a FPPE, or probation;

b. Resignation of Staff membership or clinical privileges;

c. Determination that an application will not be processed due to a misrepresentation, misstatement or omission; or

d. A determination by the Board of Directors that certain professional services shall be provided on an exclusive basis in accordance with written agreements between Our Children's House and qualified practitioners, limiting the availability of clinical privileges in those areas.

e. A voluntary performance improvement plan or placement on probation that is not accompanied by any limitation or restriction on the Practitioner's Clinical Privileges;

f. Imposition of proctoring, monitoring or any other performance improvement requirements in the course of FPPE on an initial grant of Clinical Privileges;

g. Any limitation or restriction of Clinical Privileges imposed equally on all Practitioners with the same or similar Clinical Privileges;

h. Imposition of conditions, monitoring or a consultation requirement that the Practitioner must comply with, but that does not require any approval or concurrence prior to the Practitioner's exercise of Clinical Privileges;

i. Imposition of a requirement to verify required health status through requested assessment or testing, or for treatment or counseling that may be satisfied while the Practitioner continues to exercise Clinical Privileges;

j. Retrospective chart review, conducting a review or Investigation into any matter, or a requirement to appear for a special meeting under the provisions of these Bylaws;

k. Any automatic action under Article XII, automatic relinquishment of Clinical Privileges, or automatic resignation from the Medical Staff provided for in these Bylaws;

l. Imposition of a temporary action under Article XII;

m. Imposition of a summary Corrective Action except as provided in Article XII;

n. Denial of a request for leave of absence or for an extension of a leave of absence;

o. A voluntary surrender or relinquishment of Clinical Privileges by the Practitioner, including voluntary acceptance of a limitation on Clinical Privileges, while under an Investigation or to avoid such an Investigation or a professional review action;

p. Failure to process an application for Medical Staff appointment and/or Clinical Privileges due to a determination (i) that the application is not a Complete Application, or (ii) that the Practitioner is not eligible due to a failure to meet minimum or threshold criteria or requirements, a lack of need or resources, closure of a specialty, or because of an exclusive professional services arrangement;

q. Denial of a requested change in Staff category or reassignment of Staff category at the time of reappointment due to failure to meet threshold eligibility requirements as provided in Article III;

r. Failure to grant, termination or limitation of temporary Clinical Privileges; and

3. Notice of Recommendation. When an Adverse Action is taken or recommended by the MEC, or by the Board of Directors following a recommendation or action by the MEC which was not an Adverse Action, the Practitioner shall be entitled to request a hearing and the other procedural rights of review in this Article prior to a final decision of the Board of Directors. The affected Practitioner shall be given Special Notice by the Hospital Administrator within five (5) calendar days of issuance of the Adverse Action. This notice shall contain:

   a. A statement of the nature of and reasons for the Adverse Action, including a statement of the alleged acts or omissions and subject matter forming the basis of the action with a list, if applicable, of specific patient records;

   b. A notice that the Practitioner has the right to request a hearing on the Adverse Action within thirty (30) calendar days of receipt of such notice;

   c. Notice that failure to request a hearing within the time frame and in the manner required shall result in a waiver of the right to a hearing and any other procedural rights of review under these Bylaws or otherwise; and

   d. A copy of this Article and a summary of the Practitioner's rights during the hearing.

Section C. Request for Hearing and Waiver

1. The request for a hearing shall be made in writing, by hand delivery or certified mail, return receipt requested, to the Hospital Administrator within thirty (30) calendar days of the Practitioner's receipt of notice of the Adverse Action.

2. In the event the Practitioner does not request a hearing within the timeframe and in the manner required by this Article, the Practitioner shall be deemed to have waived the right to such

hearing and any other procedural rights of review under these Bylaws and otherwise, and to have accepted the Adverse Action. Such Adverse Action, if taken by the MEC, shall become effective immediately pending a final decision by the Board of Directors. The Hospital Administrator shall provide the Practitioner with Special Notice of the Board of Directors final decision within twenty (20) calendar days of the final decision.

3. Notice of Hearing and Statement of Reasons. If a hearing is properly requested, the Hospital Administrator shall schedule the hearing and shall give Special Notice to the Practitioner who requested the hearing. The notice shall include:

   a. The time, place, and date of the hearing;

   b. A proposed list of witnesses who will give testimony or evidence in support of the Adverse Action at the hearing, to include the witnesses' titles/positions and a brief summary of the nature of the expected testimony);

   c. The names of the Hearing Panel members and chair;

   d. A list of patient records and/or information supporting the Adverse Action (this list of supporting patient record numbers and other supporting information may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the Adverse Action, and the Practitioner has sufficient time to study this additional information and rebut it); and

   e. Notice to the Practitioner of the obligation to provide a list of witnesses and exchange hearing documents as provided below.

   f. The hearing shall begin as soon as practicable, but no sooner than thirty (30) calendar days after the notice of hearing to the Practitioner unless an earlier hearing date has been specifically agreed to in writing by the parties. Once commenced, the hearing must be completed within sixty (60) calendar days, unless rescheduled upon written agreement of the parties or upon a showing of good cause, as determined by the Presiding Officer/Hearing Panel chair of the hearing.

4. Witness List. At least fifteen (15) calendar days before the hearing, the Practitioner requesting the hearing shall provide a written list of the witnesses that the Practitioner intends to present, as well as the titles/positions of the witnesses and a brief summary of the nature of the anticipated testimony.

5. Supplementation of Witness List. The witness list of either party may, in the discretion of the Presiding Officer/Hearing Panel chair, be supplemented or amended at any time prior to or during the course of the hearing, provided that written notice of the change is given to the other party and the other party is afforded time to prepare for the additional witness. The Presiding Officer/Hearing Panel chair shall have the authority to limit the number of witnesses.

6. The MEC or Board of Directors, whichever issued the Adverse Action, shall appoint one or more individuals to represent it at the hearing. The Hospital Administrator may appoint legal

counsel to accompany that individual or individuals in the hearing, which may be legal counsel for the Hospital.

Section D. Hearing Panel and Presiding Officer

1. Hearing Panel

   a. When a hearing is requested, the Hospital Administrator, after considering the recommendations of the Medical Staff President (and that of the chair of the Board of Directors, if the hearing is occasioned by a Board of Directors determination), shall appoint a Hearing Panel that shall be composed of not less than three (3) members, one of whom shall be designated as the chair. No individual appointed to the Hearing Panel shall have actively participated in the consideration of the matter involved at any previous level. Individuals who are not on the Medical Staff may be members of the Hearing Panel. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel. The Hospital Administrator shall provide the affected Practitioner with written notice of the identity and specialty of the Hearing Panel members at least thirty (30) calendar days prior to the date of the hearing.

   b. The Hearing Panel shall not include any individual who is in direct economic competition with the affected Practitioner or any individual who is professionally associated with or related to the affected Practitioner.

   c. Any objection to any member of the Hearing Panel shall be made in writing within ten (10) calendar days of issuance of notice of same. Such written objection shall be delivered to the Hospital Administrator who shall resolve the objection in his/her sole discretion, unless delegated to the Presiding Officer appointed under Section 2 below.

2. Presiding Officer

   a. The Hospital Administrator may appoint an attorney as Presiding Officer. Such Presiding Officer will not act as a prosecuting officer or as an advocate for either side at the hearing. The Presiding Officer may participate in the private deliberations of the Hearing Panel and is a legal advisor to it but shall not be entitled to vote on its recommendations. The Hospital Administrator shall provide the Practitioner with Special Notice of the identity of the Presiding Officer at least twenty (20) calendar days prior to the date of the hearing. Any objection to the Presiding Officer shall be made in writing within ten (10) calendar days of issuance of notice of same. Such written objection shall be delivered to the Hospital Administrator who shall resolve the objection in his/her sole discretion.

   b. If no Presiding Officer has been appointed, the chair of the Hearing Panel shall serve as the Presiding Officer but shall be allowed to vote.

   c. The Presiding Officer shall:

      i. Require that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to

both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

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 throughout the hearing;

v. Have the authority and discretion, in accordance with this policy, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence prior to the hearing and during the hearing, unless otherwise provided in this Article;

vi. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the Practitioner requesting the hearing is considered by the Hearing Panel in formulating its recommendations; and

vii. Conduct prehearing conferences and argument by counsel on procedural points outside the presence of the Hearing Panel to the extent practical unless the Panel wishes to be present.

Section E. Pre-Hearing and Hearing Procedure

1. Provision of Relevant Information: There is no right to formal "discovery" in connection with the hearing except as specifically provided herein. The Practitioner requesting the hearing shall be entitled, upon specific, written request, to the following at least thirty (30) calendar days prior to the hearing, subject to a stipulation signed by the Practitioner and counsel if applicable that such documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing:

   a. Copies of, or reasonable access to, all patient medical records or other documents referred to in the notice of statement of reasons under Sections A and B above, at his or her expense; and

   b. Reports of experts relied upon by the MEC or Board of Directors in issuing the Adverse Action.

   c. No information regarding other Practitioners shall be requested, provided or considered, nor is the Practitioner entitled to access minutes of Medical Staff committees, Services or other medical peer review committees unless those minutes will be presented in the hearing.

2. Evidence unrelated to the reasons for the recommendations or to the Practitioner's qualifications for appointment or the relevant clinical privileges shall be excluded.

3. If either party will be represented by an attorney or other individual in the hearing, the party must notify the other party in writing of the name of such attorney or other individual at least ten (10) calendar days prior to the date of the hearing.

4. At least fourteen (14) calendar days prior to the hearing, each party shall provide the other party with a list of and copies of all proposed exhibits unless previously provided. All objections to documents or witnesses to the extent then reasonably known shall be submitted in writing at least seven (7) calendar days prior to the hearing and shall be ruled on by the Presiding Officer. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause for not raising the objection within the required time frame.

5. If any expert is to be presented as a witness by either party, when the expert is identified as a witness as provided above in Section D above, the other party must be provided with the following:

   a. a copy of the expert's curriculum vitae;

   b. a written report from the expert setting forth the substance of the expert's testimony, opinions, and grounds for the opinions;

   c. a copy of any literature or references relied upon by the expert in reaching the opinions; and

   d. a copy of all documents or other information provided by the party to the expert for review or a list of those documents and information if previously provided to the other party.

   No expert witness may be called by a party, nor testimony, opinions, or documents submitted for consideration in the hearing, unless disclosed in accordance with this section or the Presiding Officer determines that the failure to disclose was unavoidable.

6. There shall be no contact by the Practitioner with Hospital employees concerning the subject matter of the hearing, unless arranged with Hospital counsel.

7. Failure to Appear. Failure, without good cause, of the Practitioner to appear and proceed at such a hearing shall be deemed a waiver by the Practitioner of his/her right to a hearing and to any other procedural right of review under these Bylaws or otherwise, and voluntary acceptance of the Adverse Action, which shall then be forwarded to the Board of Directors for final decision as provided in Section C above.

8. Record of Hearing. The Hospital Administrator shall arrange for a court reporter to create a record of the hearing. The cost of such reporter shall be borne by Our Children's House, but copies of the transcript shall be provided by the court reporter to the Practitioner requesting the hearing at the Practitioner's expense. The Presiding Officer may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in the State of Texas.

Section F. Rights of Both Parties

1. At a hearing, both parties shall have the following rights, subject to reasonable limits determined by the Presiding Officer and any limitations in this Article:

   a. To call, examine and cross-examine witnesses;

   b. To present evidence determined to be relevant by the Presiding Officer, regardless of its admissibility in a court of law;

   c. To have a record made of the proceedings, copies of which may be obtained on payment of any reasonable preparation costs;

   d. To representation by an attorney or other person, who may call, examine, and cross-examine witnesses and present the case;

   e. To submit a written statement at the close of the hearing; and

   f. To receive the written recommendation of the Hearing Panel, including a statement of the basis for the recommendation, as well as to receive the written final decision of the Board of Directors, including a statement of the basis for the decision.

2. Testimony of Practitioner. The Practitioner requesting the hearing who does not testify on his or her own behalf may be called and cross-examined by the MEC or Board of Directors. The Hearing Panel and the Presiding Officer may question any parties and witnesses, request that additional witnesses be called, or request the presentation of additional documentary evidence.

3. Admissibility of Evidence. The hearing shall not be conducted according to rules of evidence. Hearsay evidence shall not be excluded merely because it may constitute 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.

4. 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. 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 by either party, to present written rebuttal of any evidence admitted on official notice. The Hearing Panel may also require submission of written statements on any relevant matter, including objections.

5. Postponements and Extensions. Postponements and extensions of time beyond any time limit set forth in this Article may be requested by either party but shall be permitted only by the Presiding Officer or the Hospital Administrator on a showing of good cause.

6. Persons to be Present. Attendance at the hearing shall be restricted to the Hearing Panel, Presiding Officer, court reporter, parties, attorneys, and witnesses when testifying. Administrative personnel may be present as requested by the Hospital Administrator or the Medical Staff President. All attendees must agree to maintain the confidentiality of the proceedings consistent with the requirements applicable to records and proceedings of medical peer review committees.

7. Order of Presentation. The MEC or Board of Directors, whichever issued the Adverse Action prompting the hearing, shall first present evidence in support of the Adverse Action. Thereafter, the Practitioner who requested the hearing may present evidence. Opening statements and closing arguments are permitted.

8. Burden of Proof. Consistent with the requirement for the Practitioner to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, re-appointment, and clinical privileges, the Practitioner who requested the hearing has the burden of proving by clear and convincing evidence that: (i) he/she meets the standards for appointment/re-appointment or for the granting of clinical privileges requested or the Medical Staff category requested, and (ii) the Adverse Action that prompted the hearing was arbitrary or capricious or there is not substantial evidence to support the Adverse Action.

9. Adjournment and Conclusion. The Presiding Officer may adjourn the hearing and reconvene the same at the convenience of the Hearing Panel. Upon conclusion of the presentation of evidence by the parties, including submission of any written statements, and questions by the Hearing Panel, the hearing shall be closed.

10. Deliberations and Recommendation of the Hearing Panel. Within twenty (20) calendar days after closing the hearing, the Hearing Panel shall conduct its deliberations outside the presence of any other person (except the Presiding Officer) and shall render a recommendation set out in a written report, which shall contain a concise statement of the reasons for the recommendation. On completion of its report, the hearing is considered adjourned. The Hearing Panel may deliberate prior to issuance of the court reporter's transcript of the hearing.

11. Disposition of the Hearing Panel Report. The Presiding Officer shall deliver its report to the Hospital Administrator who shall forward it to the MEC or Board of Directors, whichever issued the Adverse Action, and by Special Notice to the Practitioner. The MEC or Board of Directors, as applicable, shall review the Hearing Panel's report within twenty (20) days and determine whether to affirm, modify or reverse the original Adverse Action. The MEC or Board of Directors shall issue a written report of its decision with a statement of the basis for its decision.

    a. If the reconsidered decision is still an Adverse Action, the Practitioner shall be notified of his or her right to an appeal by the Hospital Administrator. The notice of right to appeal shall be sent by Special Notice within ten (10) calendar days, and all further procedures shall be as set forth in Section G. below.

    b. If the reconsidered decision is not an Adverse Action, it shall be forwarded to the Board of Directors for a final decision; provided that, if the Board of Directors decision is an Adverse Action, the Practitioner shall be notified of his or her right to an appeal by the Hospital

Administrator before the decision is final. The notice of the right to appeal shall be sent by Special Notice within ten (10) calendar days, and all further procedures shall be as set forth in Section G below.

Section G. Appeal to the Board of Directors

1. Time for Appeal. Within twenty (20) calendar days after the Practitioner's receipt of the notice of the right to appeal under Section F above, the Practitioner may request appellate review of the recommendation. The request for appellate review, including a brief statement of the reasons for appeal and the specific facts or circumstances which justify further review, shall be in writing, and shall be delivered to the Hospital Administrator either by hand delivery or by certified mail, return receipt requested. If such appellate review is not requested within the required time frame and in the manner required, the Practitioner shall be deemed to have accepted the Adverse Action, which shall be forwarded to the Board of Directors for final action.

2. Grounds for Appeal. The grounds for appeal shall be limited to whether:

   a. There was substantial failure to comply with the procedures set forth in these Bylaws;

   b. The recommendation of the Hearing Panel was made arbitrarily or capriciously; or

   c. The recommendation of the Hearing Panel was not supported by credible evidence, based upon the hearing record.

3. Time, Place and Notice. When an appeal is requested as set forth in the preceding sections, the Chair of the Board of Directors shall schedule and arrange for an appellate review as soon as arrangements can reasonably be made. The Chair of the Board of Directors may take into account the schedules of all individuals involved but in no event shall the appellate review be scheduled later than forty-five (45) calendar days from the receipt of the Practitioner's request unless the Chair of the Board of Directors extends the time for good cause. The Practitioner shall be given at least thirty (30) calendar days prior notice of the time, place and date of the appellate review.

4. Nature of Appellate Review

   a. The Chair of the Board of Directors shall appoint a Review Panel composed of not less than three (3) members of the Board of Directors to conduct the appellate review.

   b. In its sole discretion, the Review Panel may accept additional oral or written evidence subject to the same right 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 was not available at the time of the hearing.

   c. The Practitioner shall be required to present a written statement in support of his or her position on appeal at least fifteen (15) calendar days prior to the appeal which statement must set out the specific grounds and support for the appeal with reference to the three grounds in Section F above. The Review Panel shall provide a copy of the statement to the

MEC or Board of Directors, which may submit a written response at least five (5) calendar days prior to the appeal. A copy of the response, if any, shall be provided to the Practitioner as well as the Review Panel.

d. In its sole discretion, the Review Panel may allow each party or its attorney or other representative to appear personally and make a time-limited thirty (30) minute argument. If oral arguments are permitted, the parties shall answer any questions presented by the Review Panel. The Review Panel shall issue written findings on the grounds for appeal in Section F above to the Board of Directors within twenty (20) calendar days of completion of the appeal.

5. Final Decision of the Board of Directors. Within thirty (30) calendar days after receipt of the Review Panel's written findings or upon expiration of the time frame allowed for the affected Practitioner to appeal and the Practitioner's failure to exercise the right to appeal, the Board of Directors shall render a final decision in writing, including the results of the appeal, if any, and the specific reasons for its final decision. The final decision shall be delivered to the chairpersons of the Credentials Committee and the MEC, and by Special Notice to the affected Practitioner within twenty (20) calendar days of the decision. The Board of Directors may affirm, modify, or reverse the Adverse Action, or in its discretion, refer the matter for further review and recommendation based upon the Board of Directors ultimate legal responsibility for granting appointment and clinical privileges.

6. Further Review. Except where the matter is referred for further action and recommendation, the final decision of the Board of Directors following the appeal (or waiver of the right to appeal) shall be effective immediately and shall not be subject to further review. However, if the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board of Directors in accordance with the instructions given by the Board of Directors. Such further review process and the report back to the Board of Directors shall in no event exceed thirty (30) calendar days in duration, except as the Board of Directors may otherwise stipulate.

7. Right to One Hearing and Appeal Only. No Practitioner shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter which may be the subject of procedural rights of review under this Article.

8. Re-application to the Medical Staff. In the event that the Board of Directors issues a final Adverse Action to deny Medical Staff appointment or re-appointment or clinical privileges, or to revoke or terminate Medical Staff appointment or clinical privileges, the affected Practitioner is not eligible to reapply within five (5) years for Medical Staff appointment or those clinical privileges, unless the Board of Directors provides otherwise.

Section H. Initiation and Notice of Mediation

1. Right to Mediation. A Practitioner may require Our Children's House to participate in mediation under Chapter 154 of the Texas Civil Practice and Remedies Code, if:

a. The Credentialing Committee has failed to take action on a completed application or re-application for Medical Staff membership or clinical privileges within the time frame required by law; or

b. The Practitioner is subject to an Adverse Action as defined in Section B; provided that, the request for mediation must be made prior to, at the same time as or in lieu of the request for hearing.

2. Request for Mediation. When a Practitioner is entitled to request mediation as provided above, the Practitioner shall have fifteen (15) calendar days following the date the application became complete or the date of the issuance of notice of an Adverse Action within which to request mediation. The request shall be made in writing to the Hospital Administrator by hand delivery or certified mail, return receipt requested. If the Practitioner does not request mediation within the time frame or in the manner required by this section, the Practitioner shall be deemed to have waived his/her right to require mediation. Waiver of the right to mediation does not constitute a waiver of the Practitioner's right to the procedural rights of review under this Article in the case of an Adverse Action.

3. Scheduling Mediation. Within fifteen (15) calendar days of filing a timely written request for mediation, the Practitioner must propose in writing to the Hospital Administrator the names of three (3) acceptable mediators, who meet the qualifications set forth in Section 154.052 of the Texas Civil Practice and Remedies Code and who have experience in hospital-medical staff privileges disputes. Within five (5) calendar days thereafter, the Hospital Administrator shall select one of the mediators proposed by the Practitioner or object in writing. If the Hospital Administrator objects in writing to all three (3) mediators proposed by the Practitioner within five (5) calendar days, the Hospital Administrator and the Practitioner each will propose a mediator who meets the above requirements. The two (2) mediators shall then select a third mediator who meets the above requirements and who will conduct the mediation. The mediation shall take place within thirty (30) calendar days of the selection of a mediator, unless the Hospital Administrator and the Practitioner agree in writing to waive that deadline.

4. The standards and duties of the mediator are those set forth in Section 154.053 of the Texas Civil Practice and Remedies Code.

5. The cost of mediation shall be borne equally by Our Children's House and the Practitioner.

6. The Practitioner is entitled to only one (1) mediation on any single matter which may be the subject of mediation and the mediation shall be limited to one full day of mediation.

A request for mediation suspends the time periods for a requested hearing. If mediation does not resolve the Adverse Action to the satisfaction of all parties, the timelines for the requested hearing shall resume.

ADOPTED BY THE BOARD OF DIRECTORS ON May 31, 2022.