THE BYLAWS

OF THE PROFESSIONAL STAFF OF

COOK CHILDREN'S MEDICAL CENTER

Adopted October 25, 2018
Including all Amendments approved by the
Cook Children's Medical Center
Board of Trustees through October 25, 2018
To be effective October 25, 2018

THE BYLAWS OF THE PROFESSIONAL STAFF OF COOK CHILDREN'S MEDICAL CENTER
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PREAMBLE

WHEREAS, Cook Children's Medical Center is a not-for-profit corporation organized under the laws of the State of Texas; and

WHEREAS, its purpose is to provide patient care, education and research; and

WHEREAS, it is recognized that the Staff is accountable to the Governing Body for the quality of health care in the hospital and its facilities and must accept and discharge this responsibility subject to the ultimate authority of the Governing Body, and that the cooperative efforts of the Staff, the Center President and the Governing Body are necessary to fulfill the Center's obligations to its patients;

THEREFORE, the physicians and dentists practicing in this Center who are members of the Staff amend and restate their Bylaws entirely as follows:

DEFINITIONS

"Adverse Recommendation or Action" means an action or recommendation as set out in Article XI.2.

"Allied Health Professional" means individuals other than physicians or dentists or employees of the Center in those disciplines designated by the Governing Body whose authority to perform specified patient care services are processed through Staff channels.

"Article" means an article in these Bylaws.

"Board eligible" means eligible to sit for the next board specialty examination.

"Bylaws" means these Professional Staff Bylaws and includes any Manuals and Policies adopted pursuant to the Bylaws unless the context clearly indicates otherwise.

"Center" means the Cook Children's Medical Center and any other health care facilities at which the Professional Staff practices pursuant to clinical privileges granted in accordance with these Bylaws.

"Center President" means the President of the Center (or his/her designee) appointed by the Governing Body to act in its behalf in the overall management of the Center.

"Chair" or "Vice-Chair" means the chair or vice-chair of a Staff committee appointed or elected in the manner and for the term specified in these Bylaws.

“Chief of Division” or “Division Chief” means the Practitioner duly elected in accordance with these Bylaws to serve as the head of a Division in the manner and for the term specified in these Bylaws.

“Chief Medical Officer” means the Cook Children's Health Care System Chief Medical Officer (or his/her designee).

“Corrective action” is an action pursuant to Article X.

“Credentialing Procedures Manual” means the credentialing procedures manual of the Center adopted as provided in Article XV.

“Days” means calendar days unless otherwise indicated.

“Division” means the group of Practitioners having clinical privileges in one of the designated general areas of medical practice.

“Ex-officio” means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

“Fair Hearing Plan” means the Manual setting out procedural rights of review for Practitioners to be afforded on behalf of the Center and adopted as provided in Article XV.

“Good standing” means appointed to the Staff without any limitation (other than one imposed on all Practitioners in that category) and not subject to any request for corrective action or corrective action (at the time of resignation or expiration of appointment in the case of former members of the Staff).

“Governing Body” means the Board of Trustees of the Center (or its designee).

“Impairment” means “impairment” as defined in the Practitioner Health and Conduct Policy of the Staff.

“Investigation” for purposes of mandatory reporting of a professional review action or surrender of clinical privileges means: (i) the investigation initiated following receipt of a request for corrective action as provided in Article X.1.B.; (ii) the time period following imposition of summary corrective action as provided in Article X.2., or (iii) the time period following issuance of an Adverse Recommendation or Action on initial appointment or reappointment or with respect to a request for clinical privileges. See Article V.1.B. for discussion of FPPE and OPPE.

“Legal Counsel” means the attorney or attorneys representing and advising the Center and/or System.

“Manual” or “Manuals” means the Rules and Regulations, Fair Hearing Plan, Credentialing Procedures Manual, and any other manuals adopted as provided in Article XV.

“Medical Board” means the executive committee of the Staff.

“Medical Director” means a medical director (or his/her designee) of a clinical unit of the Center.

“Medical peer review” shall be as defined in Article XIII.
“Medical Staff Services” means the Center department established to support the credentialing and privileging functions of the Staff.

“Network” means the certified, nonprofit corporation for which Cook Children’s Health Care System is the sole member.

“Policy” means a policy of the Staff adopted as provided in Article XV.

“Practitioner” means an appropriately licensed physician or dentist applying for or exercising clinical privileges in the Center.

“Procedural rights of review” means the hearing and appeal rights provided to a Practitioner under Article XI and the Fair Hearing Plan.

“Rules and Regulations” means the Manual setting out operational details for practice in the Center adopted as provided in Article XV.

“Special notice” means written notice by certified mail, return receipt requested, or by hand delivery. Special notice is effective on receipt (or refusal of receipt).

“Staff” or "Professional Staff" means all physicians licensed by the Texas Medical Board and all dentists licensed by the Texas State Board of Dental Examiners who are privileged to attend patients in the Center. The Staff is the “organized medical staff” for purposes of accreditation by the Joint Commission.

“Staff President” means the Practitioner elected by the Staff in the manner and for the term specified in these Bylaws to serve as its president.

“System” means the Cook Children’s Health Care System.

“System Credentials Department” means the credentials department established by the Center to support the credentialing and privileging functions of the Staff and includes Medical Staff Services.

“Unprofessional Conduct” means “unprofessional conduct” as defined in the Center’s Code of Conduct Policy.

"Vice-Chief of Division" or "Division Vice-Chief" means the Practitioner duly elected in accordance with these Bylaws to serve as the vice-chief of a Division in the manner and for the term specified in these Bylaws.

"Vice-President of Credentialing" means the Practitioner elected by the Staff in the manner and for the term specified in these Bylaws to serve as its vice-president of credentialing.

"Vice-President of Quality" means the Practitioner elected by the Staff in the manner and for the term specified in these Bylaws to serve as its vice-president of quality.

ARTICLE I. NAME

The Practitioners who are privileged to attend patients in the Center shall be referred to as the "Professional Staff of Cook Children's Medical Center."

ARTICLE II. PURPOSES

The purposes of the Staff are to:

A. Promote the objective that all patients admitted to or treated in any of the facilities, departments or services of the Center shall receive appropriate care;

B. Engage in medical peer review (see Definitions) and promote a high level of professional performance of all Practitioners and Allied Health Professionals authorized to practice in the Center through the appropriate delineation of clinical privileges that may be exercised in the Center and through an ongoing review and evaluation of their performance of health care services in the Center;

C. Provide an appropriate educational setting that will strive to maintain scientific standards and that will attempt to maintain continuous advancement in professional knowledge and skill;

D. Initiate, maintain and enforce Bylaws, Manuals, and Policies for self-governance and implementation of these purposes, and for accountability to the Governing Body;

E. Provide a means whereby issues concerning the Staff and the Center may be discussed with the Governing Body and the Center President; and

F. Make recommendations to the Governing Body regarding appointment and reappointment to the Staff, the granting of initial or renewed clinical privileges, and corrective action.

The purpose of the Bylaws is to state the qualifications and obligations of appointment and clinical privileges, the administrative and medical peer review functions of the Staff that relate to the provision of health care services at the Center, and the Staff's relationship to the Governing Body. The Bylaws are not intended to establish a higher standard of patient care than that otherwise required by law.

The Staff and its members enforce and comply with the Bylaws, Manuals and Policies approved by the Governing Body as set forth herein. The Governing Body shall uphold the approved Bylaws, Manuals and Policies. These Bylaws, including any Manuals or Policies, the bylaws of the Governing Body, and Center policies are compatible with each other and comply with law and regulation.

ARTICLE III. STAFF MEMBERSHIP

SECTION 1 NON-DISCRIMINATION

In the appointment and reappointment of members of the Staff and the granting of clinical privileges, the Center, the Professional Staff, and the Governing Body shall not discriminate because of race, color, religion, sex, national origin, or any other grounds not permitted by law.

SECTION 2 NATURE OF STAFF MEMBERSHIP

Staff membership at the Center is a privilege that shall be extended only to professionally qualified Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws.

SECTION 3 QUALIFICATIONS FOR STAFF MEMBERSHIP

A. General. To be eligible for Staff membership, Practitioners must be currently licensed to practice in the State of Texas, with state and federal authorizations to prescribe medications (except for pathologists), and must document their background, education and relevant training, and experience; current clinical competence; adherence to the ethics of their profession; good reputation; ability to work with others in a professional and cooperative manner; and any other requirements of the Staff and/or Governing Body so as to demonstrate the ability and willingness to provide health care in accord with accepted professional standards and the best interests of the Center.

    1. No Practitioner is entitled to membership on the Staff or the exercise of particular clinical privileges solely because he/she is licensed to practice in this or any other state, or because he/she is a member of any professional organization, or is certified by any clinical board, or presently or formerly held medical staff membership or privileges at another hospital or health care entity.

2. The Practitioner has the burden of establishing his/her qualifications for membership and clinical privileges. Withdrawal of an application from processing due to failure of the Center to receive requested information within a stated time period after special notice to the Practitioner of the information needed shall not entitle the Practitioner to any procedural rights of review. Errors or omissions in information provided by the Practitioner on an application for appointment and/or clinical privileges are grounds for denial of the application or immediate termination of Staff membership and clinical privileges, even if the information is later corrected by the Practitioner.

3. Physician applicants who are faculty members of medical training programs affiliated with the System and/or an affiliated entity and are authorized to practice in Texas by a faculty temporary license are not required to obtain individual state or federal permits to prescribe medications if they are authorized to prescribe by the Center President under the Center's registration.

4. In addition to the requirements set out above, Practitioners who are graduates of foreign schools of medicine, other than accredited Canadian Schools of Medicine, shall have satisfactorily completed the examination of the Educational Council of Foreign Medical Graduates.

B. Board Certification. Applicants for initial appointment to the Staff must have completed a residency training program approved by the Accreditation Council on Graduate Medical Education (ACGME), American Osteopathic Association (AOA) or the American Dental Association (ADA), and have such specialty board certification or examination eligibility, if any, as may be specified in the delineation of clinical privileges for the Division and specialty to which the applicant desires appointment and privileges, unless otherwise provided by this section.

1. If accepted based on examination eligibility, the Practitioner must achieve board certification within the period of time specified by his/her particular board or within seven (7) years of completion of residency or fellowship training, whichever is less, unless an exception is allowed by subsection 3 below. If initial board certification is not achieved within this prescribed time period, the Practitioner's privileges in the specialty area (and Staff membership if those constitute all of the Practitioner's privileges) shall be automatically terminated. If at a later date the Practitioner becomes board certified in the specialty field of practice the Practitioner may apply for corresponding specialty privileges (and Staff membership if applicable) again. Alternatively, if a Practitioner completes more training in the specialty field and becomes board eligible a second time, then the Practitioner may apply for corresponding specialty privileges (and Staff membership if applicable) again. Upon becoming board eligible a second

time that Practitioner must achieve board certification as set forth above. Otherwise the Practitioner will be subject to the automatic termination provisions as set out above. This automatic termination, while taken in the course of medical peer review, is not considered a final professional review action or corrective action, and does not entitle the Practitioner to any procedural rights of review.

2. Physician Practitioners who have been members of the Active Staff continuously since 1999 and dental Practitioners who completed their dental training prior to 1992 are not subject to this requirement.

3. If the Practitioner has completed a foreign medical training program, is not board certified or board eligible as set forth above, and the Practitioner practices in a pediatric subspecialty in which there is determined to be a community need by the Governing Body, the Practitioner may meet this requirement by demonstrating that he/she has training equivalent to the above. A determination of equivalence must include: a) confirmation of certification by the Educational Commission for Foreign Medical Graduates (ECFMG) or completion of a foreign medical training program from the list of foreign training programs approved by the Governing Body; b) confirmation of completion of the number of months of training in the areas specified by the respective certifying board with the required degree of independent judgment exercised during training; and c) a review of the qualifications and full time participation of the faculty. The Credentials Committee, Medical Board and Governing Body shall evaluate such training and determine whether it is equivalent to the above.

C. Board Recertification. Physicians with time limited certifications are not required to obtain board recertification to maintain qualification for Staff membership. However, physicians are encouraged to pursue recertification.

D. Health Status. Each Practitioner must possess the necessary health status to perform the essential functions of Staff membership and exercise the clinical privileges requested without posing a significant risk to the health or safety of others, with or without reasonable accommodation, and must cooperate fully and openly in any assessment of necessary health status. Necessary health status shall include meeting and complying with all health requirements established by the System Medical Director of Occupational Health.

1. Initial appointment may be made contingent on the applicant providing documentation of this necessary health status on request of the Credentials Committee or the Medical Board, which request may include examination by a physician acceptable to the Credentials Committee or Medical Board and/or alcohol or drug testing. Practitioners age 70 years or older must submit documentation of a medical exam (as recommended by the Credentials Committee and approved by the Medical Board) and

mental health screen (as recommended by the Credentials Committee and approved by the Medical Board) attesting to necessary health and mental status acceptable to the Credentials Committee with each application and reappointment.

2. A Staff member must provide current documentation from an examining physician of this necessary health status at any time on request of the Credentials Committee, the Peer Assistance Committee, or the Medical Board upon identification of a concern. If there is reasonable suspicion of impairment, the documentation may be requested by a Chair of one of the listed committees on its behalf and may include alcohol and/or drug testing to be performed within a prescribed time frame.

3. Failure of a Practitioner to provide requested documentation of health status or to be examined or tested within the time period set forth in a written request shall constitute a voluntary leave of absence for health reasons under Section 8 below until the documentation or examination has been received by the requesting committee and there has been a determination as to whether action is needed. The Practitioner may also be subject to corrective action for failing to comply with these health status provisions.

E. Professional Liability Insurance. Each member of the Staff shall provide evidence of professional liability insurance coverage underwritten by a System insurance program (including a self-insurance program) or by a company currently licensed or authorized by the State of Texas and acceptable to the Governing Body. All insurance coverage shall be in an amount, to be determined from time to time by the Governing Body in consultation with the Medical Board, that is appropriate to the specialty and consistent with the prevailing standards for pediatric services. Evidence of current coverage must be on file in the System Credentials Department at all times. Practitioners shall be afforded a reasonable time, to be determined by the Governing Body in consultation with the Medical Board, to comply with any changes in the amounts required.

F. Continuous Care and Call Responsibilities. All Active, Courtesy, and Senior Active Staff members must be able to reach the Center within a reasonable time of notice: (i) so as to ensure their ability to provide continuous care for the inpatients for whom they are responsible, or have an arrangement acceptable to the Credentials Committee for coverage by a Staff member in the same specialty or with appropriate clinical privileges; and (ii) to provide care when they are the designated Practitioner on the specialty call roster for the Center. Failure of an alternate arrangement under subsection (i) to be acceptable to the Credentials Committee does not entitle the Practitioner to any procedural rights of review.

G. Professional Ethics. Acceptance of membership on the Staff shall constitute the Practitioner's agreement that he/she will strictly abide by the current Principles of Medical Ethics of the American Medical Association, the American Osteopathic Association, or the Code of Ethics of the American Dental Association, as applicable, and to comply with the Center's Code of Conduct.

H. Medicare/Medicaid Exclusion. Practitioners who are currently excluded by Medicare, Medicaid, or another federal health care program are not eligible for Staff membership or clinical privileges, and such ineligibility shall not entitle the Practitioner to any procedural rights of review.

I. Felony Convictions. Practitioners who have been convicted of or entered a guilty or *nolo contendere* plea for a felony within the ten (10) years prior to application are not eligible for Staff membership or clinical privileges, and such ineligibility shall not entitle the Practitioner to any procedural rights of review.

J. Additional Education and Training Requirements. Practitioners must complete and comply with educational and training requirements (e.g., including but not limited to Infection Control/Practices, Safety, Orientation, Computer Training, CPOE, etc.) that are implemented and mandated by the Medical Board. Failure to complete the educational and training requirements as mandated by the Medical Board at the time of Initial Application or Application for Reappointment shall render the Practitioner's application incomplete and not processed further.

SECTION 4 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP

Each member of the Staff shall:

A. Provide his/her patients with health care services consistent with accepted professional standards at the Center with cost effective and appropriate utilization of services;

B. Abide by the Bylaws, Manuals, and Policies and by all other standards, policies and rules of the Center, its Governing Body, and the System as may be amended from time to time, and maintain compliance with all qualifications for membership;

C. Discharge such Staff, Division, committee, and Center functions for which he/she is responsible by appointment, election, or otherwise;

D. Prepare and complete in a timely manner the medical and other required records for all patients he/she admits or in any way provides care for in the Center;

E. Promptly notify the System Credentials Department in writing within two (2) business days of the Practitioner's receipt of notice of:

1. The suspension, revocation, refusal to renew, or relinquishment of the Practitioner’s professional license in Texas;

2. The suspension, revocation, refusal to renew or relinquishment of the Practitioner’s Texas or federal permit to prescribe medications;

3. The Practitioner's arrest, indictment, guilty or *nolo contendere* plea, or conviction by any law enforcement agency (excluding minor traffic violations) or health regulatory agency; or

4. Current exclusion from Medicare, Medicaid, or another federal health care program.

F. Unless the Practitioner has already provided notice under Section E above, promptly notify the System Credentials Department in writing within fifteen (15) days of the Practitioner’s receipt of **notice**:

1. The commencement of an investigation by the Practitioner’s professional licensing board in this or any other state or the suspension, revocation, or probation of a professional license, or the relinquishment, whether voluntary or involuntary, of any professional license in this or any other state; or

2. The suspension, restriction, probation, loss, surrender, resignation of staff membership or clinical privileges, or commencement of a corrective or disciplinary action investigation at any hospital, ambulatory health care facility, or other health care organization, whether voluntary or involuntary (this shall not apply to automatic suspension for medical records delinquency); or

3. Filing of a petition or pleading in any suit alleging professional negligence or malpractice or allegation of fraud or abuse involving the Practitioner’s professional practice; or

4. Any change in health status that may interfere with the Practitioner’s compliance with Section 3.D. above; or

5. Any voluntary or involuntary leave of absence at any hospital; or

6. Any sanctions, probation, denial, suspension, revocation, limitation, refusal to renew or relinquishment, whether voluntary or involuntary, of any state or federal permit to prescribe medications.

G. Comply with all legal and accreditation requirements relating to the practice of his/her profession and requirements relating to the delivery of health care services in the Center applicable to Practitioners, with the Center notifying Practitioners of the latter and reasonably assisting in compliance;

H. Comply with emergency service requirements, take specialty call, and provide consultations as specified in the Bylaws, Manuals, and Policies;

I. Cooperate in medical peer review activities, including without limitation quality management, utilization review, and risk management activities at the Center, including assisting with focused professional practice evaluation ("FPPE") of new Practitioners and those receiving new clinical privileges; and

J. Report significant adverse events occurring at the Center as specified in Center policy and procedure.

SECTION 5 AUTHORIZATIONS

In addition to the provisions in Article XIII, by applying for appointment or reappointment to the Staff, the Practitioner:

A. Signifies his/her willingness to appear for interviews in regard to his/her application, and agrees to provide a photograph for confirmation of his/her identity with other hospitals, organizations or individuals;

B. Authorizes the Staff, Center, and Governing Body to consult with other hospitals, ambulatory health care facilities, and other health care organizations and practitioners with which the applicant has been or is currently associated and with others who may have information bearing on clinical competence, professional conduct, and other qualifications for Staff membership and/or clinical privileges;

C. Consents to the Staff's, Center's, and Governing Body's review of all records and documents that may have bearing on the evaluation his/her clinical competence, professional conduct, and other qualifications and consents to both ongoing and focused professional practice evaluation during any appointment or reappointment period; and

D. Agrees to cooperate in the FPPE at the request of the Division Chief.

SECTION 6 INITIAL APPOINTMENT AND FOCUSED PROFESSIONAL PRACTICE EVALUATION ("FPPE")

All initial appointments shall be for a period of time not to exceed two (2) years, with those Practitioners appointed to the Active, Courtesy, and Consulting Staff categories subject to FPPE as set out in Article V unless the Practitioner is age 70 or older, in

which event, the Practitioner shall not be reappointed for a period of greater than one (1) year.

SECTION 7 REAPPOINTMENT AND ONGOING PROFESSIONAL PRACTICE EVALUATION ("OPPE")

A. All members of the Staff except for Honorary/Emeritus Staff will undergo reappointment and review at least every two (2) years, with the first appointment period ending on the member's birth date month, and then every two (2) years thereafter, unless the Practitioner is reappointed for a period of less than two (2) years or unless the Practitioner is age 70 or older, in which event, the Practitioner shall not be reappointed for a period of greater than one (1) year. There is no expectation or guarantee of reappointment and the Practitioner shall have the burden of establishing his/her qualifications for continued membership and clinical privileges.

B. All practitioners with clinical privileges will be subject to ongoing professional practice evaluation (OPPE) during the reappointment period as set out in Article V.

C. Each recommendation concerning the reappointment of a Staff member and the clinical privileges to be granted on reappointment shall be based upon:

  1. The member's clinical competence, experience and clinical judgment in the treatment of patients based on the conclusions drawn from OPPE and other quality management evaluations;

  2. Ethics and professional conduct; and

  3. Compliance with the Staff Bylaws and all other requirements of membership and clinical privileges.

SECTION 8 LEAVE OF ABSENCE

In addition to the provisions in Section 3.D.3. above, any member of the Staff may request a leave of absence not to exceed one (1) year, or not to exceed two (2) years in the case of an educational leave, by filing a written request with the Chair of the Credentials Committee. Any Practitioner who will not be practicing for more than thirty (30) days is required to submit a written request for leave of absence; provided that, a Practitioner may request an exception from the leave requirement in extenuating circumstances, such as temporary overseas medical service. However, any leave of the Practitioner for Impairment must be requested in writing regardless of the length of the leave. Any request for leave of absence must indicate in detail the reasons for the leave and the anticipated inclusive dates of the leave of absence. A leave of absence is not considered a surrender, restriction or limitation of the Practitioner's clinical privileges. Return from leave shall be subject to the procedures for reinstatement.

SECTION 9 RESIGNATION

A Practitioner who wishes to resign Staff membership and/or clinical privileges shall submit a written request to the Credentials Committee setting out the effective date of the resignation. Failure to complete all outstanding medical records and complete any scheduled specialty on-call obligations (or secure alternate coverage for such obligations) shall be considered a "resignation not in good standing." Exceptions may be granted by the Credentials Committee, with the approval of the Medical Board, in the case of resignations due to immediate health or personal issues.

SECTION 10 CENTER NEEDS AND RESOURCES

A. The Governing Body may decline to accept or have the Staff review requests for particular clinical privileges in connection with appointment, reappointment, or otherwise on the basis of:

1. The Center's present inability to provide adequate facilities or support services for the Practitioner and his/her patients or requirements or limits in the Center's written medical staff development plan; or

2. Existence of a contractual or other arrangement for the provision of professional services of the type being requested by the Practitioner that precludes affording those particular clinical privileges to the Practitioner.

B. Refusal to accept or review the request shall not constitute a denial of clinical privileges or entitle the Practitioner to any procedural rights of review. Any portion of the application that is accepted (e.g., requests for clinical privileges that are not subject to a limitation) shall be processed in accordance with the Bylaws.

SECTION 11 CONTRACTS FOR PROFESSIONAL SERVICES

A. The Joint Conference Committee may be asked by the Chair or Co-Chair of the Joint Conference Committee to make recommendations within a stated period of time to the Governing Body on quality of care issues prior to any final decision of the Governing Body to:

1. Enter into a contract with an individual Practitioner, a group of Practitioners, or the Network for professional services to be provided in the Center; or

2. Enter into an exclusive contract for professional services to be provided in the Center or to renew or terminate an exclusive contract for professional services.

B. If asked to make recommendations, the Joint Conference Committee shall be provided with a summary of the terms of the contract pertaining to quality of care for its review. In reviewing a proposed termination of an exclusive contract, the Joint Conference Committee shall allow interested members of the Staff to make a presentation and/or submit comments to the Joint Conference Committee which will be reviewed and forwarded to the Governing Body.

C. Medical Director contracts are not subject to review under this section. Compliance with this section may not be possible if termination of a contract is necessary due to immediate risk to the safety of patients or others or in order to comply with a legal or accreditation requirement.

SECTION 12 PROCESSES FOR APPOINTMENT AND REAPPOINTMENT; CREDENTIALING PROCEDURES MANUAL

A. The processes for appointment and reappointment to the Medical Staff shall include the following basic steps:

1. submission of a written application in the form required by the Governing Body;

2. primary source verification and collection of all required and requested information by the System Credentials Department to verify continuing compliance with criteria for membership and clinical privileges;

3. review and written recommendation by the Credentials Committee, to include review of data from any available focused and ongoing professional performance evaluations; and

4. review and written recommendation by the Medical Board; and review and a final decision by the Governing Body.

The process for affording procedural rights of review, when applicable, is set out in Article XI.

B. Applicants shall be required to advise the System Credentials Department of any change in information provided on an application for initial appointment or reappointment within fifteen (15) calendar days of notice of the change. Failure to do so shall be grounds for withdrawal of the application from consideration, denial of the application, or termination of Staff membership and clinical privileges, even if the information is subsequently provided.

C. The Credentialing Procedures Manual shall set out the procedures and associated details for the processes of appointment, requests for leave of absences and reinstatement, and reappointment.

ARTICLE IV. CATEGORIES OF THE STAFF

SECTION 1 ACTIVE STAFF

A. Definition. The Active Staff are those Practitioners who:

1. Have satisfied the qualifications for Staff membership as stated in Article III.3.; and

2. Assume the full responsibilities, duties, and privileges of an Active Staff member, which shall include primary responsibility for specialty call.

B. Requirements.

1. Eligibility for reappointment to the Active Staff shall require at least twelve (12) or more patient contacts during the twenty-four (24) month appointment period. A "patient contact" for purposes of this Active Staff requirement is defined as an admission for inpatient or outpatient services, a consultation, rounding on an inpatient, or the performance of an operative procedure. A Practitioner who fails to satisfy the patient contact requirement is automatically eligible for only a one (1) year reappointment. If the Practitioner fails to have at least six (6) patient contacts during that one (1) year, he/she shall automatically be eligible only to apply for Courtesy, Consulting or Associate Staff status for the following two (2) years. A Practitioner subject to this change in eligibility is not entitled to any procedural rights of review and the action, while taken in the course of medical peer review, is not considered a final professional review action.

2. Exceptions to the patient contact requirement may be approved by the Governing Body if recommended by the Credentials Committee for office based subspecialists (e.g., allergists, dermatologists), provided the Practitioner agrees to the assignment of a proctor to each inpatient admission for concurrent monitoring of the patient during hospitalization. The proctor must complete a written report for review by the Division Chief and the Credentials Committee.

3. Age exceptions to the Division specialty call obligation may be approved by the Medical Board, subject to the approval of the Governing Body, as set out in the Rules and Regulations.

C. Privileges. The Active Staff member shall be privileged to admit patients, vote on Staff and Division matters, and hold office, and may be appointed to serve on committees of the Staff as voting or non-voting members. Attendance at Staff and Division meetings is encouraged, but not required.

SECTION 2 COURTESY STAFF

A. Definition. The Courtesy Staff are those Practitioners who:

1. Have satisfied the qualifications for Staff membership as stated in Article III.3.; and

2. Do not wish, or are unable, to satisfy the requirements of the Active Staff as set forth above.

B. Requirements.

1. A Courtesy Staff member shall be required to be an active staff member in good standing at another Joint Commission-accredited hospital. It is incumbent upon the applicant for reappointment to provide the Division Chief with supporting evidence of clinical practice at other Joint Commission-accredited institutions in support of his/her reappointment application and specific privileges if he/she has insufficient clinical practice within the Center for satisfactory performance review.

2. Courtesy Staff members may be required to participate in Division specialty call if necessary, as determined by the Medical Board. Courtesy Staff members who have more than twelve (12) patient contacts during an appointment term are required to participate in their Division's specialty call until otherwise receiving notice from the Division Chief. For the purposes of determining participation in Division specialty call by Courtesy Staff members, "patient contacts" includes only patients admitted by the member for inpatient or outpatient care at the Center campus.

C. Privileges. The Courtesy Staff member shall be privileged to admit and to have up to twelve (12) patient contacts during the term of appointment. He/she may be appointed to serve on committees as voting or non-voting members, but shall not be eligible to vote on Staff or Division matters or hold office. Attendance at Staff and Division meetings is encouraged, but not required.

SECTION 3 CONSULTING STAFF

A. Definition. This Staff category relates to the Practitioner who:

1. Has satisfied the qualifications for Staff membership as stated in Article III.3.;

2. Provides consultation for Active, Courtesy, or Senior Active Staff members, but does not seek admitting privileges;

3. Is an active staff member in good standing of a Joint Commission-accredited hospital accredited; and

4. Is a specialist needed to meet patient care needs in a low volume specialty as determined by the Credentials Committee, subject to the approval of the Medical Board and the Governing Body.

B. Privileges. The Consulting Staff member may consult on or treat patients under the care of an Active, Courtesy, or Senior Active Staff member who requested the consultation. The Consulting Staff member may be appointed to serve on committees as voting or non-voting members, but may not admit patients to the Center, vote on Staff or Division matters, or hold office. Attendance at Staff and Division meetings is encouraged, but not required. The member is not required to participate in the Division specialty call.

SECTION 4 HONORARY/EMERITUS STAFF

A. Definition. This Staff category relates to Practitioners who are retired or are limited in their practice and cannot meet Active Staff membership requirements. Upon recommendation of the Medical Board and approval by the Governing Body, these Practitioners may be granted Honorary/Emeritus Staff membership.

B. Privileges. Honorary/Emeritus Staff members are not granted clinical privileges and may not admit, consult, or in any other way be actively involved with patient care. Honorary/Emeritus Staff members may attend Staff meetings without vote, may be appointed to serve on committees as voting or non-voting members, and will be eligible to receive all Center publications and attend all Staff social events. They are not eligible to hold office. Once appointed to Honorary/Emeritus Staff status, members are not required to request reappointment.

SECTION 5 ASSOCIATE STAFF

A. Definition. This Staff category relates to the Practitioner who wishes to have an affiliation with the Center and who satisfies the qualifications for Staff membership as stated in Article III, Section 3, but does not have sufficient activity to become a full member of the Staff or does not require admitting privileges.

B. Privileges. The Associate Staff member may refer patients for outpatient lab and x-ray; perform preoperative histories and physical examinations for outpatient procedures and sedation procedures; and may make social notes in the medical patient chart for communication purposes with the care team; but will have no admitting or other clinical privileges. The Associate Staff member may be appointed to serve on committees of the Staff as a voting or non-voting member, but may not vote on Division or Staff matters or hold office. Attendance at Staff and Division meetings is encouraged, but not required.

SECTION 6 SENIOR ACTIVE STAFF

A. Definition. This Staff category relates to the Practitioner who has attained longevity and desires to retain full Active Staff status. The Practitioner must:

1. Have satisfied the qualifications for Staff membership as stated in Article III.3., but are no longer able to meet the patient contacts requirements for Active Staff;

2. Have reached the age of at least fifty (50) years and been an Active Staff member at the Center for at least fifteen (15) years; and

3. Be an active staff member in good standing at another Joint Commission-accredited hospital. It is incumbent upon the applicant for reappointment to provide the Division Chief with supporting evidence of clinical practice at other Joint Commission-accredited institutions in support of his/her reappointment application and specific privileges if he/she has insufficient clinical practice within the Center for satisfactory performance review.

B. Requirements. Senior Active Staff are not subject to any patient contact requirements, but may be required to participate in the Division specialty call.

C. Privileges. The Senior Active Staff member shall be privileged to admit patients, vote on Staff and Division matters, and hold office, and may be appointed to serve on committees of the Staff as a voting or non-voting member. Attendance at Staff and Division meetings is encouraged, but not required. There is no patient contact requirement during the term of appointment.

ARTICLE V. PRIVILEGES

SECTION 1 CLINICAL PRIVILEGES

A. General. Every Practitioner shall hold only those clinical privileges specifically granted to him/her by the Governing Body, except as provided in Section 2 below.

1. Every initial application for Staff appointment and application for reappointment must include a request for specific clinical privileges using the available delineations from the Center. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated clinical competence, professional conduct, references, and other relevant information. The assessment of qualifications shall include an assessment of proficiency in: patient care; medical/clinical knowledge; practice-based learning and improvement; interpersonal and communication skills; professionalism; and system-based practice.

2. The applicant shall have the burden of establishing his/her qualifications for the clinical privileges requested. See Art. III.3.A.2. for additional detail.

B. Professional Practice Evaluations and Review.

1. Focused professional practice evaluation (FPPE) shall be required for all privileges initially granted as set forth in written Policy. The specialties in each Division shall be responsible for establishing an objective method of FPPE for each specialty. The evaluation method for each specialty must be reviewed and approved by the Medical Board and Governing Body prior to implementation. FPPE may include, but is not limited to, the following: proctoring, chart review, monitoring clinical practice patterns, external peer review by third parties and consultation with other health care providers involved in patient care. A Practitioner may also be subject to FPPE during the appointment period for significant concerns regarding the provision of safe, quality patient care or compliance with qualification for clinical privileges and/or membership are identified as set forth in the Policy.

2. All Practitioners will be subject to ongoing professional practice evaluation (OPPE) during the appointment period as set forth in written Policy. OPPE is performed in accordance with established mechanisms that have been approved by the Medical Board and Governing Body. Periodic review and modification of clinical privileges shall be based on medical peer review/quality management information from the Center, the Practitioner's continued compliance with all qualifications and obligations of membership, and information obtained from third parties, including the Practitioner's licensing agency, and other hospitals, ambulatory health care facilities, or other health care organizations at which the Practitioner practices.

3. FPPE and OPPE are used in the course of medical peer review. A Practitioner subject to FPPE for an initial grant of clinical privileges or subject to OPPE is not considered under investigation for purposes of mandatory reporting. A Practitioner subject to FPPE for specific concerns also is not considered under investigation unless the FPPE clearly provides that the FPPE is a precursor to corrective action as provided in these Bylaws.

C. Criteria. Each Division shall, subject to the approval of the Credentials Committee, Medical Board, and Governing Body, establish criteria for the consideration and granting of clinical privileges.

1. If minimum or threshold criteria for specific clinical privileges have been established by the Division and approved by the Credentials Committee, Medical Board, and Governing Body, a request for those clinical privileges on initial appointment or reappointment shall not be accepted or processed by the Credentials Committee until satisfaction of the criteria has been documented by the applicant.

2. Applications for clinical privileges not listed on an approved delineation of clinical privileges shall not be processed until the Governing Body, following receipt of recommendations from the Credentials Committee and Medical Board, has determined that offering the privileges is in the best interest of the Center and that the Center has the necessary staff, equipment, and other resources to support the clinical privileges. Once approved, criteria must first be approved as set forth above before the application is processed.

3. Failure to process an application due to failure to meet the established criteria or because the requested privilege is not listed on an approved delineation of clinical privileges shall not entitle the Practitioner to any procedural rights of review under these Bylaws or otherwise.

D. Privileges Shared by Specialties. If a Practitioner desires clinical privileges outside the established delineation of clinical privileges or scope of practice for his/her specialty, the Practitioner may file a written request with the Credentials Committee.

1. The Credentials Committee Chair shall appoint an ad hoc committee made up of members outside the specialty in which the privileges are being requested or are currently offered. The ad hoc committee shall recommend to the Credentials Committee the criteria by which these privileges may be granted regardless of the Practitioner's specialty, and the plan for focused professional practice evaluation for such privileges. In establishing criteria and the evaluation plan, the committee may interview practitioners from relevant specialties, research practices at other medical centers, and/or consult with regional, national, or international experts in the field in question. The recommended criteria and evaluation plan must be approved by the Medical Board and Governing Body, and will be used by the Credentials Committee to consider all privileges requests thereafter.

2. The Credentials Committee shall be responsible to ensure that criteria for clinical privileges that are available in more than one Division are consistent and designed to ensure the provision of a single standard of care and to resolve any conflicts in that regard, subject to the approval of the Medical Board and Governing Body.

E. Modification. At any time, a member of the Staff may apply for an increase of clinical privileges. The FPPE process at this time will be the same as for an initial appointment and as defined by the applicable Division specialty. A Practitioner's request for curtailment or resignation of clinical privileges will be effective upon receipt of the Practitioner's written request by the Credentials Committee, subject to the provisions in Article III.9.

F. History and Physical Examinations. As further detailed in the Rules and Regulations, a complete admission history and physical examination shall be dictated and placed in the Center medical record within twenty-four (24) hours of admission and before any surgery or procedure involving anesthesia, except in emergencies which preclude such documentation. If a complete history and physical examination has been recorded within thirty (30) days prior to admission, it may be used in the medical record as a preliminary history and physical examination; provided it was recorded by a Staff member and an update note is documented within twenty-four (24) hours of admission and before any surgery or procedure involving anesthesia that includes any changes or additions or a note that there are none. Except as provided below, histories and physical examinations shall be performed by physicians (or qualified oral surgeons for their own patients). Histories and physical examinations may be performed by Allied Health Professionals who have been granted those clinical privileges.

G. Dentists/Oral Surgeons. Privileges granted to dentists and oral surgeons shall be based upon their training and experience. The scope and extent of surgical procedures that they may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists and oral surgeons in the Center shall be under the overall authority of the Chief of Division of Surgery. A physician Staff member shall be responsible for the care of the patient's general medical condition during the admission for any condition or illness beyond the scope of practice of the dentist or oral surgeon. The dentist or oral surgeon shall be responsible for securing the services of the physician(s) and ensuring compliance with the requirements of this section.

SECTION 2 TEMPORARY PRIVILEGES

A. Eligibility. Temporary privileges at the Center may only be granted under the following circumstances:

1. Initial Applicants. Upon receipt of a completed, clean application from an initial applicant to the Staff, the Center President, after review of the application and the written concurrence of the appropriate Division Chief, the Chair of the Credentials Committee and the Staff President, may grant temporary privileges for a period not to exceed one hundred twenty (120) days to a Practitioner between the receipt of the application and final approval by the Governing Body, on the following basis:

a. Verification of all information requested on the application form is received;

b. A query has been issued to the National Practitioner Data Bank and the results have been obtained and evaluated and determined to be acceptable to the Credentials Committee;

c. Verification of current licensure, controlled substances registration (state and federal), relevant training or experience, current competence and ability to perform the privileges requested;

d. Receipt of evidence of the required liability coverage;

e. Absence of current or previously successful challenges to the Practitioner's licensure or registration, and absence of any involuntary termination of medical staff privileges at another organization, or involuntary limitation, reduction, denial or loss of clinical privileges; and

f. Receipt of the Practitioner's written acknowledgement that he/she has received and read the Staff Bylaws and agrees to be bound by the terms thereof.

2. To Fulfill an Important Patient Care Need. If requested by an Active, Courtesy, or Senior Active Staff member, a Practitioner who is not seeking Staff appointment may be granted temporary privileges by the Center President, with the written concurrence of the appropriate Division Chief, the Chair of the Credentials Committee, and the Staff President, in the following situations:

a. To provide care for a particular patient if the Practitioner has documented professional licensure, required liability insurance, controlled substances registration (state and federal), provided a current copy of his/her CV, and the System Credentials Department has received oral or written verification of the Practitioner's current good standing at a Joint Commission-accredited hospital. Under this situation, the exercise of temporary privileges is limited to the particular patient and limited to four (4) patients in a calendar year.

b. To serve as locum tenens coverage for a Staff member and to attend the requesting Staff member's hospitalized patients in the Center upon compliance with the application and approval procedures outlined under Article V.2.A. Temporary privileges for locum tenens are limited to specific dates or to a period of time of up to thirty (30) days. Extensions may be granted by the same

individuals as required for the initial grant of temporary privileges. Information initially provided on the application form must be updated on request and the Practitioner is required to notify the System Credentials Department within three (3) business days of notice of any change.

B. Conditions. The Practitioner exercising temporary privileges shall be subject to the authority of the Division Chief who may impose special requirements for consultation, reporting, or other procedures.

C. Termination. Temporary privileges may be terminated by the Center President, with the concurrence of the appropriate Division Chief and the Staff President. Should a Practitioner's temporary privileges be terminated, his./her hospitalized patients will be assisted by the Division Chief to select an alternate Practitioner.

D. Procedural Rights of Review. Failure to grant temporary privileges, imposition of special requirements, failure to grant an extension, or termination of temporary privileges, while taken in the course of medical peer review, are not considered final professional review actions and do not entitle the Practitioner to any procedural rights of review under these Bylaws or otherwise.

SECTION 3 PRIVILEGES IN PATIENT EMERGENCIES AND DISASTER SITUATIONS

A. In case of an emergency, any member of the Staff may request help from any licensed practitioner, to the degree permitted by that Practitioner's license and qualifications, to assist and do everything possible to save the life, limb, or organ of a patient using every facility necessary or desirable. Additionally, in case of an emergency, any member of the Staff, to the degree permitted by his/her license and qualifications, shall be permitted to assist and do everything possible to save the life, limb, or organ of a patient using every facility necessary or desirable. When an emergency situation no longer exists, the Practitioner exercising emergency privileges must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or he/she does not desire to request them, the patient shall be assisted to select an appropriate member of the Staff by the appropriate Division Chief or Staff President. For the purpose of this section, an "emergency" is defined as a condition in which serious permanent harm could result to a patient or in which the life, limb, or organ of a patient is in immediate danger and delay in administering treatment would add to that danger.

B. In the event the Center Disaster Plan is activated and the immediate needs of patients cannot be met, the Staff President, the Chief of the Control Center or the Center President, or their designees, may grant disaster privileges to practitioners who are not members of the Professional Staff and who do not have clinical privileges at the Center. The procedures for granting disaster privileges in

a disaster situation shall be described in the Center policy approved by the Medical Board and the Governing Body.

SECTION 4 ALLIED HEALTH PROFESSIONALS

A. Credentialing and Practice. Qualified individuals in Allied Health Professional categories approved by the Governing Body may be granted clinical privileges and/or scope of practice authorization to provide patient care services in the Center. Allied Health Professionals are not eligible for Staff membership and are not entitled to any procedural rights of review afforded to Practitioners. The Medical Board shall advise the Governing Body with respect to the delineation of clinical privileges and/or scope of practice, the level of delegation, direction and/or supervision required, and the qualifications for Allied Health Professionals. The rights and privileges of Allied Health Professionals shall be limited to those set forth below and in the Credentialing Procedures Manual.

1. Each Allied Health Professional shall be assigned to a Division and must comply with any Division or specialty requirements and policies, as well as the Bylaws and all Center policies and procedures. Allied Health Professionals shall be subject to the authority of the appropriate Division Chief, and the use of Allied Health Professionals by Practitioners must comply with their authorization to practice and the requirements in the Credentialing Procedures Manual.

2. Allied Health Professionals will be subject to FPPE and OPPE if granted clinical privileges.

3. Allied Health Professionals may be appointed to serve on committees (without vote unless otherwise provided in the appointment) to provide a special expertise otherwise not available, participate in continuing medical education programs, and exercise such other prerogatives as authorized by the Medical Board with the approval of the Governing Body that are consistent with their training and demonstrated abilities.

4. The Joint Conference Committee may be requested to review any contracts between the Center and Allied Health Professionals for professional services to be provided in the Center, as provided in Article III.10.

B. Practice by Others. Any practice in the Center by individuals other than Practitioners, Allied Health Professionals, or Center employees shall be in accordance with Center policy. Practice by residents or fellows, whether arranged through individual preceptor Staff members or pursuant to a contract with the Center, shall be subject to the Rules and Regulations and Center policy that shall include required levels of supervision by Staff members. As requested, the Medical Board (or its designee) shall assist the Center in development of

policies regarding such practice, including the authorized scope of practice and required supervision.

SECTION 5 CONTRACT PRACTITIONERS

A. General. The Center may contract with Practitioners or Allied Health Professionals for the provision of professional services. Each contracting Practitioner must be a member of the Staff and each Allied Health Professional must be granted clinical privileges, meeting the same requirements applicable to any other Practitioner or Allied Health Professional. Any termination or limitation of a contracting Practitioner's Staff membership and/or clinical privileges, or an Allied Health Professional's clinical privileges, shall be in accordance with the Bylaws unless otherwise provided in the contract with the Practitioner or Allied Health Professional.

B. Medical Directors. The Center, following consultation with the Medical Board, may appoint members of the Staff to serve in the position of Medical Director of the Center or of clinical units of the Center. The duties and responsibilities of the Medical Directors shall be set forth in a written contract.

SECTION 6 PROCESSES FOR CLINICAL PRIVILEGES; CREDENTIALING PROCEDURES MANUAL

A. The processes for evaluating and granting clinical privileges to Practitioners and Allied Health Professionals shall include the following basic steps:

1. submission of a written application in the form required by the Governing Body;
2. primary source verification and collection of all required and requested information by the System Credentials Department;
3. use of a focused professional practice evaluation with all grants of initial clinical privileges;
4. review and written recommendation by the Credentials Committee, to include review of training, experience, and clinical competence with consideration of available FPPE and OPPE and application of any criteria established for the requested clinical privileges;
5. review and written recommendation by the Medical Board; and
6. review and a final decision by the Governing Body.

The process for affording procedural rights of review, when applicable, is set out in Article XI.

B. The procedures and associated details for evaluating and granting clinical privileges shall be set forth in the Credentialing Procedures Manual. The procedures for FPPE and OPPE shall be set out in written Policy.

ARTICLE VI. DIVISIONS OF THE STAFF

SECTION 1 ORGANIZATION

A. Divisions. There shall be four (4) clinical Divisions within the Staff:

1. Division of Medicine
2. Division of Medical Subspecialties
3. Division of Surgery
4. Division of Critical Care

B. Division of Medicine. This division shall include at least the following specialties:

1. Family Practice
2. Internal Medicine
3. Pediatrics
4. Emergency Medicine

C. Division of Medical Subspecialties. This division shall include at least the following subspecialties:

1. Adolescent Medicine
2. Allergy/Immunology
3. Child Abuse Pediatrics
4. Dermatology
5. Developmental Pediatrics
6. Endocrinology
7. Gastroenterology
8. Genetics/Metabolic Disease
9. Hematology/Oncology
10. Infectious Disease
11. Nephrology
12. Neurology
13. Palliative Care
14. Pathology
15. Physical Medicine and Rehabilitation
16. Psychiatry
17. Radiology
18. Rheumatology

D. Division of Surgery. This division shall include at least the following specialties:

1. Anesthesiology
2. Cardiovascular Surgery
3. Craniofacial Surgery
4. Dental Surgery
5. General Surgery
6. Hand Surgery
7. Neurosurgery
8. Obstetrics/Gynecology
9. Ophthalmology
10. Orthopedic Surgery
11. Otolaryngology
12. Pediatric Surgery
13. Plastic Surgery
14. Traumatology
15. Urology

E. Division of Critical Care. This division shall include at least the following specialties:

1. Cardiology
2. Intensive Care
3. Neonatology
4. Pulmonology

F. Modification of Divisions. The Medical Board shall be authorized to add specialties or subspecialties from the Divisions, subject to the approval of the Governing Body, without the need for an amendment to these Bylaws. Any deletion of a specialty or subspecialty shall require an amendment in accordance with Article XVI.

SECTION 2 DUTIES OF DIVISION

A. Duties. The duties of the Divisions shall include:

1. Recommending to the Credentials Committee what clinical privileges should be offered in the Division and the criteria for the granting those clinical privileges;

2. Providing specialty call coverage for the Center's emergency department and inpatients in accordance with the Bylaws, Manuals, Center policies, and legal requirements;

3. Performing medical peer review including, without limitation, quality management in accord with the Center's performance improvement plan;

4. Advising the Medical Board on matters affecting the delivery of patient care by Practitioners and Allied Health Professionals in the Division or as requested by the Medical Board or Governing Body; and

5. Establishing rules and policies for operation of the Division, subject to the approval of the Medical Board and Governing Body.

B. Specialties. Any duty of a Division may be assigned to a specialty listed under Section 1 (Specialty) or a subspecialty in the case of the Division of Medical Subspecialties (Subspecialty) subject to the ultimate authority and responsibility of the Division. The provisions below applicable to assignment of membership in a Division and meetings of a Division shall apply to a Specialty or Subspecialty.

C. Use of Subcommittees or Ad Hoc Committees. A Division, Specialty or Subspecialty or its chair may appoint and delegate one or more duties to a subcommittee or ad hoc committee. The subcommittee or ad hoc committee shall report back and make recommendations to the appointing entity.

SECTION 3 MEMBERSHIP

Membership in a Division shall consist of all Practitioners in the specialties listed. Each Practitioner shall be a member of the Division most appropriate for the Practitioner's primary practice and for the clinical privileges granted. If no preference is noted by the Practitioner on appointment or reappointment, assignment to a Division shall be made in the course of credentialing. Requests to change Divisions or to belong to more than one Division shall be made to and may be granted by the Credentials Committee if the requesting Practitioner meets all criteria and qualifications for the required Division or specialty within the Division.

SECTION 4 MEETINGS

Division meetings will be held as necessary to perform Division duties and responsibilities, or more frequently on vote by the Division members of the Division or on the call of the Division Chief. The Center President and members of the Governing Body may attend Division meetings. Those Active and Senior Active Staff members present shall constitute a quorum and, unless otherwise provided in these Bylaws, any action shall require the affirmative vote of a majority of those voting.

At the Division Chief's discretion, a Practitioner whose patient's clinical course is scheduled for discussion at any regular or special meeting may be notified and requested to attend the meeting. The Division Chief shall give the Practitioner prior written notice of the place, date, and hour of the meeting.

SECTION 5 QUALIFICATIONS, SELECTION AND TENURE OF DIVISION OFFICERS

A. Qualifications. Each Division shall elect a Division Chief and Vice-Chief who shall be a member of the Active or Senior Active Staff of the Division in good standing at the time of election and must remain so during the term in office. The Division Chief and Vice-Chief must be board certified in their specialty or have established comparable competence through the credentialing process.

B. Election.

1. Nominations of between one (1) and five (5) candidates for the positions of Division Chief and Vice-Chief will be made by the Division members at the Division meeting immediately preceding the annual Staff meeting.

2. The Division Chiefs, Vice-Chiefs, and at-large members of the Medical Board from each Division shall be elected by secret ballot by the Active and Senior Active Staff members of their Division at the annual Staff meeting. The Chief and Vice-Chief of each Division and at-large members of the Medical Board shall be elected by majority vote of those present and voting.

   a. If a majority is not received by any one (1) candidate, a runoff election will be held between the two (2) candidates receiving the largest number of votes.

   b. In the case of a tie, the decision will be made by majority vote of the Medical Board at the first meeting of the Medical Board after the election and will be announced at the next meeting of the Division and the next general Staff meeting.

3. The Governing Body's approval of Division Chiefs and Vice-Chiefs and the at-large members to the Medical Board must be obtained prior to their taking office.

C. Terms. Each Chief and Vice-Chief of a Division is elected for a two (2) year term, to begin on January 1 of the year after the election occurs.

D. Removal from Office.

1. Failure to maintain Active or Senior Active Staff status in good standing throughout the term of office shall result in automatic removal from office, effective immediately.

2. Removal of a Chief or Vice-Chief of a Division may be initiated by any of the following mechanisms: (i) a majority vote of the Medical Board, (ii) a

majority vote of the Governing Body, or (iii) a petition signed by a majority of the Active and Senior Active Staff members of the Division.

3. Removal of a Chief or Vice-Chief of a Division will be considered at a special meeting of the Division. The officer for whom removal is being initiated shall be given prior special notice of the proposed removal and the date of the meeting by the other Division officer. The petition and any statement of the reasons for the requested removal shall be available in the System Credentials Department prior to the meeting and available at the meeting. The other Division officer shall chair the Division meeting. A representative of the group that initiated the removal must attend the meeting and present the reasons that removal is being requested and any support he/she deems appropriate. A majority vote of those Active and Senior Active Staff members present and voting is required for removal. Voting shall be by secret ballot and proxy voting is not permitted.

E. Vacancies in Office. Vacancies in the office of Chief of a Division will be filled by the Vice-Chief. Vacancies in the office of Vice-Chief of a Division will be filled by interim election at the first Division meeting after the vacancy occurs. The new Vice-Chief must be approved by the Governing Body before taking office. Practitioners filling such vacancies will serve until the next election.

SECTION 6 DUTIES OF DIVISION OFFICERS

A. Chief. The Chief of each Division shall:

1. Serve as a member of the Medical Board and of the Quality Improvement/Case Review Committee;

2. Give guidance and specific recommendations and suggestions to the Medical Board on the policies and functioning of the Division, and be responsible for the implementation within the Division of the Staff and Center Bylaws and any actions taken by the Medical Board or Governing Body;

3. Be responsible for and participate in all clinically related activities of the Division, and administratively related activities unless otherwise provided by the Center, coordinating and integrating those services within the Division, with other Divisions, and into the primary functions of the Center;

4. Recommend to the Credentials Committee the criteria for clinical privileges approved by the Division and be responsible for credentialing functions and recommendations for focused professional practice evaluation and clinical privileges for all applicants for initial appointment or reappointment and/or clinical privileges in the Division;

5. Be responsible for determining the qualifications and competence of health care professionals who are not subject to the Professional Staff credentialing process and others who provide patient care services within the Division;

6. Be responsible for ongoing professional practice evaluation and continuing surveillance of professional performance of all individuals in the Division who have delineated clinical privileges and assessment and improvement of the quality of care and services provided in the Division, including the maintenance of quality control programs as appropriate;

7. Be responsible for the development of policies and procedures to guide and support the services provided within the Division;

8. Be responsible for assessing and recommending to the appropriate Center personnel the sufficient number of qualified and competent persons, space, and other resources needed by the Division and off-site sources for needed patient care services not provided by the Division or the Center; and

9. Be responsible for the orientation and continuing education of all persons in the Division.

Unless otherwise provided by the Medical Board or required by legal and/or accreditation standards, the duties of a Division Chief may be assigned to a Medical Director or Center staff or the Division Chief may delegate any of his/her duties to a member of the Division. Regardless, the Division Chief shall remain responsible to ensure the duties are performed and accountable to the Medical Board for their performance.

B. Vice-Chief. The Vice-Chief of each Division shall:

1. Be responsible for all the duties of the Chief of the Division in the absence of the Chief; and

2. Serve as a member of the Quality Improvement/Case Review Committee to report on the Division's performance improvement activities and to report the committee's activities back to the Division.

ARTICLE VII. OFFICERS OF THE STAFF

SECTION 1 GENERAL

The officers of the Staff shall be the Staff President, Vice-President of Credentialing, and Vice-President of Quality. Officers of the Staff must be members of the Active or Senior Active Staff in good standing at the time of election and must remain so during

their term in office. Failure to maintain such status shall immediately and automatically create a vacancy in the office involved. Additional qualifications are set out in Section 7 below.

SECTION 2 NOMINATING PROCEDURES

A. Nominating Committee. A Nominating Committee shall consist of the Staff President acting as Chair, the Vice-President of Credentialing, the Vice-President of Quality, and the Division Chiefs and Vice-Chiefs.

B. Nominations.

1. Nominations of one (1) to five (5) candidates for the positions of Staff President, Vice-President of Credentialing, and Vice-President of Quality and the at-large positions on the Medical Board will be made at least sixty (60) days prior to the annual Staff meeting by the Nominating Committee from a pool of qualified candidates which will be compiled from Staff records. These names will be submitted to the Staff or the members of each Division at least twenty-eight (28) days prior to the election meeting.

2. An alternate route of nomination can be by petition signed by at least ten (10) voting members of the Staff that is attached to a signed statement by the qualified nominee attesting to his/her willingness to stand for election. This petition will be filed with the System Credentials Department at least seven (7) days prior to the election meeting.

SECTION 3 VOTING PROCEDURES

A. Eligibility. Members of the Active and Senior Active Staff may vote at the election Staff meeting. Voting will be by secret ballot and proxy votes will not be allowed. A separate sign-in roster of those qualified to vote will be maintained. Absentee voting is allowed by presenting a completed sealed ballot to the System Credentials Department within one (1) week prior to the election meeting. Absentee ballots shall be opened at the meeting.

B. Required Vote. To be elected, a candidate must receive a majority of the votes cast. If a majority is not obtained, a runoff election will be held between the two (2) candidates with the largest number of votes. Any runoff elections will be held within one (1) week following the election meeting and may occur by electronic ballot or a sealed written ballot submitted to the System Credentialing Department. In the event of a tie vote, the election will be decided by a majority vote of the Medical Board at its next meeting. Votes will be counted and reported by the Nominating Committee following completion of the electronic process.

SECTION 4 TERMS

The Staff President shall serve a two (2) year term. Each Vice-President shall serve a four (4) year term. The terms of the Vice-Presidents shall be staggered so that one Vice-President is elected every two (2) years. Officers may be re-elected, but may not serve as an officer for more than eight (8) out of ten (10) consecutive years.

SECTION 5 REMOVAL FROM OFFICE

A. Cause. A Staff officer may be removed from office for cause, defined as: (i) failure to perform the required duties of the office, (ii) failure to adhere to professional ethics, including but not limited to the Center's Code of Conduct, or (iii) failure to comply with or support enforcement of the Center and Staff Bylaws and policies.

B. Procedures.

   1. Removal of a Staff officer may be initiated by: (i) a majority vote of the Medical Board, (ii) a majority vote of the Governing Body, or (iii) a petition signed by at least twenty-five (25) voting members of the Staff.

   2. Removal of a Staff officer will be considered at a special meeting of the Staff. The officer for whom removal is being initiated shall be given prior special notice of the proposed removal and the date of the meeting by the most senior available Staff officer not being removed. The petition and any statement of the reasons for the requested removal shall be available in the System Credentials Department prior to the meeting and available at the meeting. The most senior available Staff officer not being removed shall chair the Staff meeting. A representative of the group that initiated the removal must attend the meeting and present the reasons that removal is being requested and any support he/she deems appropriate. A majority vote of those Active and Senior Active Staff members present and voting is required for removal. Voting shall be by secret ballot and proxy voting is not permitted.

SECTION 6 VACANCIES IN OFFICE

Should the Staff President leave office during his/her term for any reason, the Vice-President who has served for the longer period of time shall succeed the Staff President. Should the Vice-President of Credentialing or Vice-President of Quality leave office during his/her term, regardless of the reason, the Medical Board shall appoint a replacement to serve until the next election.

SECTION 7 DUTIES AND QUALIFICATIONS

A. Staff President.

1. Duties. The duties of the Staff President are to provide oversight and leadership of the Staff organization, serve as the chair of the Medical Board and preside at Staff meetings, and serve as a liaison between the Staff and Center administration and the Governing Body.

2. Qualifications. The Staff President must:

   a. Be a physician (M.D. or D.O.);

   b. Be board certified in his/her specialty or have established comparable competence through the credentialing process;

   c. Have served at least five (5) years on the Active Staff;

   d. Have at least two (2) years experience in leadership positions for the Staff or a Division, have served on the Credentials Committee or have served on a Staff quality improvement committee within the six (6) years prior to election;

   e. Have participated in educational programs relating to medical staff organization, leadership, and/or management within the three (3) years prior to election or have agreed to attend a program within the first six (6) months of election; and

   f. Not hold a staff officer position at another hospital or health care system during the term of office.

B. Vice-President of Credentialing and Vice-President of Quality

1. Duties. The Vice-President of Credentialing or the Vice-President of Quality who has served in that capacity for the longer period of time shall be responsible for the duties of the Staff President in his/her absence. The Vice-Presidents shall serve as either the Chair of the Credentials Committee or the Chair of the Quality Improvement/Case Review Committee.

2. Qualifications. Vice-Presidents must:

   a. Be a physician (M.D. or D.O.);

   b. Be board certified in his/her specialty or have established comparable competence through the credentialing process;

c. Served at least five (5) years on the Active Staff;

d. Have served in a Staff, Division, or committee leadership capacity;
e. Have attended within the prior three (3) years, or agree to attend after election, an educational seminar on medical staff quality improvement; and

f. Not hold a staff officer position at another hospital or health care system during the term of office.

3. Committee Chairmanship. The elected Vice-President will serve as the Chair of either the Credentials Committee or the Quality Improvement/Case Review Committee, depending on which committee has a vacancy at the time of the election. The Vice-President of Credentialing and the Vice-President of Quality shall serve as Chair of the same committee for the entire four (4) year term of office. Each Vice-President shall serve as an ex-officio member of the other committee

ARTICLE VIII. MEETINGS OF THE STAFF

SECTION 1 TYPE AND FREQUENCY

A. General meetings. There will be at least two (2) meetings in the calendar year, one of which is the annual meeting. The exact schedule will be determined by the Staff President who shall give the voting Staff members prior written notice by mail, facsimile, or electronic transmission (email) using the contact information currently on file in the System Credentials Department. The Staff President shall establish the agenda for the meeting.

B. Special meetings.

1. Special meetings may be called: (i) by the Staff President, (ii) on a majority vote of the Medical Board, or (iii) by written request submitted to the Staff President of not less than twenty-five (25) voting members of the Staff. A special meeting shall be called within fourteen (14) days of the request. The Staff President shall designate the time and place of a special meeting. The agenda of a special meeting shall be limited to the issue(s) for which the meeting was called.

2. Special notice stating the time and place of the meeting and the topic of the special meeting shall be forwarded to each voting member of the Staff not less than five (5) days before the date of such meeting. Attendance of a member of the Staff at a meeting shall constitute a waiver of notice of such meeting.

3. Except for the Center President and members of the Governing Body, non-Staff attendees may be asked by the Staff President to leave during the voting process.

SECTION 2 QUORUM AND VOTING

Those Active and Senior Active Staff members who are present at any general or special Staff meeting shall constitute a quorum for purposes of adoption or amendment of the Bylaws, a Manual, or Policy, and for all other actions of the Staff. Unless otherwise provided in the Bylaws, actions by a majority of the Active and Senior Active Staff members present and voting at a meeting shall be an action of the Staff. No absentee or proxy votes shall be allowed, except as allowed under Article VII.3. and Article XVI.

SECTION 3 MINUTES

Minutes of each general and special meeting shall be prepared and shall be signed by the presiding officer. A permanent file of these minutes shall be maintained in the System Credentials Department.

SECTION 4 ATTENDANCE

Attendance by members of all Staff categories is permitted and encouraged, but is not required. The Center President and voting members of the Governing Body may attend any meeting of the Staff. Other guests may be invited by the Staff President.

ARTICLE IX. STAFF COMMITTEES

SECTION 1 GENERAL

A. Purpose. The committees of the Staff provide the organizational structure for the Staff to carry out its functions and responsibilities as set forth below and as may be delegated by the Staff and/or the Medical Board.

1. Each committee shall consider, evaluate, and report on matters within its assigned area of responsibilities that may, at times, overlap. Each committee may adopt procedures consistent with the Bylaws and any legal and accreditation requirements for carrying out its duties. The committee or its Chair may delegate one or more functions to a subcommittee or ad hoc committee.

2. The Staff may utilize committees, both standing and ad hoc, to accomplish its functions. The Medical Board or the Staff President on its behalf may appoint ad hoc committees of the Staff. Committees may be established as joint committees or meet jointly with the approval of the Medical Board and Governing Body.

B. Joint Committees.

1. Joint System Committees. By these Bylaws, the Staff agrees that certain medical peer review functions are delegated to be performed by joint committees of a health care system, specifically the Center, the Cook Children's Health Care System the Cook Children's Physician Network, the Cook Children's Health Plan, and the Cook Children's Home Health ("Joint System Committee" or "Joint System Committees"). Each Joint System Committee shall include at least one (1) Staff member as a voting member, to be appointed by the Staff President. The Joint System Committees shall report to the System Board Quality Committee as well as the Governing Body and the governing bodies of the other three (3) health care entities.

   The following committees, and any others approved by the Medical Board and Governing Body, may be established as Joint System Committees, with the composition, duties, meetings, and reporting requirements set forth in a written Joint System Committee Policy on approval by the Medical Board and Governing Body, and any other entities as set forth in the policy.

   a. System Clinical Excellence Committee;
   b. System Infection Prevention and Control Committee;
   c. System Institutional Review Board;
   d. System Medical Records Committee;
   e. System Patient Safety Committee;
   f. System Quality Data Review Committee;
   g. System Research Development Council;
   h. System Risk Management Committee; and
   i. Interprofessional Continuing Education (IPCE) Committee.

2. Credentials Committee. If the Credentials Committee of the Medical Staff is established as a joint committee of a health care system, specifically the Center and the Cook Children's Physician Network ("Joint Credentials Committee") (see Section 4.G. below), the Staff officer chairing that committee under Article VII.7.B. and C. shall serve as the Center Co-Chair of the Joint Credentials Committee.

C. Committee Review Function. Each committee (whether Staff, Division, Specialty, Subspecialty, ad hoc, subcommittee, or joint as set forth in Section B above) as well as the Staff when meeting as a whole, shall be constituted and operate as a medical peer review committee/medical committee/professional review body, as such terms are defined by law, and is authorized by the Governing Body to engage in medical peer review. See Article XIII for further detail.

SECTION 2 COMMITTEE APPOINTMENT

A. Appointment. Unless otherwise provided below, appointment of Staff members to Staff committees will be made by the Staff President subject to the advice of the outgoing Staff President and the incoming Staff officers, who shall meet prior to the beginning of the year. The numbers of Staff members on committees described herein are minimum numbers and may be increased by the Staff President. Unless otherwise provided below, the Center President shall appoint committee members who are not members of the Staff.

1. In addition to any provisions for ex-officio members under the specific committees below, the Staff President, Vice-President of Credentialing, Vice-President of Quality, immediate past Staff President, Center President, Chief Medical Officer, and Legal Counsel shall serve as ex-officio members of all committees of the Staff. Their presence shall not contribute to a quorum. Voting members of the Governing Body may also attend committee meetings in an ex-officio capacity.

2. The System Senior Vice-President of Quality Management shall be an ex-officio member of all committees that report through the Quality Improvement/Case Review Committee.

3. The Chair of a committee or the Medical Board may invite anyone who may contribute to attend any meeting as an agent in a non-voting capacity. Except for those individuals listed in Section A.1. above, non-voting members and agents of any committee may be excused from certain discussions and actions of the committee at the request of the committee Chair.

B. Terms. Unless otherwise provided, each committee Staff member shall be appointed for two (2) year terms with reasonable attempts to stagger the terms.

C. Removal and Vacancies.

1. If, in any six (6) month interval, a committee member fails to attend at least one-half (1/2) of the meetings, the committee's Chair may request removal of that member by the Medical Board. The Medical Board may also remove a member for other good cause. Termination of appointment shall occur if a member resigns from the Professional Staff or resigns from the committee.

2. Any committee vacancy, including those on the Medical Board, will be filled on an interim basis (to the end of the original member's term) through appointment by the Staff President with the approval of the Medical Board.

D. Selection of Chair. The Chair of each committee shall be appointed annually by the Staff President unless otherwise provided in the Bylaws. A Vice-Chair shall be elected by a majority vote of the committee. Either may be removed by the Medical Board. Vacancies shall be filled by appointment by the Staff President.

E. Meetings.

1. Regular meetings shall be held at the place, date, and hour chosen by the Chair of the committee or by majority vote of the committee and at the minimum frequency defined in these Bylaws for the committee.

2. Special meetings of any committee other than the Medical Board may be called by: (i) the Chair of the committee, at his/her own initiative, or at the request of a voting member, or (ii) the Staff President to address specific issues that must be addressed prior to the next regular scheduled meeting. These issues must be spelled out in the agenda and the meeting shall be limited to discussing only these issues.

3. Written or telephone notice of the place, date and hour of any meeting shall be given to each member of the committee not less than three (3) days prior to the date of the meeting. The Chair or the System Credentials Department shall be responsible for the notification.

4. Any member may propose a subject for the agenda of a regular committee meeting by notifying the System Credentials Department at least three (3) days prior to the meeting. Final approval of agenda items rests with the Chair if time does not permit consideration of all proposed items.

F. Quorum and Voting. Committee business may be conducted and recorded only if a quorum of at least one-third (1/3rd) of the voting Staff members are present, but in no event less than two (2) voting Staff members. Once a quorum is established, business may continue as long as at least two (2) voting Staff members are present. If approved by the committee Chair, a committee Staff member who is unable to attend may send a representative in his/her place who shall be counted for purposes of establishing a quorum and may participate on a voting basis if the member he/she is representing is a voting member. Action may be taken on the vote of a simple majority of the members present and voting.

G. Action without Meeting. Unless otherwise restricted by these Bylaws, any action required or permitted to be taken at any committee meeting may be taken without a meeting by written consent or by electronic voting, setting forth the action so taken, by a majority of the voting committee members. No committee is permitted to recommend corrective action or make an Adverse Recommendation or Action without a meeting except for summary corrective action in accordance with Article X.2.

H. Special Attendance Requirements. At the Chair's discretion, a Practitioner whose clinical competence or professional conduct is scheduled for discussion at any regular or special committee meeting may be notified and requested to attend the meeting. The Chair of the committee shall give the Practitioner special notice of the place, date, and hour of the meeting.

I. Minutes. Minutes of each regular and special meeting of a committee shall be prepared and shall include attendance, issues discussed, and any votes on motions. The minutes shall be signed and approved by the committee Chair prior to being submitted to the Quality Improvement/Case Review Committee and/or the Medical Board. Medical Staff Services shall maintain a permanent file of the minutes of each committee. Committee minutes are available to Staff members who are members of the committee and who require the minutes for the performance of committee duties and responsibilities.

SECTION 3 MEDICAL BOARD

A. Composition and Terms. The Medical Board shall serve as the executive committee of the Staff and shall consist of the three (3) officers of the Staff, the immediate past Staff President, the Division Chiefs, two (2) at-large Staff members from each Division for a total of eight (8), and one (1) representative of the Governing Body.

Ex-officio members shall be the Chair of the Bylaws Committee, the Chair of the Interprofessional Continuing Education Committee, the Center President, the Chief Medical Officer, the Chief Quality Officer, the Vice-President of Nursing/Chief Nursing Officer, and the Chair of Peer Assistance Committee.

1. The Chair of the Medical Board shall be the Staff President, and the Vice-Chair position shall be shared by the Vice-President of Quality and the Vice-President of Credentialing.

2. Terms of Medical Board members shall be two (2) years, except for Division Chiefs. In order to maintain continuity of experience on the Medical Board, reasonable attempts shall be made to stagger the elections of the at-large members. A majority of the voting members of the Medical Board must be physicians actively practicing in the Center.

3. The at-large Staff members must be members in good standing at the time of election and remain so during the term of office. They shall be elected by the voting members of the respective Divisions at the annual Staff meeting using the procedures for election of Division officers. An at-large member may be removed for good cause by the voting members of the Staff using the procedures for removal of a Division officer in Article VI.5.D. or by majority vote of the Medical Board. Any vacancy shall be

filled by the Division Chief to serve until the next annual Staff meeting election.

B. Duties. By these Bylaws, the Staff delegates to the Medical Board the authority to carry out Staff responsibilities and to act on its behalf between Staff meetings within the scope of its responsibilities as set out below. The duties of the Medical Board shall be to:

1. Represent and to act on behalf on the Staff as set forth in these Bylaws;

2. Coordinate the activities and general policies of the various Divisions;

3. Receive and act upon committee reports;

4. Enforce the Bylaws and implement policies of the Staff not otherwise the responsibilities of the Divisions;

5. Provide a liaison between the Staff, the Center President and the Governing Body;

6. Recommend action to the Center President on matters of medico-administrative nature;

7. Make recommendations on hospital management matters and contracted patient care services to the Governing Body through the Center President;

8. Fulfill the Staff's accountability to the Governing Body for the professional health care rendered to patients in the Center;

9. Organize the Staff’s performance improvement activities and establish a mechanism designed to conduct, evaluate, and revise those activities, which mechanism shall include the review of reports and implementation of action on performance improvement activities in accord with the quality improvement program adopted by the Governing Body, and dissemination of aggregate results to the Staff, ancillary services, and the Governing Body;

10. Ensure that the Staff is kept abreast of the accreditation program and informed of the accreditation status of the Center;

11. Review and investigate the recommendations, as forwarded by the Credentials Committee, of applicants for Staff membership and/or clinical privileges and to make recommendations to the Governing Body for Staff membership, assignment to Divisions, and/or delineations of clinical privileges of these applicants;

12. Review and investigate the recommendations of the Credentials Committee regarding the performance and clinical competence of Staff members and Allied Health Professionals with clinical privileges, and to make recommendations to the Governing Body for reappointment and renewal or changes in clinical privileges;

13. Make recommendations to the Governing Body as to the Staff's structure, the processes used to determine appointment to the Staff and the granting of clinical privileges, the processes used to terminate Staff appointment and/or clinical privileges and to afford procedural rights of review, and any revisions to the Bylaws or any Manuals of the Staff;

14. Take all reasonable steps to promote professional conduct and competent clinical performance on the part of all Staff members and Allied Health Professionals with clinical privileges, including the initiation and/or participation in corrective action or review measures when warranted; and

15. Report at each general Staff meeting.

C. Meetings. The Medical Board shall meet at least ten (10) times per year, at a time and place designated by its Chair. Special meetings may be called by the Chair or on written request of three (3) voting Staff members of the Medical Board.

D. Removal of Delegated Authority. Removal of authority that has been delegated to the Medical Board as set forth above shall require amendment of these Bylaws.

SECTION 4 CREDENTIALS COMMITTEE

A. Composition. The Credentials Committee shall be composed of at least six (6) Staff members. Five (5) of the Center members shall be appointed by the Staff President from the Divisions in a manner reasonably representative of the proportions of various disciplines of the Staff. The sixth member shall be the Vice-President of the Staff, as determined in Article VII.7.B.3, who shall serve as the Vice-President of Credentialing of the Staff.

The Chief Medical Officer, the Chief Quality Officer, the Vice-President of Quality, a member of the Peer Assistance Committee, Legal Counsel, and the Center's Chief Nursing Officer shall be ex-officio members.

1. Members of the Credentials Committee shall have demonstrated experience in leadership and specific training in credentialing matters. Prerequisites for committee members are: (i) demonstrated leadership aptitude and skill; (ii) attendance within the prior three (3) years, or an agreement to attend within the first six (6) months of appointment, at a

course on medical staff credentialing acceptable to the Staff President or his or her designee; and (iii) active staff status at the Center or another Joint Commission-accredited hospital for at least six (6) years prior to initial date of committee service.

2. The members of the Credentials Committee shall serve two (2) consecutive years, with reasonable attempts to stagger terms. The reappointment to the committee of skilled members is encouraged to provide the committee with experience.

C. Duties. The duties of the committee are to:

1. Review and investigate the credentials of all applicants for appointment, reappointment, clinical privileges, and/or participation in the Center and/or Network, and to make recommendations applying the standards, criteria, and qualifications to the Medical Board;

2. Issue a recommendation on each applicant within thirty (30) days of the Credentials Committee's receipt of a completed application, which may include a recommendation for focused professional practice evaluation that exceeds the requirements of the approved evaluation method of the applicable Division specialty;

3. Review and periodically investigate all information available regarding the competence of Practitioners and Allied Health Professionals, and, as a result of these reviews, make recommendations for the granting of privileges and/or focused professional practice evaluation at reappointment, any limitation or restriction on membership, clinical privileges and/or participation in the Center, and the assignment of Practitioners and Allied Health Professionals to the Divisions of the Center Staff as applicable;

4. Review, investigate, and take action on requests for corrective action;

5. Approve the process used to review the credentials of any house staff under the supervision of any Staff member and approve their proposed clinical or non-clinical role at the Center;

6. Define, review, and recommend credentialing and privileging process standardization for the Center and Network (e.g., pre-application; privilege forms);

7. Define acceptable performance measurements for the System Credentials Department and monitors measurements for opportunities for improvement (e.g., turnaround; audit results; participating program satisfaction); and

8. Review and approve revisions to System Credentials Department policies and procedures.

D. Meetings. The committee shall meet as needed to conduct business and on the call of the Chair.

E. Action without Meeting. The committee may not recommend corrective action or make an Adverse Recommendation or Action without a meeting. New applicants may be approved without a meeting only if there is no negative information in the applicant's credentials file and there is an immediate patient care need or other extenuating circumstance that requires action without a meeting.

F. Reports. The committee shall report to the Medical Board.

G. Joint Credentials Committee with Network. If the Governing Body, following recommendation by the Medical Board, and the Network approve operating the Credentials Committee jointly with the Network ("Joint Credentials Committee'), the membership of the committee shall be increased if necessary to ensure that at least three (3) voting members of the committee are members of the Network. The committee shall be co-chaired by the Vice-President of Credentialing of the Staff and an appointee of the Executive Committee of the Network. The duties, procedures and other details for the Joint Credentials Committee shall be set out in the Credentialing Procedures Manual approved as set forth in Article XV. In the case of a Joint Credentials Committee, all references in these Bylaws to Chair of the Credentials Committee shall be to the Co-Chair or Co-Chairs of the Joint Credentials Committee.

SECTION 5 QUALITY IMPROVEMENT/CASE REVIEW COMMITTEE

A. Composition. The committee shall be composed of the Vice-President of Quality who shall serve as Chair, the Division Vice-Chiefs, the Chief Medical Officer, the Chief Quality Officer, the Chair of the System Clinical Excellence Committee, the Chair of the Pharmacy and Therapeutics Committee, and up to ten (10) at-large members.

Ex-officio members shall consist of: the Staff President, the Vice-President of Credentialing, the System Risk Manager, two (2) System Accreditation and Improvement Nurses, the Center's Chief Nursing Officer, and one (1) Nursing Director/Administrator from the Center.

B. Duties. The duties of the committee shall be to:

1. Direct the development and analysis of clinical quality assurance/assessment indicator flags for the Center;

2. Receive and assess data from the Center's patient care committee structures relative to patient care processes and outcomes and review justifications for continued hospitalization of patients;

3. Conduct ongoing professional practice evaluation of Staff members and other individuals with clinical privileges by reviewing and evaluating individual Practitioner quality concerns as identified through the System's Risk Management Occurrence Reporting Process, member/patient/family complaints regarding practitioner quality of care, variances identified through predetermined indicator flags, or reviewed through established System and/or Center committee mechanisms;

4. Recommend focused professional practice evaluation or remedial measures when indicated to a Practitioner or Allied Health Professional to be implemented on a voluntary basis, receive feedback from the same, and assess, or if focused professional practice evaluation or voluntary remedial measures are not implemented or appropriate, recommend corrective action in accordance with the Bylaws; and

5. Review Sentinel Events and significant events and direct the root cause analysis (RCA) process and monitor compliance with action plans.

C. Meetings. The committee shall meet as needed to perform its duties and on call of the Chair.

D. Reports. The Quality Improvement/Case Review Committee shall report to the Medical Board, with a copy of its report provided to the Credentials Committee.

SECTION 6 BYLAWS COMMITTEE

A. Composition. The committee shall be composed of at least four (4) Staff members.

B. Duties. The committee shall:

1. Be responsible for making recommendations relating to revisions and updating the Bylaws and Manuals;

2. Receive all correspondence regarding any suggestions of changes or additions to the Bylaws or Manuals and act on these suggestions; and

3. Be responsible for a comprehensive review of the Bylaws and Manuals at intervals of no greater than four (4) years.

C. Meetings. The committee may conduct business in person, by regular mail or electronic means and shall meet at least annually on call by the Chair, and as needed to perform its duties.

D. Reports. The committee shall report to the Medical Board.

SECTION 7 CANCER COMMITTEE

A. Composition. The Cancer Committee shall be a multi-disciplinary committee composed of physicians and non-physicians. The Cancer Committee Chair shall be appointed by the Staff President in collaboration with the Medical Director of Hematology/Oncology. The Chair shall be a physician with knowledge and special interest in hematology and oncology. The committee should include voting Staff members from at least the following disciplines: pediatric surgery, neurosurgery, diagnostic radiology, pathology, radiation oncology, hematology/oncology, neuropsychology, and palliative care.

Ex-officio members shall be appointed from the following areas: Administration, Nursing, Social Services, Cancer Registry, and Quality Improvement. Other special representatives may be appointed as deemed necessary by the committee Chair.

B. Duties. The duties of the committee shall be to:

1. Develop and evaluate goals and objectives related to cancer care;

2 Promote a coordinated, multi-disciplinary approach to patient management;

3. Promote clinical research;

4. Supervise the cancer registry and perform quality control of registry data such as abstracting, staging, and reporting;

5. Appoint a registry physician-advisor;

6. Receive and analyze clinically meaningful analyses of patient diagnosis, treatment and outcomes to ensure quality care including survival analyses or other outcome measures selected at the discretion of the cancer committee. These analyses will be shared with physician medical staff and administration annually via written reports, presentations and/or electronic postings; and

7. Supervise and ensure compliance with American College of Surgeons Standards.

C. Meetings. The committee shall meet as needed to perform its duties and on call of the Chair.

D. Reports. The committee shall report to the Medical Board.

SECTION 8 PHARMACY AND THERAPEUTICS COMMITTEE

A. Composition. The committee shall be composed of at least six (6) Staff members.

Ex-officio members shall include one (1) representative each from Nursing Service and Administration. The Center's chief pharmacist shall be a voting ex-officio member of this committee.

B. Duties. The duties of the committee shall be to:

1. Be responsible for the development and surveillance of all drug utilization policies and practices within the Center in order to promote optimum clinical results with minimum potential for hazard;

2. Serve as an advisory group to the Staff and the Center's director of pharmacy services on matters pertaining to the choices of available investigational drugs or research in the use of the recognized drugs;

3. Make recommendations concerning the Center's formulary and drugs to be stocked on nursing units and by other services;

4. Evaluate clinical data concerning new drugs or preparations requested for use in the Center; and

5. Review adverse drug reactions, patterns of activity, and potential medication errors.

C. Meetings. The committee shall meet as needed to perform its duties and on call of the Chair.

D. Reports. The committee shall report to the Quality Improvement/Case Review Committee.

SECTION 9 TISSUE COMMITTEE

A. Composition. The committee shall be a multi-disciplinary committee of at least seven (7) Staff members. Representatives from the following areas shall serve on the committee: gastroenterology, hematology/oncology, pathology,

pulmonology, radiology, risk management, a surgical subspecialty. A general pediatric surgeon shall serve as chair.

B. Duties. The duties of the committee shall be to:

1. To appraise the appropriateness of surgical/medical care by analyzing individual cases and trends where adverse factor(s) and recurring problem(s) in specimen handling/patient management have been identified by current monitoring systems; and

2. Make recommendations to correct any deficiencies encountered.

C. Meetings. The committee shall meet as needed to perform its duties and on the call of the Chair.

D. Reports. The committee shall report to the Quality Improvement/Case Review Committee.

SECTION 10 TRANSFUSION COMMITTEE

A. Composition. The committee shall be a multi-disciplinary committee of at least six (6) Staff members to include a pathologist, intensivist, surgeon, emergency medicine physician, neonatologist, and anesthesiologist. A transfusion service manager shall also be a non-voting member of the committee.

B. Duties. The duties of the committee shall be to:

1. Review the records of transfusions of blood and blood components in order to identify and study transfusion reactions, transmission of disease, blood utilization, and to make recommendations regarding improvements in transfusion services (including policies and procedures relating to the distribution, handling, and administration of blood or blood products); and

2. Perform blood utilization review studies.

C. Meetings. The committee shall meet as needed to perform its duties and on call by the Chair.

D. Reports. The committee shall report to the Quality Improvement/Case Review Committee.

SECTION 11 TRAUMA PERFORMANCE IMPROVEMENT AND PATIENT SAFETY COMMITTEE (“TRAUMA PIPS COMMITTEE”)

A. Composition. The Trauma PIPS Committee shall be a multi-disciplinary committee composed of practitioners that meet requirements as outlined in the

American College of Surgeons' Committee on Trauma, Resources for Optimal Care of the Injured Patient, as currently revised. The Medical Director of Trauma shall serve as Chair. Staff members from the following areas shall serve as voting members: pediatric surgery, neurological surgery, orthopedic surgery, emergency services, anesthesiology, critical care, pathology services, CARE Team, and Rehabilitation Services.

Ex-officio members shall include the Trauma Program Director, Trauma Performance Improvement Coordinator, and representatives from Administration. Other special nursing and ancillary representatives may be appointed as deemed necessary by one or both of the Co-Chairs.

B. Duties. The duties of the committee shall be to:

1. Conduct medical peer review of trauma services, such as quality management evaluation of response times, appropriateness and timeliness of care, complaints, and evaluation of care priorities among specialties, and make recommendations to Quality Improvement/Case Review Committee;

2. Review provider related morbidities and mortalities in trauma care;

3. Review of analysis, of at least mortality, morbidity and functional status, and periodic review of the pediatric process and outcome measures tracked by quality management that encompass pre-hospital, hospital and post-hospital trauma care, and make recommendations to Quality Improvement/Case Review Committee; and

4. Such other duties as requested by Quality Improvement/Case Review Committee or the Medical Board concerning the delivery of trauma care.

C. Meetings. The committee shall meet as needed to perform its duties and on call of the Chair.

D. Reports. The committee shall report to the Quality Improvement/Case Review Committee. Further, the committee may make summary reports to the Surgery Quality PIPS Committee.

SECTION 12 JOINT CONFERENCE COMMITTEE

A. Composition. The Joint Conference Committee shall be a committee of both the Medical Staff and the Governing Body.

1. Six (6) members shall be from the Staff and shall include the three (3) Staff officers, the immediate past Staff President, and two (2) members of the Staff who have served on the Medical Board within the last ten (10)

years who are appointed by the Staff President on an ad hoc basis when the committee meets.

2. Six (6) members shall be from the Governing Body and shall include the Chair or Vice-Chair of the Governing Body.

3. The Chair of the Governing Body shall appoint a Governing Body member from the six (6) Governing Body members to serve as Chair of the Joint Conference Committee on even years, with the Staff President appointing a Staff member from the six (6) Staff members to serve as Chair on odd years.

4. The Chief Medical Officer and Center President shall serve as ex-officio members. Other ex-officio members may be appointed from time to time by the committee Chair.

B. Duties. The purpose of the Joint Conference Committee is to create an additional forum for discussion of issues that affect the Center and the Staff, excluding individual medical peer review matters, and to provide an ongoing process for managing conflict between Staff leadership and the Governing Body. The duties of the committee shall include:

1. Participation in strategic planning for the Center and System as it affects the Staff;

2. Review of contracts as set forth in Article III.10.;

3. Program development; and

4. Making recommendations to the Governing Body for resolution of disputes between the Staff and the Governing Body and/or the Center President through conflict management as detailed below.

C. Meetings. The committee shall meet as needed to perform its duties and on call of the Chair, the Staff President, or the Governing Body Chair or Vice-Chair member of the committee.

D. Conflict Management. The conflict management process shall provide for the Joint Conference Committee to:

1. Meet as early as possible to identify the conflict, to include additional parties if essential to resolving the conflict;

2. Gather information about the conflict;

3. Work with other representatives of both the Staff and the Governing Body as needed to manage and, when possible, resolve the conflict; and

4. Protect the safety and quality of care.

The committee may utilize the services of a facilitator or mediator for meetings with the approval of the Chair.

E. Reports. The committee shall report to the Medical Board and Governing Body. If the committee cannot resolve the conflict in a manner agreeable to all parties, the Governing Body shall proceed with a final decision on the issue that gave rise to the conflict.

SECTION 13 PATIENT CARE ETHICS COMMITTEE

A. Composition. The members of the Patient Care Ethics Committee shall be appointed by the Center President. Each member shall serve a two (2) year term, and may serve additional terms. The Patient Care Ethics Committee shall be composed of the following:

1. At least three (3) Active Staff physician representatives, one of whom must be associated with the care of critically ill children;

2. The Center's Director of Pastoral Care or his/her designee;

3. At least three (3) nursing representatives from the Center, one of whom must be associated with the care of critically ill children;

4. At least two (2) representatives from a family support service such as Child Life, Case Management, Patient Representative, or Behavioral Health;

5. One (1) administrative representative from the Center;

6. One (1) representative from the Governing Body; and

7. At least three (3) community members, at least two (2) of whom must be parent representatives.

Ex-officio resource members shall be:

1. Immediate past Chair of Patient Care Ethics Committee;

2. Legal Counsel;

3. Chief Medical Officer; and

4. Medical Librarian.

The Chair shall be appointed by the Center President, and shall be either a Center employee or a Staff member in good standing. The Chair shall serve a two (2) year term, and may serve additional successive terms.

B. Duties. The committee shall:

1. Provide for education of its membership, Practitioners and staff, patients and families, and the community regarding ethical issues relevant to improving patient care;

2. Provide consultation through prospective case reviews when difficult treatment decisions need to be made, and retrospective case review when cases have been resolved or when consideration of ethical issues may promote learning;

3. Provide for policy development and recommendations which reflect the System Mission Statement;

4. Provide a supportive environment for clarification of questions and issues, guidance in ethical aspects of decision-making for patients and families, Practitioners and staff, and for all other entities affiliated with and including the System; and

5. Serve as a decision-making body, as needed or mandated under the provisions of the Texas Advance Directives Act.

C. Meetings. The committee shall meet as needed on the call of the Chair.

D. Reports. The committee acts independently by state regulation, but provides summary reports of activities directly to the Medical Board on at least an annual basis.

B. Quorum. In addition to the quorum requirements in Section 2 above:

1. If the committee is called to meet, review, and make non-binding recommendations related to a specific patient care issue, at least one (1) Active Staff member must be present.

2. If the committee is called to meet, review, and issue a decision as required by the Texas Advance Directives Act, at least one (1) Active Staff member and one (1) community member must be present.

SECTION 14 PEER ASSISTANCE COMMITTEE

A. Composition. The committee shall be composed of at least six (6) Staff members as follows, all of whom shall serve with vote: one (1) member from each Division of the Staff, appointed by the Staff President and one (1) member, who shall serve as Chair, also appointed by the Staff President. The sixth member shall be the most immediate past Staff President who is willing to serve and shall serve until there is another immediate past Staff President who is willing to serve in this position. The Network Administrative Lead of Advanced Practice shall also be a member, but will only have voting rights for matters involving an Allied Health Professional.

The most immediate past Chair of the Peer Assistance Committee shall serve as an ex-officio member. Other professionals may be appointed or consulted on an ad hoc basis, at the request of the Chair, as required to accomplish the duties and responsibilities of the committee, but shall have no vote.

B. Duties. The committee shall act pursuant to written Staff policy and:

1. Be responsible for receiving, investigating, and acting on all reports received by the committee regarding the possible Impairment of a Practitioner or Allied Health Professional, including those reports received by self-referral;

2. Provide advice and assistance to the Practitioner or Allied Health Professional in question and/or make recommendations regarding referral of the affected individual to the appropriate professional internal or external resource for diagnosis and treatment of the suspected Impairment;

3. Implement changes on a voluntary basis with the Practitioner or Allied Health Professional, issue a letter of warning when indicated, and refer a matter to the Credentials Committee when further investigation or corrective action is recommended;

4. Require a Practitioner or Allied Health Professional to obtain a health examination or testing in accord with Article III.3.D. and make recommendations to the Credentials Committee based on the results of such examination or testing (including recommendations for leave of absence, if it is determined a Practitioner or Allied Health Professional may be impaired);

5. Make recommendations to the Credentials Committee, including recommendations for leave of absence, corrective action, or reinstatement, regarding a Practitioner or Allied Health Professional who

cannot or will not document his/her health status as required by Article III.3.D.;

6. Work with appropriate professional societies and licensing agencies and oversee the monitoring of Practitioners or Allied Health Professionals with health and/or impairment problems and receive periodic progress reports from treating or monitoring entities until the rehabilitation is determined to be complete;

7. Provide written follow up to these reports to the Credentials Committee regarding the committee's findings and recommendations/actions;

8. Maintain all activities in a confidential manner, except as limited by law, ethical obligation, or when the safety of a patient is threatened;

9. Make recommendations to the Credentials Committee regarding policies and procedures on submission of reports regarding (1) the health or well being of Practitioners or Allied Health Professionals, (2) the types of health and/or impairment issues to be considered, (3) the investigation process, intervention, monitoring, reinstatement, referrals, and record keeping processes;

10. Provide education to the Practitioners and Allied Health Professionals and others about physician health, well-being and Impairment; about recognition and appropriate responses to different levels and kinds of Impairment; and about appropriate and available resources for prevention, treatment and rehabilitation; and

11. Be available to consult with the Executive Committee of the Network as needed.

C. Meetings. The committee shall meet as needed on call of the Chair.

D. Reports. The committee shall report to the Credentials Committee and shall provide written follow up, including the committee’s findings and recommendations/actions, of all investigations to the Credentials Committee. Further, the committee shall make summary reports to the Medical Board.

E. Terms. The members of the Peer Assistance Committee shall be appointed to three (3) year terms and they may serve consecutive terms.

SECTION 15 SURGERY QUALITY PERFORMANCE IMPROVEMENT AND PATIENT SAFETY COMMITTEE (“SURGERY QUALITY PIPS COMMITTEE”)

A. Composition. The Surgery Quality PIPS Committee shall be a multi-disciplinary committee composed of practitioners that meet requirements as outlined in the American College of Surgeons’ Children’s Surgery Verification Quality Improvement Program, Optimal Resources for Children’s Surgical Care, as currently revised.

The Medical Director of Surgery Quality/Clinical Excellence or his/her designee shall serve as chair or co-chair. Staff members from the following areas shall serve as voting members: pediatric surgery, neurological surgery, orthopedic surgery, emergency services, anesthesiology, critical care, radiology, neonatology, and other medical and surgical services as deemed necessary.

Ex-officio members shall include the Surgery Program Manager, representatives from Administration, Nursing, and Quality Management. Other members may be appointed as deemed necessary by the chair or co-chairs.

B. Duties. The duties of the committee shall be to:

1. Conduct medical peer review of all deaths, selected complications, and sentinel events occurring in surgical patients, with the objectives of identifying issues and developing appropriate responses.

2. Systematically review and categorize all patient deaths occurring within 30 days of an operative procedure as: unanticipated mortality with opportunity for improvement, mortality without opportunity for improvement, or anticipated mortality with opportunity for improvement. Deaths shall also be characterized as: patient related, system related, or provider related.

3. Make recommendations to correct any deficiencies encountered.

C. Meetings. The Committee shall meet as needed to perform its duties and on call of the Chair, but no less than quarterly.

D. Reports. The committee shall report to the Quality Improvement/Case Review Committee. Further, the committee may make summary reports to the Trauma PIPS Committee.

ARTICLE X. CORRECTIVE ACTION

SECTION 1 INITIATION OF CORRECTIVE ACTION

A. Grounds. Whenever the activities or professional conduct of any Practitioner are considered: (i) lower than accepted standards of professional practice, professional conduct, or the standards or aims of the Staff, (ii) in violation of these Bylaws, Manuals or Policies or any Center policies and procedures, or (iii) disruptive to the operations of the Center, corrective action against the involved Practitioner may be requested by any officer of the Staff, any Division Chief, the Chair of any Staff committee, any Medical Director, the Center President, or the Governing Body. All requests for corrective action shall be submitted in writing to the Credentials Committee and supported by reference to specific acts or conduct by the Practitioner. The Medical Board shall be notified of the receipt of a request for corrective action and periodically advised by the System Credentials Department of the status of the matter.

B. Upon receipt of a request for corrective action, except as provided in Section C. below, the Credentials Committee shall:

1. Initiate an investigation to be conducted by the Credentials Committee or a subcommittee, or by an ad hoc committee appointed by the Chair of the Credentials Committee;

2. Refer the request to the Peer Assistance Committee for initiation of an investigation if the matter involves only <u>or primarily</u> issues of Impairment; or

3. Reject the request as without merit, subject to the approval of the Medical Board and the Governing Body.

Unless the Credentials Committee rejects the request as without merit, the Credentials Committee shall provide special notice to the Practitioner of the receipt of a request for corrective action and the committee's action under this Section within ten (10) days of the action.

C. Prior to initiating an investigation, the Credentials Committee may provide the Practitioner who is the subject of the request for corrective action with an opportunity to meet with the committee and determine whether the allegations or concerns may be addressed with voluntary educational or other measures. The committee shall provide the Practitioner with special notice of the date of the meeting at least five (5) days in advance. If the Practitioner is willing to implement voluntary measures recommended by the committee, that agreement shall be confirmed in writing with the Practitioner and is not considered corrective action. If the Practitioner declines to implement voluntary measures recommended by the committee or refuses to do so after initially agreeing to the

measures, the committee shall proceed with initiation of the investigation for corrective action.

D. A letter of warning or educational letter may be issued by any Staff or Center committee to a Practitioner on a matter within its responsibilities and is not considered corrective action or subject to the corrective action process.

SECTION 2 INVESTIGATION

A. The investigation shall be completed within sixty (60) days of initiation unless the Credentials Committee determines that additional time is needed. The committee conducting the investigation ("investigating committee") shall not be limited to the examination of any particular incident or event, or to just incidents or events occurring within the Center. The Practitioner shall not be entitled to be present during the investigation, interviews with any witnesses, or committee deliberations or voting, except as provided in Section B. below.

B. The Practitioner who is the subject of the investigation shall have an opportunity to appear before the investigating committee in the course of its investigation. The investigating committee shall notify the Practitioner by special notice of the allegations and concerns that are being investigated, and invite the Practitioner to meet with the committee to discuss, explain, or refute them. This interview shall be preliminary in nature, shall not constitute a hearing, and none of the procedural rights of review in Article XI shall apply. The Practitioner may not be accompanied by an attorney, but may be accompanied by another Practitioner who is a member of the Staff of the Practitioner's choosing who must agree in writing to abide by the confidentiality of the investigating committee. The Practitioner may not tape or otherwise record his/her appearance, except for the keeping of his/her own handwritten notes.

C. The investigating committee shall prepare a written report of its investigation, setting out the areas of deficiencies, if any, found regarding the Practitioner or his/her care or conduct and including a recommendation as to whether corrective action is indicated and, if so, what type is recommended. The investigating committee shall forward its report to the Credentials Committee no later than fourteen (14) days after concluding the investigation.

D. If the request for corrective action has been filed after the performance of an investigation by the Peer Assistance Committee or the Quality Improvement/Case Review Committee, the Credentials Committee may accept the results of that investigation in lieu of conducting another investigation under Section 2 if the Practitioner has been afforded the rights under Section 2.B. below by the committee that conducted the first investigation. In such case, the procedures in Section 2 do not apply.

SECTION 3 CREDENTIALS COMMITTEE RECOMMENDATION

A. Within fourteen (14) days of receipt of the report of the investigating committee, the Credentials Committee shall issue a written recommendation as to whether corrective action is indicated, including a statement of the reasons for any recommended action. The recommendation shall be forwarded to the Medical Board.

B. If the decision of the Medical Board is favorable or not an Adverse Recommendation or Action, the decision shall be forwarded to the Governing Body. Within thirty (30) days of receipt of the recommendation of the Medical Board, the Governing Body shall review the matter and make a decision as to corrective action.

   1. If the Governing Body's decision is favorable or not an Adverse Recommendation or Action, the decision shall be final and shall be communicated to the Practitioner by special notice by the Chief Executive Officer of the Center within twenty (20) days of the decision.

   2. If the decision of the Governing Body is an Adverse Recommendation or Action, the Practitioner shall be afforded any procedural rights of review to which he/she is entitled under Article XI. All further procedures shall be as set forth in the Fair Hearing Plan.

   3. When the decision of the Governing Body is to defer for further consideration, a decision must be prepared within thirty (30) days of the deferral.

C. If the Medical Board's recommendation is an Adverse Recommendation or Action, the Practitioner shall be afforded any procedural rights of review to which he/she is entitled under Article XI. All further procedures shall be as set forth in the Center's Fair Hearing Plan.

SECTION 4 SUMMARY CORRECTIVE ACTION

A. Grounds. Whenever the failure to impose an immediate action may result in an imminent danger to the health of any individual , all or a portion of a Practitioner's clinical privileges may be summarily suspended or restricted, including but not limited to, imposition of a mandatory co-admission, consultation or proctoring requirement, without compliance with Sections 1-3 above.

   1. Any two (2) of the following individuals shall have the authority to take summary corrective action: the Staff President, a Vice-President of the Staff, the Chief or Vice-Chief of the Practitioner's Division, the Chief Medical Officer, and the Center President.

2. If the basis of any summary corrective action is suspected Impairment, the Peer Assistance Committee shall be notified of the action and consulted for appropriate intervention.

B. Notice. To the extent reasonably possible, on imposition of summary corrective action, the Practitioner shall be given immediate notice in person or by telephone of the action, followed by special notice of the action within twenty-four (24) hours, by the individuals imposing the action.

1. Immediately upon the imposition of summary corrective action, the Chief of the involved Practitioner's Division at the Center shall be notified and shall assist any Center inpatients of the affected Practitioner to select an alternative Practitioner or make alternate arrangements if necessitated based on the type of action imposed.

2. The individuals responsible for imposing the summary corrective action must also notify the Medical Board and the Chair of the Credentials Committee of this action within twenty-four (24) hours and provide them with written notice within forty-eight (48) hours.

3. If the Practitioner is a member of, or participates as a provider in, the Network, the Cook Children's Health Plan, or the Cook Children's Home Health, the Chair of the Credentials Committee or the Staff President on behalf of the Medical Board shall also notify the governing boards of the other health care entities.

C. Effectiveness and Review. Summary corrective action shall become effective immediately upon imposition and remain in effect unless terminated, rescinded, or modified. The summary corrective action shall be reviewed by the Medical Board within ten (10) business days of imposition, which may include an opportunity for the Practitioner to appear before the committee following the provision of special notice. Following review, the Medical Board shall either:

1. terminate or rescind the summary corrective action and recommend no further action;

2. terminate or rescind the summary corrective action and institute a corrective action investigation under Sections 2-3 above to determine if corrective action is indicated (all further procedures shall be as set forth in those Sections);

3. modify or continue the summary corrective action while additional investigation is conducted under Sections 2-3 above to determine a final recommendation, which investigation shall be expedited to the extent reasonable; or

4. modify or approve the summary corrective action and issue a final recommendation.

Consideration of rescission of summary corrective action is only appropriate if there is a determination that, based on the facts known at the time the summary corrective action was taken, the imposition of the action was not indicated. If the summary corrective action is rescinded, the Practitioner is not entitled to any procedural rights of review under Article XI in connection with the summary corrective action regardless of its length.

D. Procedural Rights of Review for Summary Corrective Action.

1. If, as a result of the Medical Board's review under Section C.4., the Medical Board issues a final recommendation which is an Adverse Recommendation or Action, the Practitioner shall be afforded any procedural rights of review to which the Practitioner is entitled under Article XI. In issuing its final recommendation, the Medical Board shall indicate whether any type of summary corrective action will remain in effect until the Practitioner has exercised (or waived) those procedural rights of review and a final decision is made. If the summary corrective action that remains in place is an Adverse Recommendation or Action that exceeds thirty (30) days, the hearing shall address both the summary corrective action taken and the final recommendation.

2. Except as provided below, a decision to terminate the summary corrective action and/or initiate a corrective action investigation or to modify or continue the summary corrective action while additional investigation is conducted to determine a final recommendation does not entitle the Practitioner to any procedural rights of review under Article XI.

   a. If, after additional investigation as provided in Section C.3. above, the final recommendation is an Adverse Recommendation or Action, the Practitioner shall be afforded any procedural rights of review to which the Practitioner is entitled under Article XI. If the summary corrective action is an Adverse Recommendation or Action that exceeds thirty (30) days, the hearing shall address both the summary corrective action taken and the final recommendation.

   b. If after additional investigation as provided in Section C.3. above, the final recommendation is not an Adverse Recommendation or Action, but the summary corrective action itself was an Adverse Recommendation or Action and remained in place for more than thirty (30) days, the Practitioner shall be afforded the procedural rights of review under Article XI as to the summary corrective action only.

3. An action by the Medical Board which is not an Adverse Recommendation or Action shall be forwarded to the Governing Body for a final decision.

   a. If the decision of the Governing Body is an Adverse Recommendation or Action, the Practitioner shall be afforded any procedural rights of review to which he/she is entitled under Article XI. All further procedures shall be as set forth in the Fair Hearing Plan.

   b. If the decision of the Governing Body is not an Adverse Recommendation or Action, the decision shall be final and shall be communicated to the Practitioner by special notice by the Chief Executive Officer of the Center within twenty (20) days of the decision.

E. Reporting. Summary corrective action that is approved by the Medical Board shall be a final professional review action for purposes of complying with any mandatory reporting requirements.

SECTION 5 TEMPORARY ACTION

Any two (2) of the individuals authorized to impose summary corrective action may impose a temporary suspension of all or a portion of a Practitioner's clinical privileges during which an investigation is being conducted to determine the need for corrective action or whether there are grounds for corrective action, including but not limited to summary corrective action. The temporary action shall be effective immediately for a period not to exceed fourteen (14) days and may be terminated by the Medical Board at any time prior to that date. Temporary action is taken in the course of medical peer review, but is not corrective action or a final professional review action, and does not entitle the Practitioner to any procedural rights of review.

SECTION 6 VOLUNTARY AGREEMENTS

A Practitioner may voluntarily agree not to exercise any or all clinical privileges for a specified or unlimited time period pending: a review of professional competence or conduct by a Staff committee; a corrective action investigation, including one initiated by a summary corrective action; a health status evaluation; or the exercise of procedural rights of review as the result of an Adverse Recommendation or Action. Such voluntary agreement must be communicated to and approved by the Credentials Committee or, in the case of health issues, by the Peer Assistance Committee. A voluntary agreement, while taken in the course of medical peer review, shall not constitute a surrender, restriction or limitation of clinical privileges, corrective action or a final professional review action. It, may be terminated by the Practitioner at any time by providing the System Credentials Department with at least three (3) prior written notice.

SECTION 7 EMPLOYMENT OR CONTRACTING DECISIONS

These procedures on corrective action are limited to matters involving the clinical competence or professional conduct of a Practitioner and only apply if a request for corrective action is filed. Unless otherwise provided by the Center, compliance with these procedures is not required for any action by the Center as to employment of or a contract with a Practitioner.

ARTICLE XI. PROCEDURAL RIGHTS OF REVIEW

SECTION 1 ENTITLEMENT

Whenever a Practitioner receives notice of an Adverse Recommendation or Action pursuant to these Bylaws or the procedures in the Credentialing Procedures Manual as defined under Section 2.A. below, the Practitioner shall be entitled to the procedural rights of review in the Fair Hearing Plan. These procedural rights of review are for the purpose of resolving issues related to a Practitioner's professional competence and professional conduct, and shall only apply to adverse recommendations or actions that are based on the Practitioner's professional competence or professional conduct.

SECTION 2 ADVERSE RECOMMENDATION OR ACTION

A. Defined. Except as qualified below, only the following recommendations or actions when taken by the Medical Board, or by the Governing Body where no prior right to a hearing existed, are an Adverse Recommendation or Action:

1. Denial of Staff appointment;
2. Denial of Staff reappointment;
3. Suspension of Staff appointment;
4. Termination or revocation of Staff appointment;
5. Denial of requested clinical privileges;
6. Reduction of clinical privileges;
7. Suspension of clinical privileges;
8. Termination or revocation of clinical privileges;
9. Imposition for more than 30 days of a mandatory consultation or concurrent supervision or proctoring requirement where the consultant, supervisor, or proctor must approve the Practitioner's exercise of clinical privileges or must be present for the Practitioner to exercise the clinical

privileges, except during FPPE at the time of initial appointment or an initial grant of clinical privileges pursuant to Article V.1.B; or

10. Summary corrective action that is an Adverse Recommendation or Action and exceeds thirty (30) days as provided in Article X.4.D.

B. Actions that are not an Adverse Recommendation or Action: The following recommendations or actions, and any others specifically set forth in the Bylaws, are not Adverse Recommendations or Actions:

1. Failure to process an application due to failure to complete and return the application within a stated period of time, because it is incomplete, required or requested information has not been provided, or the Practitioner cannot document compliance with minimum or threshold criteria, or failure to issue an application because of inability to satisfy the application requirements;

2. Expiration of appointment for failure to timely reapply or submit a completed request for reappointment;

3. Summary corrective action that is not an Adverse Recommendation or Action, or that is an Adverse Recommendation or Action but does not exceed thirty (30) days as provided in Article X.4.D., or is rescinded**;**

4. A recommendation to reappoint a Practitioner for a period of less than two (2) years;

5. Automatic action under Article IV.1.B. or Article XII;

6. Imposition of any conditions on the exercise of temporary privileges or denial or termination of temporary privileges or an extension or termination of emergency privileges;

7. Imposition of FPPE at the time of an initial grant of clinical privileges or continuation of FPPE, or imposition of FPPE at any other time unless it includes an Adverse Recommendation or Action;

8. Issuance of a letter of reprimand, imposition of a record review or continuing medical education requirement, requirement to obtain additional training, a requirement to obtain counseling or an evaluation, or probation or any other requirement that does not restrict or limit the Practitioner's exercise of clinical privileges;

9. Imposition of a limitation or restriction when applied equally to all Practitioners in that Staff category or who have been granted those clinical privileges; or

10. Removal from Division or Staff office or committee appointment or chairmanship.

SECTION 3 FAIR HEARING PLAN AND BASIC STEPS

A. All procedural rights of review and all further procedures after issuance of an Adverse Recommendation or Action as defined above shall be in accordance with the procedural safeguards set forth in the Fair Hearing Plan. Once the procedures in the Fair Hearing Plan have been afforded (or waived), the Practitioner shall have no further right of review, reconsideration, or challenge pursuant to these Bylaws or otherwise.

B. The basic steps for affording procedural rights of review, and which will be included in the Fair Hearing Plan, shall include:

1. written notice to the Practitioner of the Adverse Recommendation or Action, the reasons for the Adverse Recommendation or Action, and the Practitioner's right to request a hearing;

2. appointment of a hearing committee upon receipt of a timely request from the Practitioner, which shall be composed of either: (i) at least three (3) members of the Staff or (ii) a single hearing officer who is a Practitioner in the same discipline (i.e., physician for another physician) as the Practitioner requesting the hearing;

3. scheduling of the hearing on receipt of the Practitioner's written request and written notice to the Practitioner of the place, time and date of hearing, which shall not be less than thirty (30) days or more than ninety (90) days from the date of the notice, to be expedited to the extent reasonable if the Practitioner is currently subject to summary corrective action;

4. preparation of a record of the hearing by a court reporter selected by the Center President, with a copy of the transcript made available to the Practitioner on payment to the court reporter of any reasonable costs;

5. the rights to present evidence, call and cross-examine witnesses, be represented at the hearing by an attorney or other individual of the party's choice for the purpose of providing private advice and counsel, and submit a written statement at the close of the hearing;

6. the right to receive the written recommendation of the hearing committee and the reasons for the recommendation;

7. the right to appeal to the Governing Body on filing of written request, with the appeal held by the Governing Body as a whole or a subcommittee; and

8. the right to receive the final written decision of the Governing Body and the reasons for the decision.

C. In the event of any conflict between these Bylaws and the Fair Hearing Plan, the Bylaws shall control.

SECTION 4 NO REAPPLICATION AFTER ADVERSE DECISION

A Practitioner who has been subject to a final Adverse Recommendation or Action denying or terminating Staff membership and/or clinical privileges due to patient care or competence concerns, behavior or professional conduct issues (including but not limited to misstatements, omissions or misrepresentations of information), or failure to comply with the Bylaws, Manuals, Policies, and/or Center policies, shall not be eligible to reapply for Staff membership and/or clinical privileges. The above limitation shall also apply if the Practitioner resigned Staff membership and/or clinical privileges or withdrew an application for Staff membership and/or clinical privileges while under investigation for the cited reasons.

ARTICLE XII. AUTOMATIC ACTION

SECTION 1 DEFINED

Automatic action is an action taken by the Governing Body automatically on the occurrence of a specific event. Although taken in the course of medical peer review, automatic action is not a final professional review action and does not entitle the Practitioner to any procedural rights of review under these Bylaws or otherwise. Nothing in this Article precludes the taking of corrective action in addition to automatic action.

SECTION 2 GROUNDS

Occurrence of any of the following shall result in automatic action for a Practitioner:

A. Failure to complete medical records as required by Center policy, resulting in automatic suspension and/or automatic termination of a Practitioner's admitting privileges and/or membership on the Staff in accordance with Center policy;

B. Expiration, revocation, or suspension of a Practitioner's license or probation imposed by the Practitioner’s professional licensing agency, resulting in automatic termination of all clinical privileges and Staff membership;

C. Failure to achieve board certification as required by Article III.3., resulting in automatic termination of all corresponding specialty clinical privileges (and Staff membership if those are all of the Practitioner’s privileges);

D. Loss of required professional liability insurance, resulting in automatic suspension of all clinical privileges and automatic termination of Staff membership if not reinstated with coverage for any lapses within thirty (30) days of notice to Practitioner of the loss;

E. Expiration, revocation, or suspension of state or federal authorization to prescribe medications, resulting in automatic suspension of all clinical privileges and automatic termination of Staff membership if not reinstated within thirty (30) days of the suspension (not applicable to pathologists);

F. Current exclusion from Medicare, Medicaid, or any other federal health care program, resulting in automatic termination of all clinical privileges and Staff membership;

G. Conviction of or entry of a guilty or *nolo contendere* plea for a felony results in automatic termination of all clinical privileges and Staff membership and ineligibility to reapply for a period of ten (10) years from the date of conviction or plea (see Art. III.3.I.); or

H. Failure to complete, within ninety (90) days of Practitioner's receipt of special notice from the System Occupational Health Department, all necessary health status requirements established by the System Medical Director of Occupational Health, resulting in automatic suspension of all clinical privileges until documentation is presented, and automatic termination if not presented within forty-five (45) days of imposition of the suspension.

SECTION 3 REINSTATEMENT

If the grounds for the automatic action no longer exist, a Practitioner subject to automatic action may reapply for Staff privileges, which application will be processed as an initial application using the procedures in the Bylaws and the Credentialing Procedures Manual; provided that, the fact that the grounds for the automatic action no longer exists does not guarantee that appointment or clinical privileges will be granted.

ARTICLE XIII. CONFIDENTIALITY AND IMMUNITY

SECTION 1 MEDICAL PEER REVIEW COMMITTEE STATUS

A. Authorization. Each committee (whether Staff, Division, Specialty or Subspecialty, subcommittee, ad hoc committee, joint committee, or one appointed pursuant to the Fair Hearing Plan), as well as the Staff and each Division, Specialty and Subspecialty when meeting as a whole, shall be constituted and operate as a "medical peer review committee," "professional review body" and "medical committee" as such terms are defined by law, and are authorized by the Governing Body to engage in medical peer review.

B. Medical Peer Review. The term “medical peer review” as used in these Professional Staff Bylaws shall include the definition of “medical peer review” or “professional review action” set out in the Medical Practice Act, Texas Occupations Code. The term includes without limitation: (i) the process of credentialing for initial appointment, reappointment and the granting of clinical privileges; (ii) the review and investigation in connection with and the issuance of professional review actions; (iii) the process of affording procedural rights of review; (iv) any evaluation of the merits of a complaint relating to a Practitioner or Allied Health Professional and issuance of a recommendation in that regard; (v) FPPE, OPPE and any other evaluation of the accuracy of a diagnosis or quality of the care provided by the Practitioner or Allied Health Professional; (vi) a report made to a medical peer review committee or to a professional licensing board; and (vii) implementation of the duties of a medical peer review committee by a member, agent or employee of the committee. The term also includes “professional review activity” as defined by the federal Health Care Quality Improvement Act.

C. Agents. The Medical Board, the Staff President, or the chair or chief of any committee, Division, Specialty or Subspecialty as listed under Section A above may appoint Practitioners or other individuals to serve as agents of the committee, Division, Specialty or Subspecialty and assist in carrying out its functions and responsibilities. The Center President, Legal Counsel, the System Credentials Department, and the Quality Management, Patient Safety, and Risk Management departments shall be considered agents of the Staff and its committees, Divisions, Specialties, and Subspecialties when performing their functions and responsibilities. An authorized action by a member or agent of a committee, Division, Specialty or Subspecialty shall be considered an action taken on its behalf, not an action taken in the member or agent's individual capacity.

SECTION 2 CONFIDENTIALITY

A. Records and Proceedings. All records and proceedings of the Staff, a Division, Specialty or Subspecialty, or a committee thereof, as listed in Section 1.A. above, shall be confidential in accord with applicable law. Participants in meetings or other proceedings may not electronically record any proceedings or otherwise disclose any records and proceedings without the written permission of the Staff President and Center President, unless specifically required by law.

B. Medical Peer Review Information. All information generated in connection with medical peer review including, without limitation, any of the functions described below may be used to evaluate the clinical competence, professional conduct, and other qualifications of a Practitioner or Allied Health Professional and/or to evaluate the quality of health care services provided, and is considered medical peer review information and shall be privileged and confidential to the fullest extent permitted by law.

C. Communications by Committees. Committees of the Staff, a Division, Specialty or Subspecialty as listed in Section 1.A. above shall be authorized to disclose its confidential medical peer review records and proceedings to each other for purposes of medical peer review. Such disclosure shall not constitute a waiver of any applicable privileges of confidentiality pursuant to statute or otherwise. Committees may also, with the consent of the Center President, disclose confidential medical peer review records and proceedings to third party medical peer review committees for purposes of medical peer review, provided the disclosure does not jeopardize the confidentiality of the information. Any such disclosures shall be reviewed and approved in advance by Legal Counsel.

D. Waiver of Committee Privilege. Waiver of any privilege of medical peer review confidentiality by the Staff, a Division, Specialty, Subspecialty or a committee thereof as listed in Section 1.A. above shall require the written agreement of the Chair of the Staff, Division, Specialty, Subspecialty, or committee, and the Center President to be effective.

E. Breach. Breach of this confidentiality by a Practitioner or Allied Health Professional, unless required by law, shall be grounds for corrective or other disciplinary action.

SECTION 3 ACKNOWLEDGMENTS AND RELEASES OF LIABILITY

A. General. Each Practitioner and Allied Health Professional agrees, as a condition precedent to obtaining Staff membership and/or clinical privileges and as a condition of continuing to maintain Staff membership and/or clinical privileges, to be bound by the following:

1. Any act, communication, report, recommendation, or disclosure with respect to any such Practitioner or Allied Health Professional, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of medical peer review in this or any other health care facility, shall be privileged and confidential to the fullest extent permitted by the law.

2. The privilege of confidentiality shall extend to members of the Staff, the Medical Board, the Governing Body, the Center President and his/her representatives, and to third parties who supply information to any of the foregoing who are authorized to receive, release or act on such information. For the purpose of this Article XIII, the term "third parties" means both individuals and organizations from which information has been requested by an authorized representative of the Staff, the Governing Body, or the Center President.

3. To the fullest extent permitted by law, there shall be absolute immunity from civil liability for: (i) the Staff, the Center, and the System and their officers, directors, members, agents, and employees, (ii) all Center, Staff, and Governing Body committees and their members, agents, and employees, and (iii) any third parties that provide information to any of the above, arising out of any act, communication, report, recommendation or disclosure in the course of or for the purpose of medical peer review, even when the information involved would otherwise be deemed defamatory or derogatory.

4. The immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care facility's medical peer review activities related to, but not limited to: (i) application for appointment or clinical privileges, (ii) periodic reappraisals for reappointment or clinical privileges and FPPE and OPPE, (iii) corrective action or automatic action, (iv) procedural rights of review under the Fair Hearing Plan, or (v) other System, Center, Staff, Division, Specialty, Subspecialty, or committee activities related to quality of patient care, clinical competence and/or professional conduct, or operations of the Center or Staff.

5. These acts, communications, reports, recommendations, and disclosures may relate to a Practitioner's or Allied Health Professional's clinical competence, professional conduct, or other qualifications that might directly or indirectly have an effect on patient care or Center operations.

6. Each Practitioner and Allied Health Professional shall, upon request of the Center, execute releases in accordance with this Article; provided that, execution of a written release is not a prerequisite to the effectiveness of this release.

7. The authorizations provided in Article III for the protection of the Staff, other appropriate Center personnel, and third parties shall be fully applicable to the activities, immunities, and procedures covered in this Article XIII.

B. Not in Limitation. Any provisions for immunity or releases from liability in this Article or elsewhere in these Bylaws are in addition to, not in limitation of, any immunity or other protections afforded by state or federal law.

SECTION 4 INDEMNIFICATION BY CENTER

Any Staff member participating in medical peer review, including credentialing, corrective action, and quality management activities, shall be indemnified by the Center for any liability and reasonable attorneys' fees incurred as a result of any actions taken in the course of the medical peer review and in the reasonable belief that those actions were in accord with committee or assigned responsibilities, unless the member engaged in malfeasance or willful misconduct.

SECTION 5 REPORTING

Any mandatory reporting of a final professional review action on behalf of the Staff, a Staff committee, the Center, or the Governing Body shall be done by the Center President. Nothing in this section or the other provisions of the Bylaws shall prevent an individual member of the Staff, a Staff committee, or the Governing Body from making a voluntary report to state or federal agencies as permitted by law.

SECTION 6 RULES OF PROCEDURE

The most current version of *Robert's Rules of Order* shall govern all procedures not otherwise specifically set forth or addressed in these Bylaws.

ARTICLE XIV. CONFLICT OF INTEREST

SECTION 1 PRACTITIONER UNDER REVIEW

Unless otherwise provided in the Bylaws, whenever the clinical competence or professional conduct of a Practitioner is being reviewed or investigated by a committee, Division, Specialty, or Subspecialty to which the Practitioner belongs, the Practitioner shall recuse himself/herself from those proceedings, including attendance at meetings on that matter. If the Practitioner is the Chair or Chief of the committee, Division, Specialty, or Subspecialty, the Practitioner shall designate the Vice-Chair or Vice-Chief to serve in the Practitioner's place. This provision applies regardless of the nature of the review or investigation.

SECTION 2 CONFLICT WITH REVIEWER

Whenever a Practitioner is participating in medical peer review and/or performing a function for a committee, a Division, a Specialty or Subspecialty, the Staff, or the Governing Body, and the Practitioner's personal or professional interests could be reasonably interpreted as being in conflict with the interests of that entity, or of a Practitioner, Allied Health Professional or other individual under review, the Practitioner shall disclose those interests and the potential for conflict to the committee Chair, Division Chief, Staff President, or Center President, respectively, prior to such participation. A Practitioner may be required by a committee Chair, Division Chief, Staff President, or Center President to refrain from any participation in decisions that may be

affected by or affect the Practitioner's interests. The fact that a Practitioner is in the same specialty as a Practitioner being reviewed does not automatically constitute a conflict of interest.

SECTION 3 RECUSAL

In the event of recusal due to an actual or potential conflict of interest, the Practitioner shall not participate in any discussion, deliberation, or voting on the matter involving the conflict of interest. The Practitioner may provide relevant information and answer questions about the matter prior to recusal. Recusal shall be documented in the minutes of the proceeding.

SECTION 4 OTHER

Any other potential conflicts of interest may be referred to the Medical Board or the Governing Body for resolution.

ARTICLE XV. MANUALS AND POLICIES

SECTION 1 RESPONSIBILITY

In addition to the Bylaws, Manuals, including Rules and Regulations, a Credentialing Procedures Manual, and a Fair Hearing Plan, and Policies may be used as necessary to implement more specifically the general principles, requirements, and processes found within the Bylaws. These Manuals and Policies relate to the proper conduct of the Staff organizational activities as well as embody the level of practice that is to be required of each Practitioner. In the event of a conflict between the Bylaws and a Manual or Policy, the Bylaws shall control.

SECTION 2 ADOPTION AND AMENDMENT

A. General. Adoption and any additions, deletions, or changes (collectively referred to in this Article as "amendment" or "amendments") of a Manual or Policy may be initiated on the recommendation of the Medical Board or any other standing committee of the Staff, any Division, any Joint System Committee, Legal Counsel, or the Governing Body, or by the voting members of the Staff as set out below.

B. Amendment by Medical Board. Any proposal shall be submitted in writing to the Bylaws Committee for review. The Bylaws Committee shall review the proposal and forward its recommendation, with any recommended revisions to the proposed amendments, to the Medical Board. Amendment of a Manual or Policy by the Medical Board requires the approval of two-thirds (2/3rds) of those voting and present at any regular or special meeting of the Medical Board.

1. At least twenty (20) days prior to submission of an amendment of a Manual to the Medical Board, the System Credentials Department shall notify the Staff of the proposed amendment by mail, facsimile, or electronic transmission (email**)** using the contact information currently on file in the System Credentials Department, and allow the Staff to submit written comments to the Medical Board within ten (10) days of notice for the Medical Board's consideration prior to voting on the amendment.

2. In cases of a documented need for an urgent amendment of the Rules and Regulations to comply with a law or regulation, the Medical Board may provisionally adopt an amendment and forward it to the Governing Body for approval without prior notification of the Staff as provided above. In such cases, the System Credentials Department shall notify the Staff of the amendment after approval by mail, facsimile, or electronic transmission (email) using the contact information currently on file in the System Credentials Department and provide the Staff with an opportunity to submit written comments to the Medical Board within ten (10) days of notice. If there is no conflict over the amendment, no further action is required. If there is conflict over the amendment as reflected in written comments submitted by at least twenty percent (20%) of the voting members of the Staff, the conflict resolution process under Section 3.b-c. below shall be implemented by the Medical Board.

3. In the event of disagreement between the Staff and the Medical Board on adoption or amendment of a Manual or Policy, the Medical Board or the Staff, as set forth below under subsection a., may request implementation of the following conflict management procedures:

   c. A petition for reconsideration of an issue signed by at least twenty percent (20%) of the voting members of the Staff must be filed in the System Credentials Department within ten (10) days of recommendation or action on the issue by the Medical Board.

   b. The Medical Board will call a special meeting of the Staff in accordance with the procedures in these Bylaws to discuss the issue. The Medical Board may, with the approval of the Center President, use the services of a facilitator or mediator at that meeting.

   c. Within five (5) days of the meeting, the Medical Board will reconsider the issue, take a new vote on the issue, and communicate the results of the new vote to the voting members of the Staff by electronic transmission (email), newsletter or other written form.

C. Amendment by Staff. Subject to the procedures below, by petition signed by at least twenty percent (20%) of the voting members of the Staff, a proposal for amendment of a Manual or Policy may be presented for vote at a regular or special meeting of the Staff.

1. At least twenty (20) days prior to presentation at the Staff meeting, the proposed amendment must be submitted to the Bylaws Committee for review and comment and at least ten (10) days prior to the Medical Board for review and comment, with the comments of both the Bylaws Committee and the Medical Board presented at the Staff meeting.

2. At least one (1) of the members signing the petition must appear at the Staff meeting and present the basis for the amendment. Quorum and voting requirements shall be as set forth in Article VIII, except that approval of the amendment shall require the affirmative vote of at least two-thirds (2/3rds) of the Staff members present and voting.

D. Governing Body. Whether adopted or amended by the Medical Board or the Staff, the amendment(s) shall become effective only on approval by the Governing Body. Within ten (10) days of the Governing Body's approval, the System Credentials Department shall send each Staff member written notice of the adopted Manual or Policy or amendment thereof, either by mail, facsimile, or electronic transmission (email) using the contact information currently on file in the System Credentials Department.

E. Prohibition on Unilateral Amendment. Neither the Staff, the Medical Board, nor the Governing Body may unilaterally adopt or amend a Manual or a Policy.

F. Communication with Governing Body. Nothing in this Article prevents a Staff member from communicating with the Governing Body on a Manual or Policy independent of the above process, subject to any procedures established by the Governing Body for such communication.

ARTICLE XVI. ADOPTION AND AMENDMENT OF BYLAWS

SECTION 1 GENERAL

These Bylaws shall become effective upon approval by the Professional Staff and the Governing Body. These Bylaws shall replace and supersede all previous Bylaws.

SECTION 2 ADOPTION AND AMENDMENT

A. General. Amendment of these Bylaws or repeal and adoption of new bylaws (collectively referred to in this Article as "amendment" or "amendments") may be proposed by: (i) any Staff member, (ii) written petition signed by at least twenty percent (20%) of the voting members of the Staff, (iii) a Division, (iv) the Medical

Board or any other standing committee of the Staff, (v) a Joint System Committee, or (vi) the Governing Body.

1. The proposal shall be made in writing to the Bylaws Committee for consideration, including but not limited to identification of any conflict with these Bylaws or the bylaws of the Governing Body. The Bylaws Committee shall review the proposal and forward its recommendation, with any recommended revisions to the proposed amendments, to the Medical Board.

2. Except as provided below under subsection 3, the Bylaws Committee and/or the Medical Board may modify the proposed amendment (or reject the amendment in which case it is not submitted for vote by the Staff). If recommended by the Medical Board, the amendment and any recommendations or comments then shall be submitted to the Staff for a vote.

3. Any amendment proposed as a result of written petition signed by at least twenty percent (20%) of the voting members of the Staff must be submitted to the Staff for a vote, unless the amendment conflicts with a legal or accreditation requirement.

B. Notice. Prior to submission for a vote, notice of a proposed amendment must be provided in writing to the voting members of the Staff either by mail, facsimile or by electronic transmission (email) using the contact information currently on file in the System Credentials Department. Amendments may only be considered when the notice specifies that Bylaws amendments shall be on the agenda, and when the recommended changes are sent out as provided above at least twenty (20) days in advance of the meeting.

C. Approval of Amendments. Amendments to the Bylaws may be considered by the Staff at regular or special meeting called for such purpose following notice under Section B. above. Absentee voting on amendments is permitted by written ballot submitted in person or by electronic transmission (email), facsimile or by mail to the System Credentials Department and received no later than 5 p.m. on the date of the meeting. Quorum requirements shall be as set forth in Article VIII, except that amendments to the Bylaws shall require approval of two-thirds (2/3rds) of the voting Staff members present and voting (whether in person or by absentee ballot) at a properly called meeting.

D. Modification. Modifications proposed at any meeting do not require additional notice. Changes shall be effective immediately following and only with the approval by the Governing Body. Staff members shall be notified of approved changes either by mail, facsimile, or electronic transmission (email) using the contact information currently on file in the System Credentials Department, and a copy of the revised Bylaws shall be provided to all Staff members on request.

E. Prohibition on Unilateral Amendment. Neither the Staff, the Medical Board, nor the Governing Body may unilaterally adopt or amend the Bylaws.

Signed____
Chair, Medical Board, for the Professional Staff Date

Signed____
Chair, Board of Trustees, for the Center Date