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Bylaws of the Medical Staff

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BYLAWS OF THE MEDICAL STAFF
OF THE UNIVERSITY OF TEXAS MD ANDERSON CANCER CENTER

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PREAMBLE

Recognizing that the Medical Staff of The University of Texas MD Anderson Cancer Center is accountable to the Governing Body for the quality of medical care pursuant to standards of MD Anderson, and legal and accreditation requirements, and that the Medical Staff must faithfully discharge this responsibility by serving the best interests of the patients through coordinated effort, the Practitioners providing patient care at MD Anderson hereby organize themselves as a self-governing Medical Staff, according to the following Medical Staff Bylaws, which are recommended by the Medical Staff and approved by the Governing Body. The Medical Staff is an integral component of The University of Texas MD Anderson Cancer Center and is subject to the ultimate authority of the Governing Body, as defined herein.[1]

DEFINITIONS

The following definitions shall apply to these Medical Staff Bylaws, any Supplemental Documents adopted pursuant to Article XIII, and any policies of the Medical Staff and Medical Staff & Credentialing Services, as well as those of MD Anderson unless otherwise defined therein.

"Acute Cancer Care Center (ACCC)" means collectively, the Adult ACCC and the Pediatric ACCC, which serve as MD Anderson's emergency departments.

"Advanced Practice Provider" or "APP" means a health care professional in a discipline approved by the Governing Body for Advanced Practice Provider status at MD Anderson, with Practitioner collaboration, direction and/or supervision if required, to provide patient care, treatment, and services as set forth in Article IV. Advanced Practice Providers require a grant of Clinical Privileges but are not eligible for membership on the Medical Staff. They may serve on Medical Staff committees and attend continuing Medical Education programs of the Medical Staff. Advanced Practice Providers include physician assistants (PAs) and advanced practice registered nurses (APRNs). Advanced Practice Providers do not include Practitioners or Licensed Professionals.

"Adverse Recommendation" or "Adverse Action" is an action or recommendation in the course of medical peer review and/or professional review activity, as defined in Article X. A listing of the specific actions and recommendations that qualify as an Adverse Recommendation or Adverse Action is set out in Section B of Article XII.

"Allied Health Professional" or "AHP" means an appropriately licensed or trained individual who has been given permission by the Hospital to provide specific patient care services to patients in the Hospital, under the supervision of or at the request of the Practitioner who is responsible for both the patient's care and supervision of the AHP. Allied Health Professionals are not (i) Members of the Medical Staff, (ii) Advanced Practice Providers, or (iii) Licensed Professionals, and are not eligible to apply for Clinical Privileges. Allied Health Professionals will function pursuant to a Scope of Practice. The categories of AHPs approved to provide patient care at the Hospital are listed in Section 5.0 of the Organizational Manual.

"Board of Regents or Board" means the Board of Regents of the University of Texas System. The Texas Legislature, in Article VII, Section 10 of the Texas Constitution, has delegated the power and authority to administer The University of Texas System to the Board of Regents.

[1] MS.01.01.01, EP 1

“CCMS” means the Credentials Committee of the Medical Staff as described in Article VII.

“Chair of the ECMS” means the highest-ranking officer of the Medical Staff elected as provided in Article VI, or the Chair’s designee.

“Chief Medical Executive” means the physician executive appointed by the President to serve as a liaison among the Administration, the Medical Staff Officers, and the Medical Staff, and to provide administrative support and leadership for the Medical Staff, including without limitation direct responsibility to the President for overseeing the clinical Divisions and Departments of MD Anderson, or the Chief Medical Executive’s designee.

“Clinical Privileges” mean the setting-specific authorization granted to a Practitioner, Licensed Professional, or Advanced Practice Provider to provide specific patient care, treatment, and services at MD Anderson pursuant to the procedures in the Medical Staff Bylaws as set forth in Article III and/or Article IV.

“Clinical Specialist” means: (1) a Practitioner enrolled in a graduate medical education program who has received a Faculty Academic Appointment as a “Clinical Specialist” and membership on the Courtesy Staff with Clinical Privileges for the limited purpose of providing health care services at MD Anderson separate and distinct from those services provided pursuant to the educational program, or (2) a Practitioner who has received a Faculty Academic Appointment as a Clinical Specialist and is under contract with MD Anderson.

"Completed Application” means an application for appointment or reappointment to the Medical Staff and/or grant of Clinical Privileges where all of the information required under the Medical Staff documents and applicable privileges form is provided to the Medical Staff. Medical Staff & Credentialing Services may consult with the Chief Medical Executive for any questions regarding a complete or incomplete application. If the required information is determined to be missing or incomplete by Medical Staff & Credentialing Services, the applicable Department Chair, CCMS, or ECMS, the application is considered incomplete. A Completed Application may be deemed incomplete at any time if the need arises for new, additional, or clarifying information.)

"Days” means, unless otherwise indicated, calendar days. In computing any period of time prescribed by the Medical Staff Bylaws, the day after the act or event shall be considered the first day. The days shall be counted consecutively including Saturdays, Sundays, and legal holidays, unless specifically noted as “working days.” If the last day falls on a Saturday, Sunday, or a legal holiday, the time period shall end on the next day that is not a Saturday, Sunday, or legal holiday, except as otherwise required by applicable law. The time period shall end at 5:00 p.m. of the last day of the time period.

“Dentist” means an individual holding a valid license to practice dentistry in the state of Texas, with either a D.M.D. or D.D.S. degree.

“Department” means a major organizational component of MD Anderson designed to provide specialty patient care, treatment, and services, and educational and research activities, and to which each Practitioner is assigned when granted Clinical Privileges. For the purposes of these Medical Staff Bylaws, the term Department is understood to refer only to a clinical Department, a subunit of a clinical Division. The Departments that are subject to these Medical Staff Bylaws are listed in Section 4.0 of the Organizational Manual.

“Department Chair” means the Member of the Medical Staff appointed by the President as provided in Article V and who is responsible for the Department or the Department Chair’s designee. For the purposes of these Medical Staff Bylaws, the term Department Chair is understood to refer only to a clinical Department Chair. Wherever these Bylaws refer to an action to be taken by the Department Chair and the subject of the action is the Department Chair, such action will instead be taken by the Division Head or Chief Medical Executive.

"Designee” for the purposes of these Medical Staff Bylaws all references to the Chair of the ECMS, Chief Medical Executive, Chief Nursing Officer, Department Chair, Division Head, a Medical Staff Committee Chair, or the Director of Medical Staff & Credentialing Services shall include their designee unless explicitly otherwise stated.

“Distant-Site” means a Medicare-participating or Joint Commission accredited hospital or health care entity that furnishes Telemedicine services as a distant-site, such as a hospital, imaging center, urgent care center, medical practice, or independent medical provider.

“Division” means a group of related Departments organized to provide similar patient care services and educational and research activities. For the purposes of these Medical Staff Bylaws, the term Division is understood to refer only to a clinical Division of MD Anderson. The Divisions that are subject to these Medical Staff Bylaws are listed in Section 3.0 of the Organizational Manual.

“Division Head” means the Member appointed by the President as provided in Article V and who is responsible for the Division and the Departments within the Division or the Division Head’s designee. For the purposes of these Medical Staff Bylaws, the term Division Head is understood to refer only to the Member responsible for a clinical Division of MD Anderson.

“ECMS” means the Executive Committee of the Medical Staff as described in Article VII.

“Ex-officio” means as a position by virtue of office, without a vote unless otherwise specified.

"External Review” means a review performed by a qualified individual who is not an MD Anderson workforce member to evaluate the clinical competence, professional conduct, or quality and appropriateness of care provided by a Practitioner, LP, or APP. No Practitioner, LP, or APP can require the Hospital to obtain External Review if it is not deemed appropriate by the body conducting the Peer Review, including without limitation the ECMS, CCMS, Governing Body, or an Investigating Committee.

“Faculty Academic Appointment” means an academic appointment to the faculty of MD Anderson through the Office of Faculty Academic Affairs.

“Faculty Senate” means the designated forum of MD Anderson for addressing issues that impact on the scholarship and academic pursuits of the faculty of MD Anderson and to provide a mechanism for faculty representation within the institution.

“Fair Hearing Manual” means the Supplemental Document to these Medical Staff Bylaws adopted pursuant to Article XIII.

“Focused Professional Practice Evaluation” or “FPPE” means the time-limited component of Peer Review used to evaluate a Practitioner’s, LP’s, and Advanced Practice Provider’s competence in performing specific Clinical Privileges, professional conduct, or patient care, treatment, and

services as set forth in written policy. (See also, the definitions of “For Cause FPPE” and “Initial FPPE” below). *[Focused Professional Practice Evaluation Policy CLN1004]*

“For Cause FPPE” means FPPE that is implemented whenever a question arises regarding a Practitioner’s, LP’s, or APP’s medical or clinical knowledge, ability to provide safe, high-quality patient care, practice-based learning and improvement, interpersonal and communication skills, professionalism, or systems-based practice. (See also, the definitions of “Focused Professional Practice Evaluation” above and “Initial FPPE” below).

"Good Standing” means the individual is not the subject of a current corrective action Investigation or similar review, is not currently the subject of an ongoing hearing or appeal as set forth in Article XII of these Bylaws or the subject of a pending recommendation for adverse action by the Executive Committee of the Medical Staff, is not currently the subject of an ongoing investigation by any state or federal entity with oversight of medical practice, licensure, certification, or human subjects research, and has not voluntarily resigned or limited the individual’s Clinical Privileges while under Investigation or to avoid an Investigation, or involuntarily limited, restricted, suspended or otherwise encumbered for disciplinary cause or reason, and has not been subject to a substantial finding or corrective action related to the Practitioner’s competence or professional conduct within the previous two (2) years.

“Governing Body” means the President of The University of Texas MD Anderson Cancer Center, as appointed by the Board of Regents.

“Incident Command System (ICS)” means a standardized, on-scene, all-hazard Incident management concept that allows its users to adopt an integrated organizational structure to match the complexities and demands of single or multiple Incidents.

“Incident Commander” means the individual in the ICS responsible for organizing and directing the overall response efforts of the institution during an Emergency and overseeing the successful completion of the Incident management objectives.

“Initial FPPE” means FPPE that is implemented for all initial appointments and newly requested Clinical Privileges. (See also, the definitions of “Focused Professional Practice Evaluation” and “For Cause FPPE” above).

"Investigation” or “Formal Investigation” means the non-routine Peer Review process of gathering and reviewing information related to a concern regarding the competence, professional conduct, or quality and appropriateness of care provided by a Practitioner, LP, or APP, which is undertaken after approval by the ECMS or Governing Body to initiate an Investigation.

“Licensed Professional” or “LP” means a health care professional in a discipline approved by the Governing Body for LP status, who is permitted by state law to provide patient care, treatment, and services independently at MD Anderson. LPs require a grant of Clinical Privileges in the same manner as Practitioners, as set forth in Article IV, but are not eligible for membership on the Medical Staff. Licensed Professionals include Doctors of Optometry and Speech Pathologists. For purposes of these Medical Staff Bylaws, the term does not include a Practitioner or an Advanced Practice Provider. LPs are entitled to the same hearing and appeal rights as Practitioners, as set forth in Article XII.

“Material Misstatement” means a misrepresentation or omission on an application for appointment, reappointment, and/or Clinical Privileges, which, if known to the Medical Staff,

Department Chair, CCMS, ECMS, or other Medical Staff leader, may have altered the Credentialing or Privileging review process or outcome.

“MD Anderson” or “Hospital” means the hospital known as The University of Texas MD Anderson Cancer Center including any locations operating under MD Anderson’s Medicare enrollment.

“Medical Physicist” means an individual holding a valid current license to practice one or more of the following specialties in Texas: diagnostic radiological physics, therapeutic radiological physics, medical nuclear physics, or medical health physics.

“Medical Staff” means the Practitioners that have been granted membership on the Medical Staff of MD Anderson by the Governing Body.

“Medical Staff Bylaws” means these Medical Staff Bylaws and, unless the context indicates otherwise, includes any Supplemental Documents adopted as provided in Article XIII, including without limitation the Organizational Manual, and the Fair Hearing Manual.

“Medical Staff & Credentialing Services” means the MD Anderson department responsible to serve as agents for and to assist the Medical Staff committees and officers, Departments, and Divisions in privileging, credentialing, medical peer review and/or professional review activities.

“Medical Staff Year” as used herein means the fiscal year beginning September 1.

"Member” means any Practitioner who has been appointed to the Medical Staff by the Governing Body.

“Membership” means having the status of being a Member of the Medical Staff duly appointed by the Governing Body. Being granted Clinical Privileges does not automatically confer Membership to the individual.

“Notice” means a written communication delivered personally or sent by United States mail postage prepaid, facsimile, or by electronic transmission and addressed to the individual at the last address as it appears in the Medical Staff or Hospital records. (See also, the definitions of “Date of Receipt” above and “Special Notice” below).

“Ongoing Professional Practice Evaluation (OPPE)” means the summary of routine and ongoing data collected for the purpose of assessing a Practitioner’s, LP’s, or Advanced Practice Provider’s clinical competence and professional behavior. The information gathered during the OPPE process is factored into decisions to maintain, revise, or revoke existing Clinical Privileges prior to or at the end of the Clinical Privileges renewal cycle. *[Medical Staff Ongoing Professional Practice Evaluation Policy CLN0538]*

“Organizational Manual” means the Supplemental Document to these Medical Staff Bylaws adopted pursuant to Article XIII.

"Peer” means a qualified health care provider of similar training or experience who can render an informed opinion on the competence or quality of patient care, treatment, or services delivered by a Practitioner, LP, or APP.

“Peer Review” or “Professional Review” means the entire process to review and evaluate the competence, professional conduct, and quality of patient care, treatment, and services delivered by Practitioners, LPs, and Advanced Practice Providers as set forth in written policies, including

Credentialing, Privileging, Focused Professional Practice Evaluation, Ongoing Professional Practice Evaluation, and actions relating to the authorization to provide patient care at MD Anderson. *[Medical Staff Ongoing Professional Practice Evaluation Policy CLN0538, Focused Professional Practice Evaluation Policy CLN1004]*

“Physician” means an individual holding a valid current license to practice medicine in the state of Texas, with either a M.D. or D.O., or a Texas Medical Board-accepted graduate degree from a medical school of a foreign country .

“Podiatrist” means an individual holding a valid current license to practice podiatry medicine in the state of Texas, with a D.P.M. degree. Podiatrists are not eligible for admitting Clinical Privileges at MD Anderson.

“Practitioner” means a Physician, Dentist, Podiatrist, Neuropsychologist, Psychologist or Medical Physicist applying to or who holds Medical Staff membership and/or Clinical Privileges to provide patient care services at MD Anderson pursuant to the Medical Staff Bylaws.

“President” means the licensed physician appointed to manage the Hospital as the chief executive officer for MD Anderson.

"Privileging” means a Peer Review process that includes evaluating and assessing the initial request for Clinical Privileges or the request for modification of Privileges for Practitioners, LPs, and APPs through the Medical Staff process. Re-Privileging is the process of re-evaluating and re-assessing the request for Clinical Privileges for Practitioners, LPs, and APPs through the Medical Staff process at reappointment.

“Proctor” or “Proctoring” means a Practitioner or APP who is responsible for the assessment of the skills and knowledge of the Practitioner, APP, or AHP being observed and who meets the qualifications for a Proctor as set forth in the Focused Professional Practice Evaluation Policy. The Proctor must be approved in advance by the Department Chair. If the observation is being conducted at the Hospital, the Proctor must have Clinical Privileges in the specialty area being proctored.

“Psychologist” means an individual holding a valid current license to practice Psychology in the State of Texas. The term “Psychologist” includes Neuropsychologists and Psychologists granted privileges at MD Anderson.

“Qualified Medical Personnel” or “QMP” means the following categories of individuals who are licensed or certified in professional categories, have demonstrated current competence in the performance of a Medical Screening Examination, as defined in the Emergency Medical Screening Examination, Stabilization and Appropriate Transfer Policy CLN3280 and are approved by the Governing Body:

- Advanced Practice Registered Nurses with training in the ACCC.
- Physicians
- Physician Assistants with training in the ACCC.

“Quality Assessment and Performance Improvement (QAPI)” means the MD Anderson hospital-wide plan to maintain an effective, ongoing organization-wide, data-driven quality assessment and performance improvement program.

“Scope of Practice” means the permission granted to an AHP to engage in a specific practice at MD Anderson under appropriate Practitioner supervision pursuant to the procedures in the Medical Staff Bylaws as set forth in Article IV.

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

“Supervising Practitioner” means one or more Active Members of the Medical Staff in the same Department(s) as the Advanced Practice Provider or AHP, who has been granted Clinical Privileges sufficient to supervise or collaborate with the Advanced Practice Provider or AHP, and who is responsible for supervision or collaboration of the Advanced Practice Provider (if required) or AHP in accordance with State and federal law, Medical Staff and Hospital Policies, and the Clinical Privileges granted to the Advanced Practice Provider or the Scope of Practice granted to the AHP.

“Supplemental Documents” means the Organizational Manual, the Fair Hearing Manual, and such policies adopted by the Medical Staff in accordance with Article XIII of these Bylaws.

“Telemedicine” means the delivery of health care services, including diagnosis, consultation, treatment, monitoring, exchange of medical information, and education to a patient at MD Anderson by a Practitioner, LP, or APP from a distant-site via electronic communication.

“Telemedicine Platform” means the tools and technologies that facilitate the delivery of health care services to a patient in a different physical location than the Practitioner, LP, or APP, including but not limited to interactive audio, video, telephone communications, remote monitoring, “store and forward,” or other data communications.

ARTICLE I. NAME

1.1 Name. The name of this organization shall be the “Medical Staff of The University of Texas MD Anderson Cancer Center”.

ARTICLE II. PURPOSES AND RESPONSIBILITIES

2.1 Purposes and Responsibilities. The purposes and responsibilities of the Medical Staff are to:

- Initiate and maintain self-governance of the Medical Staff and provide the necessary structure for MD Anderson to fulfill legal and accreditation requirements, including adoption and amendment of Medical Staff Bylaws and Supplemental Documents for approval by the Governing Body[2], which include the implementation of a process for recommending to the Governing Body[3] membership on the Medical Staff and the granting of Clinical Privileges;

- Provide for a uniform quality of patient care, treatment, and service[4] for all patients admitted to MD Anderson and establish, implement, and maintain appropriate policies and procedures for providing that care;

- Provide oversight of patient care, treatment, and services provided by Practitioners, Licensed Professionals (LPs), Advanced Practice Providers (APPs), and Allied Health Professionals (AHPs) recommend corrective action when indicated, participate in the MD Anderson hospital-wide QAPI Plan as requested by the Governing Body, and report to and be accountable to the Governing Body for fulfillment of these obligations and for the quality of care provided by Practitioners, LPs, and APPs at MD Anderson;[5]

- Support, in consonance with sound medical judgment, the rights of all patients of MD Anderson to equitable and humane treatment, particularly regarding privacy, dignity, confidentiality, and free communication with those responsible for their medical care; and

- Provide a means whereby problems of concern to the Medical Staff may be discussed with the Chief Medical Executive and the Governing Body.

2.2 Accountability. The Medical Staff is accountable to the Governing Body for the quality of medical care provided to patients, and for fulfillment of its purposes and responsibilities and for assuring that all patient care activities are conducted consistent with accepted professional standards and legal and accreditation requirements.

2.3 Medical Staff Bylaws. The Medical Staff Bylaws set out the responsibilities between the Medical Staff and the Governing Body, and between the Medical Staff and its Members and others holding or seeking Clinical Privileges.[6]

2.4 Consistency. These Medical Staff Bylaws and any Supplemental Documents adopted pursuant to Article XIII, including any policies related thereto, shall not conflict with the Texas Constitution, the Governing Body Charter, or the rules of the Board of Regents.[7]

[2] MS.01.01.01, EP 1; MS.01.01.01, EP 2
[3] MS.01.01.01, EP 6
[4] MS.03.01.03, EP 6
[5] MS.03.01.01, EP 3
[6] MS.01.01.01, EP 2
[7] MS.01.01.01, EP 4

ARTICLE III. MEDICAL STAFF MEMBERSHIP[8]

3.1 Nature of Medical Staff Membership.

A. Membership is a Privilege. The privilege of membership on the Medical Staff shall be available to Practitioners who continuously meet the qualifications, standards, and requirements stated in the Medical Staff Bylaws. Membership on the Medical Staff requires fulfillment of the obligations as detailed below to an extent commensurate with the Medical Staff category assigned.

B. Faculty Academic Appointment. A Faculty Academic Appointment is required for membership in the Active, Affiliate, and Administrative Staff categories. A Faculty Academic Appointment is not required for membership in the Courtesy and Emeritus Staff categories. The requirements for Medical Staff membership and Clinical Privileges are separate and distinct from those pertaining solely to Faculty Academic Appointment.

C. Clinical Privileges Separate and Distinct. The requirements for Medical Staff membership are separate and distinct from those pertaining to Clinical Privileges. A Practitioner, LP, or APP may be granted Clinical Privileges and be subject to these Medical Staff Bylaws, without being granted membership on the Medical Staff.

3.2 Medical Staff Categories.[9]

A. Active Staff Category

(1) Qualifications: In addition to the qualifications for Medical Staff Membership under this Article 3, each applicant for the Active Staff must meet the following qualifications:

(a) Confine their practice to MD Anderson.

(b) Maintain a Faculty Academic Appointment.

(2) Prerogatives: Appointees to the Active Staff Category have the following prerogatives:

(a) Exercise Clinical Privileges approved by the Governing Body, including admitting Privileges.

(b) Attend Medical Staff, Division, and Department meetings, and CME events.

(c) Vote on all matters presented at general and special meetings or for electronic voting of the Medical Staff, or any Medical Staff committee of which they are a member.

(d) Be nominated for, elected, or appointed, and serve as a Department Chair, Division Head, or Medical Staff Officer in accordance with these Bylaws.

[8] MS.01.01.01, EP 14
[9] MS.01.01.01, EP 15

(e) Sit on or be the chairperson of any Medical Staff committees if appointed or elected to such committee or position, unless otherwise specified elsewhere in these Bylaws.

(3) Responsibilities: Practitioners assigned to the Active Staff Category have the following responsibilities:

(a) Maintain Clinical Privileges as granted by the Governing Body.

(b) Be available to provide on-call emergency services coverage as required by the Department to which the Practitioner is assigned and in accordance with the Emergency Medical Screening Examination, Stabilization and Appropriate Transfer Policy (#CLN3280) (see also Section 3.4.A (5)).

(c) Fulfill the basic obligations of Medical Staff Membership as set forth in Section 3.4 of these Bylaws.

B. Affiliate Staff Category

(1) Qualifications: In addition to the qualifications for Medical Staff Membership under this Article 3, each applicant for the Affiliate Staff must meet the following qualifications:

(a) Maintain a full-time practice as a Medical Physicist, Neuropsychologist, or Psychologist at MD Anderson.

(b) Maintain a Faculty Academic Appointment.

(2) Prerogatives: Appointees to the Affiliate Staff Category have the following prerogatives:

(a) Exercise Clinical Privileges approved by the Governing Body.

(b) Attend Medical Staff, Division, and Department meetings, and CME events.

(c) Vote on all matters presented at general and special meetings or for electronic voting of the Medical Staff or any Medical Staff committee of which they are a member.

(d) Be nominated for, elected or appointed, and serve as a Department Chair in accordance with these Bylaws.

(e) Be invited to participate in Medical Staff committee meetings.

(3) Responsibilities: Practitioners assigned to the Affiliate Staff Category must fulfill the basic obligations of Medical Staff Membership as set forth in Section 3.4 of these Bylaws.

C. Courtesy Staff Category

(1) Qualifications: In addition to the qualifications for Medical Staff Membership under this Article 3, each applicant for the Courtesy Staff must meet at least one of the following qualifications:

(a) Maintain a Faculty Academic Appointment and a part-time practice at MD Anderson;

(b) Maintain a modified service appointment at MD Anderson;

(c) Maintain a clinical specialist appointment at MD Anderson while completing training at MD Anderson; or

(d) Maintain a private practice or a faculty appointment with another institution and provide consultative services at MD Anderson.

(2) Prerogatives: Appointees to the Courtesy Staff Category have the following prerogatives:

(a) Exercise Clinical Privileges approved by the Governing Body.

(b) Attend Medical Staff, Division, and Department meetings, and CME events.

(c) Be invited to participate in Medical Staff Committee meetings.

(d) Courtesy Staff appointees are not eligible to vote on Medical Staff matters, to chair any Medical Staff committee, to be nominated for, elected or appointed, or serve as a Department Chair, Division Head, or Medical Staff officer.

(3) Responsibilities: Practitioners assigned to the Courtesy Staff Category must fulfill the basic obligations of Medical Staff Membership as set forth in Section 3.4 of these Bylaws.

D. Visiting Staff Category

(1) Qualifications: In addition to the qualifications for Medical Staff Membership under this Article III, each applicant for the Visiting Staff Category must meet the following qualifications:

(a) Be a medical staff member in good standing with clinical privileges at a Medicare-participating hospital or health care entity.

(b) Be visiting from another institution to provide or receive medical education or training for a limited period of time not to exceed six (6) months.

(c) Be approved for the Visiting Staff Category by the CME and the Chair of the ECMS.

(2) Prerogatives: Appointees to the Visiting Staff Category have the following prerogatives:

(a) Exercise limited Clinical Privileges approved by the Governing Body. Visiting Staff members may not admit patients, write orders, or independently treat patients and must work under the direct supervision of an Active Staff Member.

(b) Visiting Staff appointees are not eligible to vote on Medical Staff matters, attend medical staff meetings, be appointed to or chair any Medical Staff committee, to be nominated for, elected or appointed, or serve as a Department Chair, Division Head, or Medical Staff officer.

(c) Visiting Staff are not entitled to certain rights granted under these Bylaws. The denial or the modification of membership to the Visiting Staff does not constitute an Adverse Action as defined in these Bylaws, and shall not entitle the individual to any of the procedural rights provided in Article XII of these Bylaws, including a hearing or appeal.

(3) Responsibilities: Practitioners assigned to the Visiting Staff Category must fulfill the basic obligations of Medical Staff Membership as set forth in Section 3.4 of these Bylaws.

E. Administrative Staff Category

(1) Qualifications: In addition to the qualifications for Medical Staff Membership under this Article 3, each applicant for the Administrative Staff Category must meet the following qualifications:

(a) Be retained by MD Anderson to provide administrative leadership at MD Anderson.

(b) Be approved for the Administrative Staff Category by the CME and the Chair of the ECMS.

(2) Prerogatives: Appointees to the Administrative Staff Category have the following prerogatives:

(a) Administrative Staff appointees may not hold Clinical Privileges.

(b) Attend Medical Staff, Division, and Department meetings, and continuing medical education events.

(c) Be nominated for, elected or appointed, and serve as a Division Head in accordance with these Bylaws.

(d) Administrative Staff appointees are not eligible to vote on Medical Staff matters, to chair any Medical Staff committee, or to be nominated for, elected or appointed, or serve as a Department Chair, or Medical Staff officer.

(3) Responsibilities: Practitioners assigned to the Administrative Staff Category must fulfill the basic obligations of Medical Staff Membership as set forth in Section 3.4 of these Bylaws.

F. Emeritus Staff Category

(1) Qualifications: Each applicant for the Emeritus Staff Category must meet the following qualifications:

(a) Be recommended by the Chief Academic Officer and approved by the ECMS as an individual that the CAO and ECMS wishes to honor due to a history of sustained professional excellence and leadership within the Medical Staff.

(b) Have retired from clinical practice after at least 10 years of a full-time Faculty Academic Appointment and Medical Staff membership at MD Anderson.

(c) Not be excluded by the U. S. Department of Health and Human Services' Office of Inspector General from participation in Medicare, Medicaid, or any other state or federal health care program.

(d) Not have been convicted of, or entered a plea of guilty or no contest to, any felony, within the past seven (7) years.

(e) Not have been convicted of, or entered a plea of guilty or no contest to any misdemeanor involving (a) insurance or health care fraud or abuse, (b) violence, physical abuse, or exploitation directed at a person, or (c) violation of law pertaining to controlled substances or illegal drugs, unless the Applicant is enrolled and satisfactorily participating in, or has successfully completed, a treatment program approved by the ECMS, within the past seven (7) years.

(2) Prerogatives: Appointees to the Emeritus Staff Category have the following prerogatives:

(a) Attend Medical Staff, Division, and Department meetings, and continuing medical education events.

(b) Emeritus Staff appointees are not eligible to hold Clinical Privileges.

(c) Emeritus Staff appointees are not eligible to vote on Medical Staff matters, to chair any Medical Staff committee, or to be nominated for, elected or appointed, or serve as a Department Chair, Division Head, or Medical Staff officer.

(3) Responsibilities: Practitioners assigned to the Emeritus Staff Category do not have responsibilities.

3.3 Qualifications for Membership.[10]

A. General. Membership on the Medical Staff (except for Emeritus Staff) shall be available only to a Practitioner whose background, experience, training, current clinical competence, and peer recommendations demonstrate that the Practitioner possesses the necessary competence and ability to render patient care, treatment, and/or services in compliance with the accepted professional standards at MD Anderson as well as applicable legal and accreditation requirements.[11] Each Practitioner (except for Emeritus Staff) must meet the qualifications set out below[12] and any others established by the Medical Staff and maintain compliance with those qualifications during membership on the Medical Staff and the exercise of Clinical Privileges.[13]

B. Basic Qualifications. Each Practitioner (except for Emeritus Staff as set forth below) must demonstrate continuous compliance with each of the basic qualifications set forth below in order to have an application for Medical Staff Membership or Clinical Privileges accepted for review, and to maintain Medical Staff Membership or Clinical Privileges. Each Practitioner must continuously:[14]

[10] MS.01.01.01, EP 13; MS.06.01.07, EP 6; MS.07.01.01, EP 1
[11] MS.07.01.01, EP 2
[12] MS.01.01.01, EP 5
[13] MS.06.01.03, EP 6; MS.06.01.07, EP 2
[14] MS.06.03.03, EP 6; MS.06.01.05, EP 2; MS.06.01.07, EP 6.

(1) Be a graduate of an approved professional school and, if available in the Practitioner's discipline, have successfully completed an ACGME-approved residency training program (or approved foreign equivalent) in the specialty or subspecialty appropriate to the intended practice;[15]

(2) Hold a valid full professional license to practice in the state of Texas (or, for Physicians, have been granted a temporary or limited license by the Texas Medical Board which permits the provision of patient care, treatment, and services at MD Anderson for a temporary period as specified in these Medical Staff Bylaws and Hospital policies) *[Medical Staff Policy on Criteria for the Initial Grant and Renewal of Clinical Privileges CLN1014];*[16]

(3) Be currently certified and maintain certification by an appropriate specialty board approved by the Hospital or achieve board certification within five (5) years of appointment, unless:[17]

> (a) Exempted due to lack of availability of board certification or equivalent foreign board in the particular specialty, as determined and approved by the ECMS Chair and the Chief Medical Executive; or
>
> (Practitioners who were Members of the Medical Staff on or before January 1, 2001, were not board certified at that time, and who have maintained Medical Staff Membership continuously since that time, are exempt from this board certification requirement);

(4) Hold federal controlled substances authorization if required by the Department to which the Practitioner would be assigned;

(5) Provide the required peer references (from Practitioners in the same professional discipline and with personal knowledge of the Practitioner's ability to practice) as to relevant training and experience, current clinical competence, any effects of health status on the Practitioner's ability to exercise the Clinical Privileges requested, and other qualifications of membership;[18]

(6) Demonstrate that the Practitioner has not been excluded by the U. S. Department of Health and Human Services' Office of Inspector General from participation in Medicare, Medicaid, or any other state or federal health care program;

(7) Not have been convicted of, or entered a plea of guilty or no contest to any felony within the past 7 years;

(8) Not have been convicted of, or entered a plea of guilty or no contest to any misdemeanor involving (a) insurance or health care fraud or abuse, (b) violence, physical abuse, or exploitation directed at a person, or (c) violation of law pertaining to controlled substances or illegal drugs, unless the Applicant is enrolled and satisfactorily participating

[15] MS.04.01.01, EP 9.
[16] MS.06.01.05, EP 1.
[17] MS.06.01.05, EP 1.
[18] MS.06.01.05, EP 8; MS.07.01.03, EP 1; MS.07.01.03, EP 4.

in, or has successfully completed, a treatment program approved by the ECMS, within the past seven (7) years;

(9) Not be debarred, suspended, disqualified or otherwise declared ineligible as an investigator by a federal agency, or restricted from conducting clinical research by the FDA pursuant to the Generic Drug Enforcement Act of 1992 or any other equivalent or successor statutes; and

(10) Document that the Practitioner is covered by professional liability insurance in amounts acceptable to MD Anderson.

C. Deliberative Qualifications. In addition to the basic qualifications for Medical Staff Membership or Clinical Privileges above, each Practitioner must:

(1) Demonstrate current clinical competence in the Practitioner's area of practice;

(2) Demonstrate the Practitioner's adequate experience, education, and training in the requested Clinical Privileges;

(3) Be capable of consistently working in a professional and cooperative manner with others in a hospital setting and refraining from harassment of others so as not to adversely affect patient care or Hospital operations;

(4) Demonstrate the Practitioner's adherence to the ethics of the Practitioner's profession, good reputation, and ability to work professionally and cooperatively with others; and

(5) Demonstrate the Practitioner's ability to perform the essential functions of Medical Staff membership and exercise the Clinical Privileges requested without posing a risk to the safety or well-being of others with or without reasonable accommodation (see Section 3.5).

D. Waiver of Qualifications.

(1) The Governing Body has the discretion to deem a Practitioner to have satisfied a qualification for Medical Staff Membership above only in the following situations and only as it relates to the following specified areas of Clinical Privileges or Membership. The Governing Body has discretion to waive the qualification, following receipt of recommendations from the CCMS, and the ECMS, if the Governing Body determines:

(a) The Practitioner has the burden and has demonstrated by clear and convincing evidence that the Practitioner has substantially comparable qualifications;

(b) Waiving the qualification is not inconsistent with applicable laws and accreditation standards;

(c) Waiving the qualification is necessary to serve the best interests of the patients and the Hospital; and

(d) Waiving the qualification fulfills an important patient care need, treatment or service.

(2) There is no obligation to grant any such waiver, and Practitioners have no right to have a waiver considered and/or granted. A Practitioner who is denied a waiver or consideration of a waiver shall not be entitled to any hearing and appeal rights under these Bylaws. The waiver, if granted, may set a waiver period and/or any additional conditions associated with such waiver. If the waiver is granted and the Practitioner does not meet any of the conditions associated with the waiver by any time period or deadline, then the Practitioner's Clinical Privileges shall be automatically suspended as of the date the Practitioner fails to meet such condition(s).

3.4 Obligations of Medical Staff Membership.

A. Duties. Each Member shall be required to fulfill the obligations of Medical Staff membership which shall include without limitation:

(1) Provide patients with care, treatment, and services in accordance with the standards of MD Anderson, and national professional standards when appropriate, and with effective utilization of services;[19]

(2) Abide by the Medical Staff Bylaws and by all policies of the Medical Staff and MD Anderson, and maintain compliance with all qualifications for Medical Staff membership and Clinical Privileges;

(3) Comply with all applicable requirements and Hospital policies for completing medical history and physical examinations. A history and physical examination will include the following requirements: [20]

(a) A medical history and physical examination will be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services in accordance with Hospital policy.

(b) When the medical history and examination is completed within 30 days before admission or registration, an updated examination of the patient, including any changes in the patient's condition, is completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a Physician, an oral and maxillofacial surgeon, or other licensed individual in accordance with state law, these Medical Staff Bylaws and Hospital policy.[21]

(c) Assessment In Lieu of Comprehensive History and Physical Examination for Outpatient Surgeries and Procedures[22]

i. A comprehensive medical history and physical examination is not required for those specific patients receiving the specific outpatient surgical or procedural services identified in the Hospital policy on assessments in lieu of a comprehensive history and physical examination. In lieu of a

[19] MS.05.01.03, EP 3.
[20] MS.03.01.01, EP 7; MS.03.01.01, EP 11.
[21] MS.01.01.01, EP 16; MS.03.01.01, EP 6; MS.03.01.01, EP 8.
[22] MS.03.01.01, EP 19.

comprehensive history and physical examination, a Practitioner or APP with Clinical Privileges to perform the comprehensive history and physical examination may instead perform an assessment of the patient to be completed and documented after registration but prior to the specific outpatient surgical or procedural services requiring anesthesia services.[23]

ii. The Medical Staff must demonstrate evidence that the Hospital policy on assessments in lieu of a comprehensive history and physical examination applies only to those patients receiving the specific outpatient surgical or procedural services as well as evidence that the policy is based on:

a. Patient age, diagnoses, the type and number of surgeries and procedures scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure;

b. Nationally recognized guidelines and standards of practice for assessment of specific types of patients prior to specific outpatient surgeries and procedures; and

c. Applicable state and local health and safety laws.

(4) Fulfill all Medical Staff, Division, Department, and committee functions for which the Member is responsible by virtue of membership, Medical Staff category, election, appointment, or otherwise;

(5) Comply with all legal and accreditation requirements relating to the practice of the Member's profession and requirements relating to the delivery of patient care, treatment, and services in MD Anderson;

(6) Comply with on-call emergency services requirements of the Departments to which assigned in accordance with the Emergency Medical Screening Examination, Stabilization and Appropriate Transfer Policy (#CLN3280), and provide consultations as specified in Hospital policy;[24]

(7) Cooperate in Peer Review activity including without limitation credentialing, assisting with Ongoing Professional Practice Evaluation, and Focused Professional Practice Evaluation, and implementation of the Peer Review, utilization review, and risk management activities of the Medical Staff and MD Anderson; and

(8) Abide by the ethical standards and principles of the state and national professional associations of the Member's discipline.

B. Disclosure Requirements.

(1) In addition to the requirements of Section 3.4(A) above, it shall be a continuing duty on the part of all Members and others holding Clinical Privileges to update the information provided on the most recent application for membership or Clinical Privileges on an ongoing basis as provided below. Notice must be provided to Medical Staff & Credentialing

[23] MS.01.01.01, EP 38.
[24] MS.03.01.03, EPs 4, 5, & 12.

Services on the next business day following the Member's receipt of notice of any of the following:

(a) any voluntary or involuntary change in medical staff membership or Clinical Privileges at any other hospital or health care entity, including without limitation resignation or failure to seek reappointment, denial, reduction, limitation, probation, suspension, or termination, imposition of disciplinary or corrective action, or initiation of an investigation for possible disciplinary or corrective action;

(b) any voluntary or involuntary change in professional license in any state or in state or federal controlled substances registration, including without limitation relinquishment, denial, reduction, limitation, probation, suspension, termination, or revocation or initiation of an investigation by the responsible agency;

(c) any change in health status that might impact their ability to perform the essential functions of Medical Staff Membership or to exercise the Clinical Privileges held or requested, as detailed below in Section 3.5.A;

(d) any complaint, investigation, sanction, or exclusion by Medicare, Medicaid, or another federal or state health care program or agency, including without limitation all documentation and communication to and from the applicable federal or state program related to the complaint, investigation, sanction, or exclusion;

(e) debarment, suspension, disqualification or any other declaration of ineligibility as an investigator by a federal agency, or restriction from conducting clinical research by the FDA pursuant to the Generic Drug Enforcement Act of 1992 or any other equivalent or successor statutes;

(f) whether the applicant is registered as a sex offender or required to register as a sex offender; or

(g) any criminal complaint, criminal information or charge, criminal indictment, criminal conviction, no contest plea, guilty plea, or criminal offense except for misdemeanor offenses punishable only by a fine unless a misdemeanor involving (a) insurance or health care fraud or abuse, (b) violence, physical abuse, or exploitation directed at a person, or (c) violation of law pertaining to controlled substances or illegal drugs.

(2) Any Member or other individual holding Clinical Privileges who is concerned that a Practitioner or other individual holding Clinical Privileges may be practicing while potentially impaired by a physical, mental, or emotional condition that could adversely affect their ability to practice safely and competently, or who is told by a patient, family member, or other individual of a concern, has a duty to report the concern to the Chief Medical Executive or the Chair of the ECMS. The report may be made verbally or in writing. Individuals making such a report do not need to have proof of a potential impairment but should describe the facts that form the basis for the concern. The person receiving the report may inform the reporting individual that the report will be treated confidentially, and that the reporting individual's identity will not be disclosed to the affected individual unless the ECMS or Hospital determines it is necessary to do so. The reporting individual may be informed that follow-up action was taken, but the specifics of any action may not be shared in light of their confidential nature.

3.5 Health Status.[25]

A. General. Each Practitioner must possess the necessary physical and mental health status to perform the essential functions of Medical Staff Membership or to exercise the Clinical Privileges requested without posing a risk to the safety or well-being of others, with or without reasonable accommodation (hereinafter referred to collectively as "necessary health status"), and must cooperate fully and openly in any assessment or documentation of necessary health status.

B. Health Assessment. Each Practitioner, LP, or APP granted or seeking Clinical Privileges shall, at the request of the CCMS, ECMS, or other individual or committee designated by the ECMS, undergo an examination or assessment by a health care professional(s) that is mutually acceptable to the Practitioner, LP, or APP and the requesting entity when a question arises concerning the Practitioner's, LP's, or APP's physical or mental well-being that may affect the safe and competent delivery of care to patients in accordance with Hospital policies on Practitioner health and impairment. If a mutually acceptable health care professional(s) cannot be agreed upon within thirty (30) days from receipt of the request, then the requesting entity shall select the health care professional(s) acceptable to the requesting entity. The Practitioner, LP, or APP will execute a release allowing the requesting entity to discuss with the health care professional(s) the reasons for the examination or assessment, and allowing the health care professional(s) to discuss and report the results of the examination or assessment to the requesting entity;[26]

C. Policies. All issues regarding necessary health status shall be coordinated and conducted in accordance with the written policies of MD Anderson [see, for example, Practitioner Peer Assistance Committee and *Practitioner Health and Impairment Policy CLN0619* and *Fitness for Duty Policy ADM0274*].[27]

D. Non-Compliance. Failure of an applicant to comply with these Medical Staff Bylaws and Hospital policies on necessary health status shall constitute withdrawal of the application for Medical Staff membership and/or Clinical Privileges from further processing. Failure of a Member or other individual holding Clinical Privileges to comply with written policies of MD Anderson may result in summary action in accordance with Article XI and/or other actions as set forth in those policies.

3.6 Application for Initial Term of Membership.[28]

A. Recommendations. All recommendations by Department Chairs and committees shall be in writing and shall include a statement of the reason for any recommendation to deny, limit, restrict, or impose conditions on Medical Staff membership and/or Clinical Privileges.[29]

B. Applications and Submission of Information. Applications (except for Courtesy Staff and Emeritus Staff) are only accepted from Practitioners who have received or have been offered a current Faculty Academic Appointment. Practitioners must submit applications in writing to

[25] MS.06.01.05, EP 6.
[26] MS.02.01.01, EP 7.
[27] MS.11.01.01, EP 1 to EP 10.
[28] MS.06.01.03, EP 4.
[29] MS.06.01.09, EP 2.

Medical Staff & Credentialing Services in the form approved by the CCMS, which applications shall include without limitation:[30]

(1) peer references;

(2) professional liability claims history;

(3) any challenges, investigations, voluntary or involuntary relinquishment, or actions involving professional licensure, registration, or certification;

(4) any voluntary or involuntary limitation, restriction, reduction, probation, suspension, loss, or termination or denial of medical staff membership or Clinical Privileges;

(5) documentation of necessary health status;

(6) whether the applicant is registered as a sex offender or required to register as a sex offender;

(7) any criminal complaint, criminal information, criminal indictment, no contest plea, guilty plea, or criminal offense except for misdemeanor offenses punishable only by a fine; and

(8) any additional information requested.

C. Completed Application. A completed application shall be defined by written policy and must include all requested information from the applicant and any third parties. Any committee responsible for review of the application and applicant may defer issuance of a recommendation for a stated period of time for the purpose of obtaining additional information, during which time the application shall be considered incomplete.[31]

D. Burden on Practitioner. The Practitioner bears the burden of providing all information requested and for resolving any questions raised during the application process. Failure to submit a completed application, requested information, or comply with an interview request within a stated time period shall result in voluntary withdrawal of the application from further processing. In addition to the above, it shall be a condition of membership that the Practitioner advise Medical Staff & Credentialing Services in writing of any material change in the information provided on the application or in response to a request within the time frame set forth on the application to the Medical Staff.

E. Material Misstatements by Practitioner. Material Misstatement of information on an application for membership, reappointment, and/or Clinical Privileges or at any stage of the credentialing process shall be grounds for withdrawal of the application from further processing, denial of Medical Staff membership, reappointment, and/or Clinical Privileges, or corrective action if membership and/or Clinical Privileges have already been granted.

F. Withdrawal and/or Reapplication for Medical Staff Membership and Clinical Privileges. An applicant may withdraw the applicant's application for initial appointment or reappointment at any time prior to the effective date of a final decision, without prejudice or restriction to subsequent reapplication.

[30] MS.06.01.05, EP 9
[31] MS.06.01.05, EP 11

G. Policies. Written policies and procedures for implementation of the application submission and processing requirements set forth above must be approved by the ECMS, following consultation with the CCMS, and approved by the Governing Body.

H. Procedures.[32]

(1) Applications shall be received by Medical Staff & Credentialing Services in its capacity as agent for the CCMS. Processing as set forth below must be accomplished within one hundred and eighty (180) days of receipt of a completed application.[33]

(2) Medical Staff & Credentialing Services shall perform primary source verification, request additional information as appropriate, and coordinate the collection of information with the appropriate Department Chair as necessary pursuant to policy. Verification of information shall include, without limitation, verification of training, queries to the National Practitioner Data Bank,[34] state professional licensing agency, and Medicare/Medicaid Sanctions Report. Applications shall not be forwarded for further processing until the application is complete and all requested information has been received.[35]

(3) Unless the request and recommendation for Medical Staff membership originated with the applicant's Department Chair, the completed application shall be forwarded by the CCMS to the appropriate Department Chair for review and recommendation within thirty (30) days of receipt. The Department Chair shall be responsible for reviewing the qualifications of and interviewing the Practitioner and shall submit a report of the findings as soon as possible through the Division Head and to the CCMS, with a recommendation as to Medical Staff membership, specific Clinical Privileges, and Medical Staff category. All grants of Medical Staff membership shall be made to a specific Department and Division and, when applicable, to a specific Section or Service, based on the Practitioner's education, training, experience, and other relevant information.

In instances in which the Practitioner does not fall under an existing Department or Division or if the Practitioner will be filling the position of Division Head if granted Medical Staff membership, the Chief Medical Executive shall be responsible for review and recommendation to the CCMS. If the Practitioner will be filling the position of Department Chair if granted Medical Staff membership, the Division Head shall be responsible for review and recommendation to the CCMS.

(4) The CCMS shall review the application within ninety (90) days of receipt of the completed application and may require the Practitioner to appear for an interview with the CCMS or a subcommittee of the CCMS. During consideration, the Practitioner's Department Chair or Division Head shall be available to the CCMS to answer any questions about the Practitioner. The application may be returned to that individual for further information or processing. The CCMS shall forward the application and its written recommendation of Medical Staff membership, Clinical Privileges, and Medical Staff category to the ECMS.

[32] MS.01.01.01, EP 27; MS.06.01.03, EP 1; MS.06.01.07.
[33] MS.06.01.07, EP 4.
[34] MS.06.01.05, EP 7.
[35] MS.06.01.03, EP 6.

(5) The ECMS shall review the application at its next regular meeting, within sixty (60) days, and issue a written recommendation of Medical Staff membership, Clinical Privileges, Medical Staff category, and any conditions.[36]

(a) Unless the ECMS issues an Adverse Recommendation or Action as set forth below, its recommendation shall be forwarded to the Governing Body for a final decision.[37]

(b) If the recommendation of the ECMS is an Adverse Recommendation or Action, the Practitioner shall be afforded the procedures set forth in Article XII of these Medical Staff Bylaws and all further procedures shall be as set forth in the Fair Hearing Manual.[38]

(6) In the event the Governing Body does not concur with the recommendation from the ECMS, the Governing Body will notify the committee through the Chair of the ECMS and, if requested by the Chair of the ECMS, will meet with the ECMS to discuss the issue. If the decision of the Governing Body is an Adverse Recommendation or Action, the Practitioner shall be afforded the procedures set forth in Article XII of these Medical Staff Bylaws and all further procedures shall be as set forth in the Fair Hearing Manual.

(7) Within ten (10) days of a final decision, the Governing Body shall send written notice of his or her decision to the Practitioner.[39]

(8) The timeframes in this Section 3.6.B are guidelines and are not directives that create any rights for an applicant to have an application processed within these precise periods. The processing may be delayed or discontinued for an incomplete application.[40]

I. Administrative Rejection of an Application

(1) An applicant's request or application for Medical Staff Membership and/or Clinical Privileges will be administratively rejected and will not be processed if at any time:

(a) The information received indicates that the applicant does not meet the Basic Qualifications for membership set forth in Sections 3.3(A) & (B) of these Bylaws, or the objective eligibility requirements for Clinical Privileges requested as set forth in the appropriate application forms (such as completing a fellowship or performing a minimum number of specialized procedures);

(b) The application or request for Medical Staff Membership and/or Clinical Privileges contains a Material Misrepresentation;

(c) If the application is for initial Medical Staff appointment or Clinical Privileges, the applicant's offer of employment with MD Anderson has been withdrawn, rejected, or otherwise terminated;

[36] MS.06.01.03, EP 2; MS.07.01.01, EP 5
[37] MA 02.01.01, EP 8; MS.06.01.03, EP 3; MS.06.01.07, EP 8; MS.07.01.01, EP 5
[38] MS.06.01.09, EP 5
[39] MS.06.01.09, EP 1 & 3
[40] MS.06.01.07, EP 4

(d) The applicant fails to appear for a requested interview regarding the applicant's application, or fails to provide any requested additional or clarifying information; or

(e) The applicant fails to return a Completed Application within the time frames required by these Bylaws.

(2) If the application is determined to be incomplete it will be returned to the application for submission of any requested information or documentation. The applicant will have thirty (30) days from the date of the application was returned to resubmit the Completed Application.

(a) If the application is for initial Medical Staff appointment or Clinical Privileges, and the Completed Application is not received within thirty (30) days from the date the application was returned, the application will be considered withdrawn, and the applicant will be so notified.

(b) If the application is for reappointment, and the Completed Application or application fee is not received within thirty (30) days from the date the application was returned, Medical Staff & Credentialing Services, will notify the applicant by Special Notice that the applicant's failure to return a Completed Application in accordance with these Bylaws shall result in the applicant being deemed to have voluntarily resigned from the Medical Staff and to have relinquished the applicant's Clinical Privileges on the date the applicant's then-current appointment and Clinical Privileges expire.

(3) If the application is administratively rejected in accordance with this Subsection I, the applicant will be notified in writing that the applicant is not eligible to apply for Medical Staff membership or to request Clinical Privileges, as appropriate, that the applicant's application or request will not be processed, the basis for the administrative rejection, and that the applicant is not entitled to any procedural rights including a hearing or appeal under these Medical Staff bylaws.

J. Fast Track Credentialing.[41]

(1) Fast Track procedure may be requested by the Practitioner's or APP's Department Chair for initial credentialing or reappointment (i.e., new or renewed Clinical Privileges or initial appointment or reappointment to the Medical Staff) or may be considered for timely routing. In cases where the application is complete, all qualifications in Section 3.3.B have been met, required verifications have been completed, and all requested information has been received, the Chair of the ECMS or Chair Elect of the ECMS as designee, Chair of the CCMS or Vice Chair of the CCMS as designee, may (but shall not be required to) approve the application on behalf of CCMS, allowing the application to proceed directly to the Governing Body, if:[42]

(a) the Practitioner or APP either:

i. holds a full Texas professional license, or

[41] MS.06.01.11, EP 1
[42] MS.06.01.11, EP 2

ii. holds a temporary or limited Texas license and a current professional license in at least one state or Canada; and

(b) the Practitioner or APP has not been subject to:

i. any current or previously successful challenges to licensure or controlled substances registration,[43]

ii. involuntary termination of medical staff membership at another health care entity,[44]

iii. involuntary limitation, reduction, denial, or loss of Clinical Privileges at another health care entity,[45]

iv. exclusion by the U. S. Department of Health and Human Services' Office of Inspector General from participation in Medicare, Medicaid, or any other state or federal health care program; or

v. an unusual pattern or excessive number of professional liability actions resulting in a final judgment against the Practitioner;[46] and

(c) the ECMS's final recommendation does not include any adverse recommendations or limitations.

(2) Medical Staff membership and Clinical Privileges may be approved through the Fast Track process upon recommendation of the ECMS, and subject to final approval of the Governing Body.[47]

(3) For purposes of this Section 3.6(C), the ECMS may delegate authority to a subcommittee of the ECMS composed of at least three (3) ECMS members, to include the following: Chair of the ECMS, Chair-Elect of the ECMS, Chair of the CCMS, and Vice Chair of the CCMS. Any vote of the ECMS subcommittee to approve a Fast Track applicant must be unanimous.

(4) The ECMS subcommittee for Fast Track for APPs must also include the following ECMS non-voting members, who must approve the APP applicant for Fast Track:

(a) The Executive Director for Advanced Practice appropriate to the applicant (e.g., PA or APRN), and

(b) For Fast Track for APPs applicants who are APRNs, the Chief Nursing Officer. References to the ECMS under this Section 3.6(C) include the ECMS and the ECMS subcommittee.

K. Initial Term. Membership on the Medical Staff shall be for an initial period of not more than twenty-four (24) months. During the first twelve (12) months of this initial appointment period, the

[43] MS.06.01.11, EP 3
[44] MS.06.01.11, EP 4
[45] MS.06.01.11, EP 5
[46] MS.06.01.11, EP 6
[47] MS.06.01.11, EP 7

professional competence and conduct of the Member shall be evaluated by the Department Chair or such other Members designated by the Department Chair through the Focused Professional Practice Evaluation (FPPE) Process outlined in Article XI.

3.7 Reappointment.[48]

A. Reappointment. Members of the Medical Staff must be recredentialed at least every two (2) years.[49] Continued membership is not automatic or guaranteed. Members shall be evaluated for continued satisfaction of the qualifications for Medical Staff membership and such other requirements as may be established from time to time by the Governing Body. As to board certification, Members are to be involved in the recertification process as required by their specialty. Each Member will be evaluated using available Practitioner-specific data generated through medical peer review and/or professional review activity, usage of the facilities, committee and Medical Staff leadership work, emergency services coverage, continuing medical education, and other activities related to the Member's professional services. The measures used for reappointment shall be distinct from requirements used in connection with Faculty Academic Appointment.[50]

B. Procedures. The procedures for review of an application for reappointment shall be as set forth in Section 3.6 above.[51]

C. Conditional Reappointment. When appropriate, the Department Chair, the CCMS, or the ECMS may recommend to the Governing Body that specified conditions be placed on a Member at the time of reappointment or that the reappointment is for a time period of less than two (2) years to facilitate more frequent review of the Member. Any conditions that constitute an Adverse Recommendation or Action that are approved by the ECMS (or the Governing Body following a recommendation by the ECMS that was not an Adverse Recommendation or Action) shall entitle the Member to the procedural rights of review set forth in Article XII and the Fair Hearing Manual.

3.8 Leave of Absence.

A. General. Leave of absence for a Member of the Medical Staff, APP, LP, and any individual holding Clinical Privileges shall be in accordance with the policies of MD Anderson, but may not result in an extension of the term of Membership on the Medical Staff beyond the two (2) year appointment period.

B. Prerogatives and Responsibilities.

(1) During a leave of absence, the Member, APP, or LP may not exercise Clinical Privileges at the Hospital. A leave of absence does not constitute a surrender of Clinical Privileges.

(2) Unless stated or otherwise indicated, the Clinical Privileges and Medical Staff obligations of the Member shall be in abeyance and inactive during the period of the leave. The obligation to maintain professional qualifications for Medical Staff Membership as set forth in Section 3.3 above shall continue during the period of leave.

[48] MS.01.01.01, EP 27.
[49] MS.07.01.01, EP 3.
[50] MS.07.01.03, EP 2; MS.12.01.01, EP 5.
[51] MS.06.01.05, EP 7.

C. Requests. Request for leave of absence may originate directly from the Member of the Medical Staff, through communication from the MDACC Leave Center, or on behalf of the Member through their Department Chair/designee.

D. Types of Voluntary Leave. Members of the Medical Staff may request leave of absence for various reasons. The categories of voluntary leave of absence are: Military, Educational, Health, Parental and Personal.

E. Completion of Medical Records. Unless precluded by an emergency, prior to a leave of absence, the Member must complete all medical records for which the Member is responsible as of the date of the scheduled departure. In the event of an emergency which prevents completion of medical records, any incomplete medical records must be completed as soon as practical and, in any event, prior to the Member's return from leave of absence.

F. Return from Leave of Absence.

(1) In addition to any requirements set forth in the policies of MD Anderson, prior to providing patient care a Member, LP, or APP, except for an individual on parental leave, must request reinstatement of Membership and Clinical Privileges by submitting a written request to Medical Staff & Credentialing Services with a written summary of professional activities during their leave, and an attestation that no changes have occurred in any information provided on their last application or, if changes have occurred, a detailed description of such changes.

(2) The Department Chair shall verify that the Member continues to meet the qualifications for Medical Staff Membership and Clinical Privileges and is able to safely exercise those Privileges. The Department Chair shall then make a written recommendation to the Chief Medical Executive and the Chair of the ECMS regarding the Member's return.

(3) Reinstatement from leave of absence must be approved by the CME and the Chair of the ECMS prior to resuming any patient care activities.

(4) If a Practitioner's request for reinstatement from a leave of absence is denied by the CME and the Chair of the ECMS the Practitioner will be notified by Special Notice including the reason for the denial and the Practitioner's right to request a hearing in accordance with Section 12.1 of these Bylaws.

(5) Reinstatement from any leave of absence where a concern has been raised regarding a Practitioner's, LP's, or APP's professional performance, competence, or ability to provide safe, quality patient care may be subject to For Cause FPPE in accordance with Section 11.1 of these Bylaws and Hospital policy. *[Focused Professional Practice Evaluation Policy CLN1004]*.

G. Early Request for Reappointment. If the Medical Staff Member's, LP's, or APP's then-current Medical Staff membership or Clinical Privileges will expire during the requested leave of absence, the Medical Staff Member or APP may submit an early application for reappointment in advance of or during the leave of absence.

H. Failure to Apply for Reappointment. The Medical Staff Member's, LP's, or APP's failure to return a completed application for reappointment in accordance with the Bylaws during a leave of absence will result in the Medical Staff Member, LP, or APP being deemed to have voluntarily

resigned from the Medical Staff and to have relinquished their Medical Staff Membership and/or Clinical Privileges, as applicable, on the date the individual's then-current appointment and Clinical Privileges expire. The former Medical Staff Member, LP, or APP may reapply for Medical Staff Membership and/or Clinical Privileges, and the application will be processed as a new applicant.

3.9 Requests for Modification of Category. A Member may, either in connection with reappointment or at any other time, request modification of Medical Staff category or Department assignment by submitting a written request to the Member's Department Chair or Division Head. The procedures for review of a request for modification shall be as set forth in Section 3.6 above

A. Requests for modification and appointment to the Administrative Staff Category must first be reviewed and approved by the Chief Medical Executive and the Chair of the ECMS.

B. Requests for modification and appointment to the Emeritus Staff Category must first be reviewed and approved by the Chief Academic Officer.

3.10 Special Appearance.

A. The ECMS, Board, CCMS, or an Investigating Committee may, at its discretion, require the appearance of a Practitioner during review of an application or during an Investigation of a Practitioner's clinical competence or professional conduct (a "Special Appearance"). If possible, the chair of the committee should give the Practitioner at least ten (10) days' advance written Notice of the time and place of the Special Appearance.

B. In addition, whenever a Special Appearance is requested because of an apparent or suspected deviation from standard clinical practice, notice shall be given by Special Notice, and shall include a statement of the issue involved and that the Practitioner's appearance is mandatory.

C. Failure of a Practitioner to appear at any meeting with respect to which the Practitioner was given notice of a Special Appearance shall (unless excused by such committee chair or the Executive Committee of the Medical Staff upon a showing of good cause) result in an automatic suspension of the Practitioner's Clinical Privileges until the required Special Appearance is made or other action is taken by the Executive Committee of the Medical Staff. The Practitioner shall not be entitled to the procedural rights described in these Bylaws for an automatic suspension based on failure to attend a Special Appearance under this Section 3.10.

3.11 Nondiscrimination

A. MD Anderson will not discriminate in granting Medical Staff Membership or Clinical Privileges on the basis of any protected class as defined by federal, state, or municipal law, including but not limited to on the basis of race, color, ethnicity, national origin, citizenship, sex, age, disability, religion, creed, veteran's status, sexual orientation, gender identity or gender expression, or other criterion so long as such criterion is unrelated to the delivery of quality and safe patient care or to professional competence or conduct.

ARTICLE IV. CLINICAL PRIVILEGES[52]

4.1 General.

A. Requirement. Every Practitioner providing patient care, treatment, and services at MD Anderson shall be required to apply for and be granted the appropriate setting-specific Clinical Privileges. A Practitioner is entitled to exercise only those Clinical Privileges specifically granted by the Governing Body, except as provided in this Article.[53]

B. Request and Evaluation. Applications for Medical Staff membership and reappointment may or may not contain a request for Clinical Privileges. The evaluation of such requests shall be based upon the Practitioner's education, training, experience, demonstrated current clinical competence, ability, peer evaluations, and other relevant information, including an appraisal by the Department Chair for the Department in which the Clinical Privileges are sought. The Practitioner shall have the burden of establishing all required qualifications and current clinical competence with respect to the Clinical Privileges requested. Each Department shall establish and record the Clinical Privileges granted the Practitioner in that Department.[54]

C. Redetermination. Periodic redetermination of Clinical Privileges shall occur at least every two (2) years following the procedures for an initial grant of Medical Staff membership in Section 3.6 above.[55] Periodic redetermination of Clinical Privileges and the increase or curtailment of same shall be based upon Practitioner-specific data generated through Focused Professional Practice Evaluation, Ongoing Professional Practice Evaluation, medical peer review and/or professional review activity, information required by legal and accreditation standards, and any other pertinent information as determined by the Department, CCMS, ECMS, or the Governing Body.[56] Data may be based on direct observation of care provided, comprehensive evaluation through ongoing monitoring and departmental review, and/or review of the records of patients treated or review of the records of the Medical Staff which document the evaluation of Practitioner participation in the delivery of patient care, treatment, and services.

D. Additional Privileges. A request for additional privileges must be made in writing, on a form approved by the CCMS, to the Department Chair for review and recommendation. If recommended by the Department Chair, the request will be reviewed using the procedures for an initial grant of Medical Staff membership in Section 3.6 above.

4.2 Delineation of Clinical Privileges.[57]

A. Delineation. Each Department shall establish a delineation of Clinical Privileges available for that Department which shall be approved by the CCMS, the ECMS, and the Governing Body.[58]

B. Criteria. In addition to the qualifications and requirements in the Medical Staff Bylaws, written criteria are established for Clinical Privileges as minimum or threshold qualifications that must be met by a Practitioner before a request for Clinical Privileges will be accepted for processing. Criteria may relate to training, experience, specialty or subspecialty board eligibility

[52] MS.06.01.05, EP 4; MS.06.01.05, EP 5; MS.06.01.07, EP 6.
[53] MS.03.01.01, EP 2; MS.03.01.01, EP 18.
[54] MS.06.01.05, EP 1; MS.06.01.05, EP 2.
[55] MS.06.01.07, EP 9.
[56] MS.07.01.03, EP 2.
[57] MS.01.01.01, EP 14; MS.02.01.01, EP 11.
[58] MS.06.01.05, EP 5.

and/or certification, and other pertinent factors. Criteria established by each Department Chair shall be subject to the approval of the CCMS, the ECMS, and the Governing Body, and shall be distinct from any requirements associated with Faculty Academic Appointment. A Practitioner's compliance with the criteria established for Clinical Privileges does not guarantee the granting of those Clinical Privileges.

C. Consistency. The CCMS, ECMS, and the Governing Body shall ensure the appropriateness and consistency of criteria for Clinical Privileges that are offered by more than one Department.[59]

4.3 Temporary Privileges for Important Patient Care, Treatment, and Service's Needs (Collectively, "Important Patient Care Needs").

A. Authority to Grant. The Governing Body, on written request of a Medical Staff member and recommendation of the Chair of the ECMS or designee shall have the authority to grant temporary privileges for important patient care needs, to an appropriately licensed Practitioner with documented current clinical competence as set forth below and as detailed in written policy.[60] [*Medical Staff Policy for Temporary Privileges for Important Patient Care, Services and Treatment Needs CLN3314*]

For purposes of this Section 4.3, the Chair of the ECMS's authorized designee includes the following, in order of preference based on reasonable availability: The Chair-Elect of the ECMS, the Chair of the Credentials Committee of the Medical Staff (CCMS), or the Vice Chair of the CCMS.

B. Procedure. Temporary privileges are granted to a Practitioner who does not hold Clinical Privileges and is not seeking membership or full Clinical Privileges but who can fulfill an urgent, important patient care need. Privileges are granted for a period not to exceed thirty (30) days and shall be limited to the care of specific patient(s). Minimum criteria require to grant temporary privileges for important patient care needs include:[61]

(1) the Practitioner holds a current, unrestricted Texas professional license or certification;

(2) the Practitioner's clinical competence is evidenced through at least one peer reference;

(3) the Practitioner has professional liability insurance coverage;

(4) the Practitioner has not been debarred, suspended, disqualified or otherwise declared ineligible as an investigator by a federal agency, or restricted from conducting clinical research by the FDA pursuant to the Generic Drug Enforcement Act of 1992 or any other equivalent or successor statutes; and

(5) the Practitioner has not been excluded by the U. S. Department of Health and Human Services' Office of Inspector General from participation in Medicare, Medicaid, or any other state or federal health care program.

Additional verifications are set forth in Medical Staff Policy.

[59] MS.06.01.05, EP 3; MS.06.01.07, EP 5
[60] MS.06.01.13, EP 1; MS.06.01.13, EP 4; MS.06.01.13, EP 5
[61] MS.06.01.13, EP 2; MS.06.01.13, EP 3

C. Authority and Supervision. In exercising temporary privileges, the Practitioner shall be under the authority and supervision of the appropriate Department Chair (or Active Staff designee) that shall be responsible to advise the Practitioner of the supervision requirements. During the exercise of temporary privileges, the Practitioner shall comply with all obligations of Medical Staff membership.

D. Expiration and Termination.

(1) Any grant of temporary privileges shall be reviewed by the CCMS at its next meeting.

(2) Temporary privileges automatically expire at the earlier of the following: (i) the expiration of the period for the grant of temporary privileges (thirty (30) days, or any shorter period specified); or (ii) the patient's discharge or the resolution of the patient's immediate patient care need, and hand-off of the patient to a qualified Practitioner with appropriate Clinical Privileges.[62]

E. LPs and Advanced Practice Providers. Temporary privileges shall also be available to LPs and Advanced Practice Providers subject to the requirements and conditions above.

4.4 Temporary or Limited License Practitioners. Practitioners appointed to the Medical Staff or granted temporary privileges who hold a temporary or limited license shall be subject to the conditions of that temporary or limited license, as well as any additional conditions placed by the Governing Body**.** *[Medical Staff Policy on Criteria for the Initial Grant and Renewal of Clinical Privileges CLN1014.)*

4.5 Licensed Professionals and Advanced Practice Providers.

A. General. Clinical Privileges available to LPs and Advanced Practice Providers shall be established by the Governing Body on recommendation of the appropriate Departments, the CCMS, and the ECMS. The Clinical Privileges shall detail any qualifications and criteria for the LP or APP to apply for and maintain Clinical Privileges.

B. Basic LP and APP Qualifications. Each LP and Advanced Practice Provider must:

(1) be a graduate of an approved professional school for his or her discipline;

(2) hold a valid full professional license or certification to practice in the state of Texas for his or her discipline*;*

(3) hold federal controlled substances authorization if required for the Privileges requested and by the Department to which the LP or Advanced Practice Provider would be assigned;

(4) provide the required peer references (from LPs and Advanced Practice Providers in the same professional discipline, and one Practitioner, with personal knowledge of the LP's or Advanced Practice Provider's ability to practice) as to relevant training and experience, current clinical competence, any effects of health status on the LP's or Advanced Practice Provider's ability to exercise the Clinical Privileges requested;

[62] MS.06.01.13, EP 6

(5) demonstrate that the LP or Advanced Practice Provider has not been excluded by the U. S. Department of Health and Human Services' Office of Inspector General from participation in Medicare, Medicaid, or any other state or federal health care program;

(6) document that the LP or Advanced Practice Provider is covered by professional liability insurance in amounts acceptable to MD Anderson;

(7) for Advanced Practice Providers, have one or more Supervising Practitioners, if required in accordance with State or Federal law, or the Clinical Privileges for the APP's specialty; and

(8) satisfy the requirements for health status in accordance with Section 3.5 above.

C. Deliberative LP and APP Qualifications. In addition to the basic qualifications above, each LP and APP must:

(1) Demonstrate current clinical competence in the LP's or Advanced Practice Provider's area of practice;

(2) Demonstrate the LP's or Advanced Practice Provider's adequate experience, education, and training in the requested Clinical Privileges;

(3) Be capable of consistently working in a professional and cooperative manner with others in a hospital setting and refraining from harassment of others so as not to adversely affect patient care or Hospital operations;

(4) Demonstrate the LP's or Advanced Practice Provider's adherence to the ethics of the LP's or Advanced Practice Provider's profession, good reputation, and ability to work professionally and cooperatively with others; and

(5) Document the LP's or Advanced Practice Provider's ability to perform the essential functions and exercise the Clinical Privileges requested without posing a risk to the safety or well-being of others with or without reasonable accommodation (*see* Section 3.5).

D. Obligations. Each LP or Advanced Practice Provider will be required to fulfill the same obligations as Medical Staff Members under Section 3.4 above.

E. Applications. Applications for Clinical Privileges for LPs and Advanced Practice Providers shall be submitted in accordance with Section 3.3 and processed using the procedures in Section 3.6 above for an initial grant of Clinical Privileges and Section 3.7 as to reappointment. The APP subcommittee of the Credentials Committee of the Medical Staff (CCMS, as defined below) may review and make recommendations to the CCMS on APP applications for Clinical Privileges. The patient care, treatment, and services provided by LPs and Advanced Practice Providers shall be reviewed through medical peer review and/or professional review activity as applicable. While exercising Clinical Privileges, LPs and Advanced Practice Providers shall comply with sections 3.4A and B and 3.5. *[Physician Assistants Policy CLN0584, Advanced Practice Registered Nurse Policy CLN0672]*

F. Clinical Privileges. LPs and Advanced Practice Providers may apply for Clinical Privileges in the same manner as Practitioners in accordance with Article IV, except that Advanced Practice Providers must have one or more Supervising Practitioners, if required in accordance with State or Federal law, or the Clinical Privileges for the APP's specialty. Supervising Practitioners must

have current Medical Staff Membership and Privileges to practice in at least one of the same Department(s) as the LP or Advanced Practice Provider. The LP's or APP's supervision shall be carried out in accordance with applicable State and Federal laws and applicable Medical Staff Bylaws and Hospital policies.

G. Visiting Privileges. LPs and Advanced Practice Providers in good standing with clinical privileges at a Medicare-participating hospital or health care entity who are visiting from another institution to provide or receive clinical education or training may be granted Clinical Privileges for a limited period of time not to exceed six (6) months upon by the CME and the Chair of the ECMS and subject to the qualifications and conditions set forth in this Section 4.5 and applicable Hospital policy.

H. Any LP's and Advanced Practice Providers who are in the approved categories of QMPs will be evaluated to ensure they have demonstrated competence to perform the Medical Screening Examination in accordance with the Emergency Medical Screening Examination, Stabilization and Appropriate Transfers Policy [CLN3280].

I. Departments. Each LP and Advanced Practice will be assigned to a Department in the same manner as Medical Staff members in accordance with Article V.

J. Rights of Review. LPs and Advanced Practice Providers are not eligible to serve as Members of the Medical Staff, nor are they entitled to any procedures pursuant to Article XII or the Fair Hearing Manual. LPs and Advanced Practice Providers shall be afforded an appeal process as to certain adverse actions pertaining to Clinical Privileges pursuant to written policy approved by the ECMS and the Governing Body. [*Licensed Professional & Advanced Practice Provider Fair Hearing Process Policy CLN0996*]

K. Automatic Termination of Clinical Privileges. Any grant of Clinical Privileges to a LP or Advanced Practice Provider shall automatically terminate upon (i) loss of any qualification under Section 4.5.B, (ii) termination of the employment of the individual by, or termination of a contractual relationship with, MD Anderson, or (iii) for Advanced Practice Practitioners, if a Supervising Practitioner is required under applicable State or Federal laws or the Clinical Privileges for the APP's specialty, termination of the Supervising Practitioner's qualifications or termination of the Advanced Practice Provider's relationship with the Supervising Practitioner, unless another qualified Supervising Practitioner assumes responsibility. If a LP or Advanced Practice Provider is transferred to another Department, the individual's Clinical Privileges in that Department shall automatically terminate; and the individual shall be required to request Clinical Privileges in the newly assigned Department as provided in this Article.

4.6 Emergency Privileges.

A. Emergency Privileges. In the case of emergency, any Member of the Medical Staff, LP or Advanced Practice Provider holding Clinical Privileges, to the degree permitted by license and regardless of Medical Staff category or lack thereof, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of MD Anderson necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, the Emergency Privileges automatically expire, and the Member of the Medical Staff, LP or Advanced Practice Provider must relinquish care and hand-off the patient's care to a qualified Member of the Medical Staff, LP or Advanced Practice Provider with appropriate Clinical Privileges. For the purpose of this section, an "emergency" is defined as a condition that would

result in which serious permanent damage to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would increase the danger.

4.7 Disaster Privileges. Procedures for granting specialty-specific and time-specific Clinical Privileges to volunteer Practitioners, Advanced Practice Providers and/or Licensed Professionals who are not Members of the Medical Staff in the event of a disaster shall be set forth in written policy. Disaster Privileges may be granted by the Chief Medical Executive or designee(s). Disaster privileges automatically terminate when the Incident Commander announces termination of the disaster situation. *[Medical Staff Policy for Disaster Privileges CLN3313]*

4.8 Allied Health Professionals (AHPs).

A. General. Scope of Practice for AHPs shall be established by the Governing Body on recommendation of the appropriate Departments, the CCMS, and the ECMS. The Scope of Practice shall detail any qualifications and criteria for the AHP to apply for and maintain Scope of Practice.

B. Basic AHP Qualifications. Each AHP must:

(1) receive training and education appropriate for his or her discipline;

(2) hold a valid full professional license or certification to practice in the state of Texas, if required for his or her discipline*;*

(3) provide the required peer references (from AHPs in the same professional discipline, and one Practitioner, with personal knowledge of the AHP's ability to practice) as to relevant training and experience, current clinical competence, any effects of health status on the AHP's ability to exercise the Scope of Practice requested;

(4) demonstrate that the AHP has not been excluded by the U. S. Department of Health and Human Services' Office of Inspector General from participation in Medicare, Medicaid, or any other state or federal health care program;

(5) document that the AHP is covered by professional liability insurance in amounts acceptable to MD Anderson;

(6) have one or more Supervising Practitioners; and

(7) satisfy the requirements for health status in accordance with Section 3.5 above.

C. Deliberative AHP Qualifications. In addition to the basic qualifications above, each Practitioner must:

(1) demonstrate current clinical competence in the AHP's area of practice;

(2) Demonstrate the Practitioner's adequate experience, education, and training in the requested Clinical Privileges;

(3) Be capable of consistently working in a professional and cooperative manner with others in a hospital setting and refraining from harassment of others so as not to adversely affect patient care or Hospital operations;

(4) demonstrate the AHP's adherence to the ethics of the AHP's profession, good reputation, and ability to work professionally and cooperatively with others; and

(5) demonstrate the AHP's ability to perform the essential functions and exercise the Scope of Practice requested without posing a risk to the safety or well-being of others with or without reasonable accommodation (see Section 3.5).

D. Obligations. Each AHP will be required to fulfill the same obligations as Medical Staff members under Section 3.4 above, except that AHPs are not responsible for completing H&Ps or complying with on-call services, and AHPs must abide by requirements for Scope of Practice, and not Clinical Privileges.

E. Applications. Applications for Scope of Practice for AHPs shall be submitted in accordance with Section 3.3, using the AHP application form approved by the Hospital, and processed using the procedures in Section 3.6 above for an initial grant of Clinical Privileges for Practitioners and Section 3.7 as to reappointment. The patient care, treatment, and services provided by AHPs shall be reviewed through medical peer review and/or professional review activity as applicable.

F. Scope of Practice. AHPs may apply for Scope of Practice in the same manner that Practitioners apply for Clinical Privileges in accordance with Article IV, except that AHPs may only apply for Scope of Practice and are subject to Practitioner supervision. Supervising Practitioners who supervise AHPs must have current Medical Staff membership and Privileges to practice in at least one of the same Department(s) as the AHP. The Supervising Practitioner's supervision shall be carried out in accordance with applicable state and federal laws and applicable Medical Staff Bylaws and Hospital policies.

G. Departments. Each AHP will be assigned to a Department in the same manner as Medical Staff members in accordance with Article V.

H. Rights of Review. AHPs are not eligible to serve as Members of the Medical Staff, nor are they entitled to any procedures pursuant to Article XII or the Fair Hearing Manual. AHPs shall be afforded to opportunity to submit a grievance, as follows:

(1) The Chair of the ECMS will provide an AHP with written notice of any Adverse Recommendation or Action regarding the AHP's Scope of Practice, except that requiring supervision by a Supervising Practitioner is not an Adverse Recommendation or Action. The written notice shall also state a summary of the bases of the action.

(2) AHPs have the right to have any Adverse Recommendation or Action regarding the AHP's Scope of Practice that would otherwise constitute grounds for a hearing under the Medical Staff Bylaws reviewed by filing a written notice of grievance with the Chair of the ECMS within fifteen (15) days of receipt of written notice of such action.

(3) Upon receipt of a timely notice of grievance, the Chair of the ECMS shall appoint an ad hoc grievance committee. The ad hoc committee will include at least one member in the same or similar discipline as the AHP who submitted the grievance, which ad hoc committee member may be, but is not required to be employed by or granted AHP status at the Hospital. The ad hoc committee shall conduct a review and afford the AHP an opportunity for an interview concerning the grievance. Any such interview shall not constitute a "hearing" as that term is used in Article XII of the Medical Staff Bylaws and

shall not be conducted according to the procedural rules applicable to such hearings. The AHP shall not have the right to an attorney or other representative.

(4) Before the interview, the AHP shall be informed of the general nature and circumstances giving rise to the action, and the AHP may present information relevant thereto at the interview. A record of the interview shall be made.

(5) The ad hoc committee shall make a recommendation to the ECMS based on the interview and all other information available to it. The ECMS shall consider the recommendation of the ad hoc committee and shall make a recommendation to the Governing Body.

(6) The Governing Body may adopt, reject or modify the recommendation of the Executive Committee of the Medical Staff or the ad hoc committee. The AHP shall be sent written notice of the Governing Body's decision and a summary of the bases of the decision. The decision of the Governing Body is final, and the AHP has no further rights to appeal.

I. Automatic Termination of AHPs. Any grant of Scope of Practice to an AHP shall automatically terminate upon (i) loss of any qualification under Section 4.8.B, or (ii) termination of the employment of the individual by, or termination of a contractual relationship with, MD Anderson. If an AHP is transferred to another Department, the individual's Scope of Practice in that Department shall automatically terminate; and the individual shall be required to request Scope of Practice in the newly assigned Department as provided in this Article.

4.9 Telemedicine.

A. Telemedicine Platform Privileges Included.

(1) The grant of Clinical Privileges to Practitioners, LPs, or APPs is deemed to include the privilege to exercise such Clinical Privileges using those Telemedicine Platforms available at the Hospital consistent with the Practitioner's, LP's, or APP's licensure.

(2) The grant of Scope of Practice to AHPs is deemed to include the privilege to exercise such Scope of Practice using those Telemedicine Platforms available at the Hospital consistent with the AHP's licensure and subject to appropriate Practitioner supervision.

B. Privileges for Telemedicine Services From a Distant-Site

(1) For providers who apply for Clinical Privileges to solely provide Telemedicine services from a distant-site, the Medical Staff shall determine whether such services are appropriate for delivery through Telemedicine, and if so will develop and delineate Clinical Privileges based on commonly accepted standards to be recommended to the Governing Body for approval.[63]

(2) Practitioners, LPs, and APPs providing Telemedicine services must apply for and be granted appropriate Clinical Privileges by the Hospital in the manner outlined for Members of the Medical Staff in Section 3.6 above.[64]

[63] MS.13.01.03, EP 1; MS.13.01.03, EP 2
[64] MS.13.01.01.

C. In all cases, the Distant-Site Practitioner or APP must hold a current license issued or recognized by the State of Texas;

D. If the Hospital has a pressing clinical need for Telemedicine services and a Distant Site Practitioner, LP, or APP can supply such services via Telemedicine, the Distant Site Practitioner, LP, or APP may be granted Temporary Privileges to provide Telemedicine services for a limited time in accordance with Article IV Section 4.3 of these Bylaws.

ARTICLE V. ORGANIZATION [65]

5.1 Departments.

A. Assignment. Each Practitioner appointed to the Medical Staff shall be assigned to one or more Departments consistent with the Practitioner's primary area(s) of practice. The Practitioner must hold Clinical Privileges in each Department in which the Practitioner is providing patient care, treatment, and services. The Medical Staff shall adopt clinical Departments upon review and approval by the ECMS and the Governing Body, and in accordance with the Hospital policies on Divisions and Departments.

B. Policies and Procedures. Departments may establish policies and procedures, provided they are in accordance with the Medical Staff Bylaws. *[Institutional Policy and Procedure Development and Implementation Policy ADM0158]*

C. Sections and Services. Sections and Services within a Department may be established, renamed, or dissolved upon recommendation of the Department Chair with the approval of the Division Head and the Chief Medical Executive. The Department Chair shall select a Member of the Medical Staff to serve as Chief of each authorized Section or Service who shall carry out the duties and responsibilities assigned by the Department Chair.

D. Creation or Dissolution of Clinical Departments. The creation or dissolution of a clinical Department must be approved by the ECMS and the Governing Body and will be conducted in accordance with Hospital policies. *[Establishing or Changing Names of Divisions and Departments Policy ACA0060]*. Renaming of a clinical Department does not require approval of the ECMS.

5.2 Department Chairs.[66]

A. Appointment and Term. Each Department shall be organized under the direction of a Department Chair who is appointed by the President and affirmed by majority vote of the ECMS. The Department Chair shall serve until removed by the President. Each Department Chair may nominate a Deputy Chair to be empowered to act as their designee with regard to their responsibilities to the Medical Staff, subject to the written approval of the Chief Medical Executive.

B. Qualifications. Department Chairs must be certified by an appropriate specialty board or have documented comparable competence through the credentialing process.

C. Responsibilities. Each Department Chair shall be responsible to the Medical Staff for the following:

(1) clinically related and, unless otherwise provided for by the Chief Medical Executive, administratively related activities of the Department;

(2) continuing surveillance of the professional performance of all Practitioners, LPs, and Advanced Practice Providers holding Clinical Privileges in the Department, in accordance with the medical staff peer review process, including without limitation at the time of reappointment, and implementation of corrective action when indicated;

[65] MS.01.01.01, EP 12
[66] MS.01.01.01, EP 36

(3) recommending to the CCMS the criteria for granting Clinical Privileges within the Department, the Clinical Privileges for each Practitioner, LP, and Advanced Practice Provider in the Department, and any modifications to the delineation of Clinical Privileges;

(4) Recommending Clinical Privileges for each Member of the Department;

(5) assessing and recommending space and other resources needed by the Department including without limitation off-site sources for needed patient care, treatment, and services not provided by the Department or MD Anderson;[67]

(6) integration of the Department into the primary functions of MD Anderson and the coordination and integration of intra-departmental and inter-departmental services;

(7) development and implementation of policies and procedures to guide and provide standards for the provision of patient care, treatment, and services within the Department, and ensure that they are in accordance with applicable legal and accreditation requirements as well as institutional requirements and policies, including without limitation the delivery of emergency services;

(8) recommending a sufficient number of qualified and competent personnel to provide the patient care, treatment, and services required of the Department;

(9) determining the qualifications and competence of all personnel who are not Practitioners, LPs, or Advanced Practice Providers and who provide patient care, treatment, and services within the Department;

(10) ongoing assessment and improvement of the quality of patient care, treatment, and services provided by the Department through implementation and maintenance of medical peer review and/or professional review activity mechanisms, including without limitation quality control measures that are measurable, objective, evidenced-based, and allow peer comparison when appropriate;

(11) orientation and continuing education of all persons in the Department;

(12) assuring the election of the Department representative to the CCMS as set forth in Article VII;

(13) establishing on-call schedules for members of the Department in accordance with the Emergency Medical Screening Examination, Stabilization and Appropriate Transfers Policy [CLN3280]; and

(14) additional functions as may be delegated by the Division Head, the Chief Medical Executive, or the President.

D. Filling Vacancies. Vacancies created in a Department Chair office shall be filled on an interim basis by the Chief Medical Executive through appointment of a Member who meets the qualifications for the position and who shall serve until replaced by the President.

[67] MS.06.01.01, EPs 1 & 2.

5.3 Divisions. Departments shall be grouped into appropriate Divisions. The Medical Staff shall adopt clinical Divisions upon review and approval by the ECMS and the Governing Body and in accordance with the Hospital policies on Divisions and Departments.

A. Creation or Dissolution of Clinical Divisions. The creation or dissolution of a clinical Division must be approved by the ECMS and the Governing Body and will be conducted in accordance with Hospital policies. *[Establishing or Changing Names of Divisions and Departments Policy ACA0060].* Renaming of a clinical Division does not require the approval of ECMS.

5.4 Division Heads.

A. Appointment and Term. Each Division shall be organized under the direction of a Division Head who is appointed by the President and affirmed by majority vote of the ECMS. The Division Head shall serve until removed by the President. Each Division Head may nominate a Deputy Division Head be empowered to act as their designee with regard to their responsibilities to the Medical Staff, subject to the written approval of the Chief Medical Executive.

B. Qualifications. Division Heads must be certified by an appropriate specialty board or have documented comparable competence through the credentialing process.

C. Responsibilities. Division Heads are responsible for the Division. Division Heads shall assume administrative and coordinative functions of the Division and may be involved in clinical issues affecting more than one Department and resolving conflicts in clinical issues within the Division. They represent their Division to other Divisions and the administration of MD Anderson and serve as ex-officio members of the ECMS.

D. Filling Vacancies. Vacancies created in a Division Head office shall be filled on an interim basis by the Chief Medical Executive through appointment of a Member who meets the qualifications for the position and who shall serve until replaced by the President.

ARTICLE VI. OFFICERS

6.1 Positions. The officers of the Medical Staff shall be the Chair of the ECMS and the Chair Elect of the ECMS.[68]

6.2 Qualifications.

All Medical Staff officers must:

A. Be an Active Staff Member in Good Standing with a Faculty Academic Appointment for at least five (5) years prior to nomination and hold a current Faculty Academic Appointment of associate professor or higher, and remain in Good Standing as an Active Staff Member while in office;

B. Have served as a chair of a Medical Staff committee or advisory committee, or served as a voting member of the ECMS for at least one (1) year prior to nomination;

C. Have and maintain appropriate specialty board certification, unless exempted or granted a waiver in accordance with these Medical Staff Bylaws and Hospital policy;

D. Be and remain up to date on all training required by federal or state law or regulation, as a condition of accreditation, or by policies adopted by the Hospital, unless exempted or granted a waiver under Section 3.3(D);

E. At the time of nomination, not be subject to any other investigation of alleged misconduct of any kind, unless granted a waiver by the CME in conjunction with the Chair of the ECMS; and

F. Not have any significant conflict of interest as set forth in Section 9.2 unless such conflict is currently under a COI Management Plan in accordance with hospital policy.

6.3 Nomination

A. Nomination by the Chief Medical Executive.

(1) Any Member of the Active Staff may submit the name of a possible nominee in writing to the Chief Medical Executive for consideration.

(2) The Chief Medical Executive will consider those names submitted and any other potential candidates and will develop a slate of candidates meeting the qualifications of office, as described in Section 6.2 above.

B. Nomination by Members. If a name that was submitted pursuant to subsection A(1) above was not selected as a nominee by the Chief Medical Executive, the name may be submitted by written petition signed by at least twenty-five percent (25%) of the Active Staff Members. The written petition must be submitted to Medical Staff & Credentialing Services at least fifteen (15) working days prior to the date of voting and, if the Member whose name is submitted is willing to serve and meets the required qualifications, the Member's name shall be included as a nominee on the ballot.

[68] MS.01.01.01, EP 19

C. Slate of Candidates. The names of the nominees shall be posted electronically or sent by mail by Medical Staff & Credentialing Services at least ten (10) working days prior to the date of voting.

6.4 Election. Officers shall be elected, as needed every year at an election that occurs at least thirty (30) days prior to the date of the annual meeting of the Medical Staff. Only members of the Active Staff and Affiliate Staff shall be eligible to vote.[69] Election shall require the affirmative vote of at least a majority of the votes cast by the members of the Active Staff and Affiliate Staff. No proxy voting will be permissible. Voting will be conducted by electronic ballot managed by Medical Staff & Credentialing Services. Written mail ballots may be utilized in the event of a technical issue if necessary. In the event of a tie vote, the Chief Medical Executive may vote. The results shall be announced at the annual meeting of the Medical Staff.[70]

6.5 Term of Office. The Chair shall serve for a three (3) year term. The Chair Elect shall serve for a three (3) year term and shall succeed the Chair at the conclusion of the Chair's term of office or termination of service for any reason. If there is no Chair Elect or the Chair Elect is unable or unwilling to succeed the Chair at the conclusion of the Chair's term of office, an election for the office of both Chair and Chair Elect shall be conducted using the procedures in Sections 6.2 and 6.3. A Member may not serve more than one (1) term as Chair Elect and one (1) term as Chair consecutively.

6.6 Duties.

A. Chair. The Chair of the ECMS shall call and preside at all meetings of the ECMS and the Medical Staff, shall chair the ECMS, and may vote only in the event of a tie. The Chair of the ECMS will periodically consult with the Governing Body throughout the Medical Staff Year on matters relating to the quality of care provided to patients of MD Anderson.

B. Chair Elect. The Chair Elect of the ECMS shall, in the absence of the Chair, assume all the Chair's duties and authority. The Chair Elect shall perform such functions as may be assigned by the Chair.

6.7 Vacancies. A vacancy in the position of Chair of the ECMS for any reason shall be filled by the Chair Elect of the ECMS for the remainder of the Chair's current term of office. A vacancy in the position of Chair Elect of the ECMS shall be filled by the ECMS, with election requiring the affirmative vote of at least two-thirds (2/3rd) of the voting Members present at a meeting (which, for purposes of this election only, shall include Members who voted electronically prior to the meeting due to inability to attend). The Member elected by the ECMS to fill the vacancy shall serve until a successor is elected at the next annual meeting using the procedures in Sections 6.2 and 6.3 above.

6.8 Removal of Officers.

A. Procedures.

(1) A Medical Staff officer may be removed by the Governing Body on the Governing Body's own initiative or by the vote of ECMS as set forth below and subject to approval of the Governing Body.

[69] MS.01.01.01, EP 17
[70] MS.01.01.01, EP 17

(a) The Medical Staff may, by written petition signed by at least ten percent (10%) of the voting Members of the Medical Staff, submit a written request stating the grounds for removal of a Medical Staff officer to the Chair of the ECMS or the Chief Medical Executive.

(b) Any voting member of the ECMS may submit a written request stating the grounds for removal of a Medical Staff officer to the Chair of the ECMS or the Chief Medical Executive.

(c) The Chair of the ECMS or the Chief Medical Executive will bring the request for removal before the ECMS. All voting ECMS members (including the affected Medical Staff officer) shall receive a minimum of one (1) week's written Notice of consideration of removal prior to the ECMS meeting.[71] Voting on the request for removal shall be by mailed or electronically transmitted secret ballot and shall require the affirmative vote of at least two-thirds (2/3rd) of the voting members of the ECMS present or participating in the vote in which a quorum is present in accordance with Section 7.3 of these Bylaws.

(d) The removal of the Medical Staff officer shall become effective upon approval by the Governing Body.

B. Grounds. Grounds for removal include without limitation:

(1) Failure to satisfy the requirements for office;

(2) Failure to appropriately carry out the duties of office;

(3) Failure to comply with these Medical Staff Bylaws, a supplemental document, or a Medical Staff policy;

(4) Failure to comply with MD Anderson bylaws or policies;

(5) Impairment affecting or that may affect the ability to perform the duties of office; or

(6) A final decision by the Governing Body to impose corrective action pursuant to Article XI.

C. A Medical Staff officer will be automatically removed if the Medical Staff officer fails to meet the qualifications for office as set forth in Section 6.2 above or upon the imposition of a summary or automatic action pursuant to Article XI unless granted a waiver by the CME in conjunction with the Governing Body.[72]

[71] MS.01.01.01, EP 18
[72] MS.01.01.01, EP 18

ARTICLE VII. COMMITTEES

7.1 General. The committees of the Medical Staff are critically important to the operations of the Medical Staff and MD Anderson. They provide inter-specialty and inter-disciplinary coordination of Medical Staff action to meet the objectives of providing the highest quality patient care and the most effective utilization of hospital services and provide Medical Staff representation and participation in activities affecting the discharge of Medical Staff responsibilities. Unless specified in the Medical Staff Bylaws, committees shall have decision-making authority for the purpose of providing recommendations to the ECMS, the Chief Medical Executive, the President, and the Governing Body. Minutes or records of all Medical Staff committees shall be reported to the ECMS, as well as any other committees requested by the ECMS that may be pertinent to its duties and responsibilities.

7.2 Membership and Terms.

A. Chairs. Unless otherwise provided in the Medical Staff Bylaws or Organizational Manual, committee chairs shall be Physician Members appointed by the Chair of the ECMS, in consultation with the Chief Medical Executive; and shall vote only in the event of a tie. Committee chairs shall serve for a term of three (3) years and may serve consecutive terms.

B. Members and Agents. The chair of each committee shall appoint the members of the committee (and any alternates with voting rights) in accordance with the Organizational Manual, and may appoint ad hoc members or agents as needed to fulfill the duties and responsibilities of the committee. Unless otherwise provided in the Medical Staff Bylaws or Organizational Manual, the term of membership shall be three (3) years, which terms may be staggered, and members may serve consecutive terms.

C. Regular Ex-Officio Members. Except as provided below for the ECMS, the Chair of the ECMS shall be an ex-officio voting member of all Medical Staff committees, including subcommittees, ad hoc committees, and task forces. The Chief Medical Executive and the President shall also be ex-officio members of all Medical Staff committees, without a vote unless otherwise provided in the Medical Staff Bylaws.

7.3 Quorum and Voting.

A. Regular. The presence of at least fifty percent (50%) of the voting members of the committee shall constitute a quorum for meetings of the CCMS and the ECMS. For all other committee, advisory committee, ad hoc committee, or task force meetings, the presence of at least twenty-five percent (25%) of the voting members shall constitute a quorum. Approval by a majority of voting members present at a meeting with the required quorum is necessary to affect any action. Alternates of voting members, appointed pursuant to Section 7.2.A above, may attend meetings in the absence of their voting members, be counted for purposes of the quorum, and vote. Members and appointed alternates may not vote by proxy.

B. Electronic Voting and Meetings. The CCMS, the ECMS, and other committees, advisory committees, ad hoc committees, and task forces may conduct electronic voting on appropriate agenda items and may arrange for member participation in meetings by means other than being physically present, including without limitation via conference telephone, videoconferencing, or the Internet, as long as each participating member can receive communications from and transmit communications to other participating members concurrently, as determined by the committee or task force chair. Any electronic meetings shall comply with the quorum and majority vote

requirements in Section 7.3.A above. Electronic voting shall comply with the quorum and majority voting requirements in Section 7.3.A above, except that in exigent circumstances, the chair of the committee or task force may reduce the quorum requirement to three (3) members.

7.4 Meetings and Procedures. Committees may establish schedules for regular meetings and/or meet on call of the chair of the committee as needed. Subject to the approval of the ECMS and the Chief Medical Executive, specific procedures for the accomplishment of committee functions may be developed and established by the committees; provided that, in the event of any conflict between those procedures and the Medical Staff Bylaws, the Medical Staff Bylaws shall control.

7.5 Executive Committee of the Medical Staff (ECMS).[73]

A. Composition.[74]

(1) The ECMS shall be composed of the following voting Members of the Active Staff, a majority of whom shall be Physicians:[75]

- the Chair (who shall vote only in the event of a tie) and Chair Elect of the ECMS;
- the immediate past Chair of the ECMS;
- the Vice Chair of the CCMS;
- the Division Patient Safety & Quality Officers;
- a clinician representative from the Faculty Senate;
- the chairs of the standing committees of the Medical Staff; and
- Four (4) at-large members of the Medical Staff, one who represents the Houston Area Locations.

(2) The at-large members shall be elected from the Active or Affiliate Staff, as needed every year at an election that occurs at least thirty (30) days prior to the date of the annual meeting of the Medical Staff.

(a) At-large members must be a Medical Staff Member in Good Standing for at least five (5) years and must have served as a member of a Medical Staff committee for at least one (1) year prior to election.

(b) Election shall require the affirmative vote of at least a majority of the votes cast. No proxy voting will be permissible. Voting will be conducted electronically by Medical Staff & Credentialing Services. Written mail ballots may be utilized in the event of a technical issue if necessary. The results shall be announced at the annual meeting of the Medical Staff.

[73] MS.02.01.01, EP 1
[74] MS.01.01.01, EP 20 to EP 22
[75] MS.02.01.01, EP 3 to EP 4

(c) The at-large members of ECMS may be removed by a majority vote of the ECMS. A vacancy in an at-large position shall be filled on an interim basis by the affirmative vote of at least two-thirds (2/3rd) of the voting members of the ECMS. A permanent replacement will be elected using the procedures above at the next annual meeting.

(3) The Division Patient Safety & Quality Officers (Division PSQOs) shall be appointed by the Division Head and approved by majority vote of the ECMS. The term of membership for Division PSQOs shall be three (3) years, which terms may be staggered, and Division PSQOs may serve consecutive terms. The Division PSQOs may be removed by the affirmative vote of at least two-thirds (2/3rd) of the voting members of the ECMS, or by the Division Head subject to approval by majority vote of the ECMS.

(4) The clinician representative of the Faculty Senate on the ECMS must hold current Clinical Privileges at MD Anderson, and shall be appointed by the Faculty Senate and approved by a majority vote of the ECMS. The clinician representative of the Faculty Senate may be removed by the affirmative vote of at least two-thirds (2/3rd) of the voting members of the ECMS, or by the Faculty Senate subject to approval by majority vote of the ECMS.

(5) The Chief Medical Executive, as a representative of the President, may attend all meetings of the ECMS as an ex-officio member, without vote.

(6) The following are Ex-officio members of the ECMS, without a vote:[76]

- The Senior Vice President and Chief Nursing Officer;
- The Vice President, Academic Operations;
- The Vice President, Pharmacy;
- The Chief Education and Training Officer;
- The Executive Director, PA Programs;
- The Executive Director, APRN Programs;
- The Chief Patient Safety Officer;
- The Chief Quality and Value Officer;
- The Division Heads; and
- The Medical Director of Physician Referral Services (PRS).

(7) The ex-officio ECMS members will be automatically removed from the ECMS if they no longer serve in the ex-officio capacity for any reason.

[76] MS.02.01.01, EP 2

B. Duties.[77] The Medical Staff delegates authority to the ECMS to act on its behalf between meetings,[78] to carry out Medical Staff responsibilities within the context of the hospital functions of governance, leadership, and medical peer review and/or professional review activity, including without limitation quality improvement in accordance with the MD Anderson hospital-wide QAPI Plan, and to adopt policies in that regard. The ECMS has the primary authority for activities related to self-governance of the Medical Staff, how such authority is delegated or removed and for quality improvement of the patient care, treatment, and services provided by Practitioners, LPs, and Advanced Practice Providers with Clinical Privileges. It is the principal committee of the Medical Staff, to which all standing and ad hoc Medical Staff committees report.

The ECMS is accountable to the Governing Body for the qualifications and clinical competence of the Practitioners, LPs, and Advanced Practice Providers holding Clinical Privileges and/or Medical Staff membership. The ECMS promotes the delivery of quality patient care through the ongoing review and evaluation of the clinical practices in MD Anderson pursuant to the medical staff peer review process, including without limitation the collection and review of information on important aspects of patient care to assess and maintain the quality and appropriateness of care rendered. The ECMS also collaborates with the Patient Safety Committee in the review of sentinel events and rapid root cause analyses, and the incorporation of action plans into overall Medical Staff procedures.

The ECMS reports and/or makes recommendations to the Governing Body on at least the following:[79]

(1) the structure of the Medical Staff[80] and the content of the Medical Staff Bylaws, including without limitation the mechanism for hearing and appellate review of an Adverse Recommendation or Action;

(2) the mechanisms and criteria used to review credentials, delineate setting-specific Clinical Privileges, and grant Medical Staff membership;[81]

(3) the delineation of Clinical Privileges[82] and/or the granting of Medical Staff membership for each Practitioner, LP, and Advanced Practice Provider privileged through the Medical Staff process, both initially and at the time of recredentialling;

(4) actions to improve clinical performance and the quality of patient care, treatment, and services as to Practitioners, LPs, and Advanced Practice Providers with Clinical Privileges relating to its oversight responsibilities;

(5) denial, limitation, or termination of Clinical Privileges and/or Medical Staff membership or other corrective action when indicated;[83]

(6) the sources of clinical services to be provided by consultation, contractual arrangements, or other agreements; and

[77] MS.01.01.01, EP 20
[78] MS.01.01.01, EP 23; MS.02.01.01, EP 5
[79] MS.01.01.01, EP 6
[80] MS.02.01.01, EP 9
[81] MS.02.01.01, EP 8
[82] MS.02.01.01, EP 11
[83] MS.01.01.01, EP 33; MS.02.01.01, EP 6

(7) the mechanisms and processes for supervision by Practitioners of graduate medical education program participants when delivering patient care, treatment, and services, and communication between the program and the Medical Staff and the Governing Body.

The ECMS shall carry out any other duties required by the Governing Body to ensure compliance with legal and accreditation standards for the Medical Staff.

The Medical Staff may revoke or change any delegated authority of the ECMS through amendment of these Bylaws in accordance with Article XIV.

C. Meetings and Reporting. The ECMS shall schedule meetings as necessary to perform its duties, but at least ten (10) times each Medical Staff Year. In accomplishing its duties, the ECMS shall review and act on the reports of all Medical Staff committees, Departments, Divisions, and Institutional Patient Safety Committee, including without limitation the implementation of appropriate actions and recommendations by these groups to improve performance and the delivery of quality patient care.[84] It shall report these actions and recommendations to appropriate Medical Staff leaders, MD Anderson leaders, and the Governing Body.[85]

D. Closed Session. To promote the confidentiality of Peer Review, the ECMS may enter into a closed session by vote of the ECMS or at the request of the Chair of the ECMS. *Ex Officio* non-voting members and other subject matter experts may, at the discretion of the Chair of the ECMS, be invited to participate in the closed session for discussion of specific agenda items.

7.6 Credentials Committee of the Medical Staff (CCMS).

A. Composition.

(1) Each Department shall be represented by a Physician Member appointed by the Department Chair from among the Active Staff Members assigned to that Department who spend the majority of their time in clinical activities and have held Clinical Privileges at MD Anderson for at least five (5) years (Departments that do not have Practitioners who have held Clinical Privileges for at least five (5) years shall not be subject to this requirement). CCMS members shall serve three (3) year staggered terms.

(2) Additional voting members representing other disciplines may be appointed by the Chair of the CCMS on an ad hoc basis and shall participate only in reviews of individuals in those same disciplines.

(3) The members of the CCMS shall elect a Chair and Vice Chair from the CCMS voting membership, each of whom shall serve a three (3) year term. Although not required, it is expected that the Vice Chair shall succeed the Chair at the conclusion of the Chair's term of office.

(a) Any Member of the CCMS may submit the name of a possible nominee for Chair or Vice Chair in writing to the Chair of the ECMS for consideration. The Chair of the ECMS will consider those names submitted and any other potential candidates and will develop a slate of candidates meeting the qualifications.

[84] MS.03.01.01, EP 4; MS.05.01.03, EP 5
[85] MS.02.01.01, EP 12

(b) Election shall require the affirmative vote of at least a majority of the votes cast by the members of the CCMS.

(c) The Vice Chair is authorized to assume all duties of the Chair of the CCMS in the Chair's absence. Vacancies shall be filled by election for the remainder of the terms.

B. Duties. Acting in an advisory capacity to the ECMS, the CCMS serves as the coordinating body for medical peer review and/or professional review activity for the Medical Staff, including without limitation evaluation of the qualifications and competence of the Practitioners, LPs, Advanced Practice Providers, Allied Health Practitioners and the quality of patient care, treatment, and services that they provide. The CCMS shall receive, evaluate, and act on reports and recommendations from Departments, Divisions, Medical Staff committees, or other institutional committees or groups performing medical peer review and/or professional review activity functions or with information pertaining to the individual performance of Practitioners, LPs, and Advanced Practice Providers. These duties shall include without limitation:

(1) evaluation, and issuance of recommendations as to Practitioners, LPs, and Advanced Practice Providers for initial Medical Staff membership and/or credentialing and as to reappointment;

(2) recommending setting-specific Clinical Privileges and any limitations or conditions on those Clinical Privileges following receipt of the recommendation of the appropriate Department Chair;

(3) accessing and evaluating information generated in the course of medical peer review and/or professional review activity on the clinical performance of Practitioners, LPs, and Advanced Practice Providers for the purposes of credentialing and reappointment, as well as recommendations for establishing criteria for Clinical Privileges; and

(4) initiating and maintaining a confidential credentials file (held by Medical Staff & Credentialing Services) for each Practitioner, LP, and Advanced Practice Provider seeking or who is granted Medical Staff membership and/or Clinical Privileges.

C. Meetings and Reporting. The CCMS shall schedule meetings at least monthly and shall meet not less than quarterly.

7.7 Standing Committees and Organizational Manual. The standing committees of the Medical Staff shall be those required by law, regulation, accreditation, or custom and any others deemed necessary for proper functioning of the Medical Staff. Standing committees (other than the ECMS and CCMS) may be added, combined, or inactivated by amendment to the Organizational Manual to meet changing circumstances. The standing committees, their composition and responsibilities, and any other procedures pertinent to Medical Staff committees shall be set out in the Organizational Manual.

7.8 Advisory Committees. The Chair of the ECMS in collaboration with the Chief Medical Executive may establish advisory committees to carry out a specific function, with reporting to one of the Standing Committees. The purposes, membership, and duties of advisory committees will be further defined in the Organizational Manual. The advisory committees shall be composed of at least one (1) current Member of the Medical Staff. Each advisory committee must have a

chair who is a current Member of the Medical Staff, appointed by the Chair of the ECMS in collaboration with the Chief Medical Executive.

7.9 Subcommittees. The ECMS may utilize subcommittees to accomplish ongoing functions. The creation of subcommittees must be approved by the Chair of the ECMS in conjunction with the Chief Medical Executive. The subcommittee shall be composed of at least three (3) current members of the ECMS who are appointed and removed by the Chair of the ECMS. Each subcommittee must have a chair, appointed by the Chair of the ECMS, and a written record of the specific duties assigned, and shall confine its work to the purposes for which it is appointed. Records shall be kept of all subcommittee meetings with reporting to the ECMS. Subcommittees may, but are not required to, be set out in the Organizational Manual.

7.10 Ad Hoc Committees or Task Forces. The Chair of the ECMS or the chair of another standing committee, the Chief Medical Executive, or the President may appoint an ad hoc committee or task force as may be necessary, from time to time, to carry out an identified or specific function or accomplish a specific goal. Ad hoc committees and task forces must have a chair, appointed by the individual establishing the committee or task force, and may, but are not required to, include Members of the Medical Staff. The ad hoc committee or task force shall maintain a written record of the specific duties assigned, shall confine its work to the purpose for which appointed, and shall be automatically dissolved when the purpose for which it was appointed has been completed. Records shall be kept of all ad hoc committee or task force meetings with reporting to the ECMS unless otherwise directed by the Chair of the ECMS. Ad hoc committees and task forces may, but are not required to, be set out in the Organizational Manual.

7.11 Medical Staff Representation on Institutional Committees. The Medical Staff shall be represented on institutional committees addressing matters affecting the Medical Staff, including without limitation the Institutional Review Board, and Patient Safety Committee.

ARTICLE VIII. MEETINGS

8.1 Medical Staff.

A. Annual Meeting. An annual meeting of the Medical Staff shall occur during the first quarter of each fiscal year for the purpose of receiving the reports of the retiring Medical Staff officers and standing committees of the Medical Staff, and electing or announcing new officers of the Medical Staff and elected positions set forth in the Medical Staff Bylaws. Unless otherwise provided herein, a quorum for purposes of the annual meeting of the Medical Staff shall mean the number of Members of the Active Staff present at the meeting, but not less than ten (10) Members, and any action at the annual meeting shall require the affirmative vote of at least a majority of those Members present with the required quorum.

B. Special Meetings. Special meetings may be called at any time by the Chair of the ECMS or at the written request of the President, the Chief Medical Executive, or any five (5) Active Staff Members. At least forty-eight (48) hours' notice by letter, memorandum, or email, stating the reason for the special meeting, will be given to the Active Staff Members prior to the date of the meeting. At the special meeting, no business shall be transacted except that stated in the notice calling the meeting. The quorum and voting requirements for a special called meeting shall be the same as for the annual meeting.

8.2 Divisions. Division Heads shall establish rules for attendance at Division meetings, as well as quorum and voting requirements. Meetings may be scheduled and/or called on the request of the Division Head.

8.3 Departments. Each of the Departments shall establish a regular schedule of departmental meetings for the purpose of discussing and acting upon departmental matters and matters pertaining to the review, quality, and improvement of patient care, treatment, and services. Special meetings may be called on the request of the Department Chair. The Departments are encouraged to hold at least monthly meetings for all Medical Staff Members within their Departments.

8.4 Attendance at Meetings. All Members of the Medical Staff are required to attend at least fifty (50%) percent of the Medical Staff committee meetings on which they are assigned to serve, unless a higher level of attendance is otherwise provided in the Organizational Manual. Committee attendance is recorded and reviewed annually. Members whose attendance falls below the required benchmark will be replaced and their committee appointments terminated. Members of the Active Staff are expected to attend the annual meeting of the Medical Staff and regular meetings of the Department(s) to which assigned.

8.5 Rules of Order. The rules contained in the latest edition of Robert's Rules of Order may be used to guide questions of procedure at any meetings of the Medical Staff, ECMS, Department, Division, or Medical Staff committee in which they are applicable, unless procedures are otherwise provided for in the Medical Staff Bylaws or written policy. The failure to follow Robert's Rules of Order will not invalidate any action taken at such meetings.

8.6 Medical Staff Meetings. The Medical Staff may conduct electronic voting on appropriate agenda items as determined by the Chair of the ECMS in meetings by means other than being physically present, including without limitation via conference telephone, videoconferencing, or the Internet, as long as each participating member can receive communications from and transmit

communications to other participating members concurrently, subject to the attendance, voting and quorum requirements under this Article VIII.

ARTICLE IX. COMPLIANCE AND CONFLICT OF INTERESTS

9.1 Institutional Compliance Program. All Members, LPs, and Advanced Practice Providers are required to uphold the Institutional Code of Conduct and to comply with the requirements of the Institutional Compliance Program and MD Anderson's compliance plans (e.g., Hospital Compliance Plan, Pathology and Laboratory Compliance Plan, Billing Compliance Plan, Endowment Compliance Plan, and Equipment Compliance Plan). To that end, Members, LPs, and Advanced Practice Providers shall complete the requisite initial and annual compliance training, as well as any additional training specified by the Institutional Compliance Program.

9.2 Conflict of Interest[86].

A. Medical Staff officers shall disclose to the Chief Medical Executive those personal, professional, or financial affiliations or relationships of which they are reasonably aware or that have been identified by Physician Referral Services or the Conflicts Management Committee that could affect their ability to make a fair and impartial decision and foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff, as requested, or as required under the Hospital policy on conflicts of interest. All conflicts of interest will be managed in accordance with the Hospital policies on conflicts of interest [see *Conflict of Interest and Conflict of Commitment Policy ADM0255,* and *Conflicts of Interest and Conflicts of Commitment Policy for Faculty Members, Investigators, Institutional Decision Makers, and Trainees ACA0001*]

B. Whenever a Member is participating in medical peer review and/or professional review activity or performing a function for a committee, Division, Department, Service, Section, or the Medical Staff, and the Member's personal or professional interests could be reasonably interpreted as being in conflict with the interests of the committee, Division, Department, Service, Section, Medical Staff, or individual under review, the Member shall disclose those interests and the potential for conflict to the appropriate decision makers or seek consultation with MD Anderson's Department of Legal Services prior to participation. A Member may be required by a committee chair, Division Head, Department Chair, Medical Staff officer, or the Chief Medical Executive to refrain from any participation in decisions that may be affected by or affect the Member's interests.

C. Any committee member who has a conflict of interest, either personal, professional, or financial, or was an active participant in the matter before the committee at any previous level, that may affect the committee member's ability to make a fair and impartial decision on a matter before the committee, or the safety or quality of care, treatment and services, will disclose the conflict to the committee chair. Other committee members may also present the question of a conflict of interest on a matter for any other committee member. The committee chair will make the final determination whether a committee member does or does not have a conflict of interest for the matter before the committee. If the committee chair determines that the committee member has a conflict of interest in the matter, the committee member may provide any relevant factual information on the matter before the committee but will recuse themselves (and leave the room) during deliberations and vote on the matter.

9.3 Conflict Management Process.

[86] TJC, LD.02.02.01

A. Resolution of Conflicts Between the Medical Staff and the Executive Committee of the Medical Staff: [87]

When there is a conflict between the Medical Staff and the Executive Committee supported by at least ten percent (10%) of the voting Members of the Medical Staff regarding a new Medical Staff policy or amendment to an existing Medical Staff policy, the matter may be submitted for conflict management.

(1) Upon receipt of such a petition, the ECMS will schedule a special meeting to discuss the matter with up to five (5) of the voting Members of the Medical Staff who signed the petition or their designated representatives to discuss the conflict in a collegial manner. The agenda for the special meeting of the ECMS will be limited to attempting to resolve the differences that exist with respect to the policy at issue.

(2) If a satisfactory resolution cannot be achieved during such special meeting, the conflict along with the recommendations of the Medical Staff Members and the ECMS may be submitted to the Governing Body for final action.

(3) Nothing in this section is intended to prevent any Medical Staff Member from communicating with the Governing Body regarding any new policy or proposed amendment to a policy. The Governing Body will determine the manner of communication and the Governing Body's response.

(4) This conflict management process is limited to the matters noted in this Section 9.4. It is not to be used to address any other issue, including without limitation any Peer Review matter concerning an individual Member of the Medical Staff.

B. Resolution of Conflicts Between the Executive Committee of the Medical Staff and the Governing Body:[88]

(1) When there is a conflict between the Executive Committee of the Medical Staff and the Governing Body with regard to a proposed new policy or a proposed amendment to an existing policy, either the Governing Body or the Chair of the ECMS may submit a written request to other for conflict resolution through a joint conference committee. The joint conference committee will include without limitation the Governing Body, the Chair of the ECMS, the Chief Medical Executive, at least (2) two individuals affiliated with MD Anderson appointed by the CME, and at least (2) two individuals affiliated with MD Anderson appointed by the Chair of the ECMS.

C. If the matter cannot be resolved by the joint conference committee within thirty (30) days, the Governing Body will take final action on the matter.

D. This conflict management process is limited to the matters noted in this Section 9.4. It is not to be used to address any other issue, including without limitation any Peer Review matter concerning an individual Member of the Medical Staff.

[87] MS.01.01.01, EP 2; MS.01.01.01, EP10
[88] LD.02.01.01, EP 1; LD.02.04.01.

ARTICLE X. CONFIDENTIALITY AND IMMUNITY

10.1 Peer Review Authorization and Status.

A. Peer Review Activity. Each committee (whether Medical Staff, Division, Department, Service, Section, standing committee, ad hoc committee, subcommittee, task force, joint committee, or Hearing Committee as defined in the Fair Hearing Manual) and each Division, Department, Service, and Section, as well as the Medical Staff when meeting as a whole, shall be constituted and operate as a "medical peer review committee," "medical committee," and "professional review body," as such terms are defined by state and/or federal law, and is authorized by the Governing Body through these Medical Staff Bylaws to engage in Peer Review and/or professional review activity as defined below. This provision shall also apply to any medical committees or other institutional committees engaged in medical peer review and/or professional review activity at MD Anderson.

B. Defined. Peer Review includes without limitation:

(1) the process of credentialing for initial membership, reappointment, and the granting of Clinical Privileges;

(2) the process of issuing adverse or professional review actions, including without limitation an Adverse Recommendation or Action or corrective action, and affording procedural rights of review as provided in the Medical Staff Bylaws or by written policy;

(3) any evaluation of the merits of a complaint relating to a Practitioner, LP, or Advanced Practice Provider and issuance of a recommendation or action in that regard;

(4) any evaluation of the accuracy of a diagnosis or quality of the patient care, treatment, or services provided by one of the above individuals or other health care providers within MD Anderson, including without limitation implementation of the Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation process and other components of the Medical Staff Peer Review process;

(5) a report made to an individual or a committee engaged in medical peer review and/or professional review activity or to a professional licensing board;

(6) implementation of the duties of a committee engaged in medical peer review and/or professional review activity by a member, agent, or employee of the committee; and

(7) "medical peer review" as defined in the Texas Medical Practice Act and "professional review activity" as defined by the federal Health Care Quality Improvement Act.

C. Agents and Members.

(1) The President, Chief Medical Executive, MD Anderson legal counsel, Medical Staff & Credentialing Services, Risk Management, Clinical Effectiveness, Performance Improvement, and all other institutional departments and councils supporting medical peer review and/or professional review activity shall be considered agents of the Medical Staff committees, Divisions, Departments, Services, Sections, and the Medical Staff as applicable when performing their respective functions and responsibilities.

(2) An action by an agent or member of a committee**,** Division, Department, Service, Section, or the Medical Staff when performing such functions and responsibilities shall be considered an action taken on behalf of the appropriate committee, Division, Department, Service, Section, or the Medical Staff as applicable, not an action taken in the agent's or member's individual capacity. This shall include without limitation actions by a Medical Staff officer, Department Chair, and Division Head.

10.2 Confidentiality.

A. General. All records and proceedings of the Medical Staff, Divisions, Departments, Services, Sections, and all Medical Staff and institutional committees of MD Anderson, including without limitation any minutes of meetings, disclosures, discussion, statements, actions, or recommendations in the course of medical peer review and/or professional review activity, shall be privileged and confidential, subject to disclosure only in accordance with written policies of the Medical Staff and MD Anderson, unless otherwise required by state and/or federal law, and shall be privileged to the fullest extent permitted by state and federal law.

B. Obligation to Maintain Confidentiality. All Practitioners, LPs, and Advanced Practice Providers, as well as all other individuals participating in, providing information to, or attending meetings of the Medical Staff, Divisions, Departments, Services, Sections, or Medical Staff committees, or serving as agents or members thereof, are required to maintain the records and proceedings related to any medical peer review and/or professional review activity confidential, subject to disclosure only in accordance with policies of the Medical Staff and MD Anderson, unless otherwise required by state or federal law. Any breach of this confidentiality shall be grounds for corrective action as provided in Article XI due to its potential detrimental impact on the performance of medical peer review and/or professional review activity and the delivery of quality patient care.

C. Maintenance and Access.

(1) The records, and proceedings of all meetings of Medical Staff committees, Divisions, Departments, Services, Sections, and the Medical Staff shall be confidential and maintained by Medical Staff & Credentialing Services, the Division, or the Department, as appropriate.

(2) The records, and proceedings will be available for inspection by the ECMS, the Chief Medical Executive, the President, the Governing Body, and any employees and agents of MD Anderson whose authorized functions necessitate access. With the exception of the records and proceedings of the ECMS, they shall be available also to the CCMS and to members of Medical Staff committees whose authorized functions necessitate access.

(3) Access is also permitted pursuant to written policy and as required by state or federal law, accreditation requirements, or third-party contract of MD Anderson.

10.3 Immunity from Liability.

A. Immunity. MD Anderson, the Medical Staff and its Members, the Governing Body, and any committees, representatives, agents, employees, or members thereof, and third parties as defined below, will have immunity from civil liability for any act, communication, report, recommendation, or disclosure made or taken in good faith in the course of performing functions authorized by or pursuant to the Medical Staff Bylaws, including without limitation for the purpose

of medical peer review and/or professional review activity. This immunity shall be to the fullest extent permitted by state and federal law.

B. Third Parties. For the purpose of this Article, the term "third parties" means individuals and organizations from which information has been requested and/or received for purposes of medical peer review and/or professional review activity by MD Anderson, the Governing Body, or the Medical Staff, or any committees, representatives, agents, employees, or members thereof, or an authorized representative of a hospital or other health care entity, its governing board, the medical staff and its members, or any committee or component thereof.

C. Authorizations and Releases. All applicants for Medical Staff membership, reappointment, and/or Clinical Privileges shall execute a release of liability consistent with subsection A above and an authorization for MD Anderson and third parties to disclose confidential information as necessary for medical peer review and/or professional review activity in the course of application and at all times thereafter, provided that the effectiveness of the immunity provisions of the Medical Staff Bylaws is not contingent on execution of these authorizations and releases. Further, any releases of liability shall be in addition to and not in limitation of any immunity afforded by state and federal law.

10.4 Mandatory Reporting.

A. Duty. The Chief Medical Executive in consultation with MD Anderson legal counsel shall be responsible to comply with any mandatory reporting requirements of MD Anderson under state and/or federal law pertaining to Medical Staff Membership and Clinical Privileges.

ARTICLE XI. ECMS PERFORMANCE REVIEW AND CORRECTIVE ACTION[89]

11.1 Professional Practice Evaluation.[90]

A. The Medical Staff is accountable to the Governing Body for the quality of care provided to patients. To fulfill its responsibility, the Medical Staff will develop processes for the evaluation of care provided by Medical Staff members and others with Clinical Privileges. Ongoing performance evaluation and monitoring will be designed to assure timely identification of matters that may require correction. Concerns regarding professional performance or conduct will be addressed pursuant to these Bylaws.

B. Initial Focused Professional Practice Evaluation

(1) All initial grants of Clinical Privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be subject to Initial FPPE.[91] Initial FPPE may include without limitation chart review, monitoring, External Review, or additional proctoring of any Clinical Privileges that are used so infrequently as to make it difficult or unreliable to assess current competency. If such proctoring requirements are imposed solely for lack of activity, the initial proctoring requirement itself is not reportable to the National Practitioner Data Bank and shall not result in any hearing or appeal rights under these Bylaws.

(2) When a Practitioner, LP, or APP completes Initial FPPE requirements, the Department shall convey this information to CCMS. CCMS shall review the Initial FPPE information and shall provide a summary of the review and recommendations to the ECMS. After receipt of the recommendation and any written report from the CCMS, the ECMS shall provide the ECMS's recommendation and written report, if any, to the Governing Body.

(3) If a Practitioner, LP, or APP who has been granted a new Clinical Privilege in the middle of the Practitioner's, LP's, or APP's appointment fails to complete the Initial FPPE requirements for that Clinical Privilege within two (2) years after being granted the Clinical Privilege due to lack of clinical activity, then that Clinical Privilege shall expire. If a Clinical Privilege is terminated solely due to lack of activity and completion of Initial FPPE, the Practitioner, LP, or APP shall not be entitled to any hearing and appeal rights under these Bylaws.

C. Ongoing Professional Practice Evaluation[92]

(1) All Practitioners, LPs, or APPs with Clinical Privileges shall be subject to Ongoing Professional Practice Evaluations ("OPPE") in accordance with the Medical Staff Ongoing Professional Practice Evaluation Policy.

(2) The Medical Staff and Hospital shall develop and routinely update OPPE criteria based on current practices and standards of care, which shall be used in evaluating those applying for Membership and Clinical Privileges and the performance of Members.[93] Each

[89] MS.05.01.01; MS.05.01.03, EP 4
[90] MS.08.01.01, EP 4; MS.05.01.03, EP4
[91] MS.08.01.01, EP 1
[92] MS.08.01.03, EP 1
[93] MS.08.01.01, EP 2

Department shall be responsible for recommending the type of data to be collected, subject to the approval of the ECMS and Board.[94]

(3) OPPE may consist of:

(a) Ongoing review of cases, by volume, outcome, complication rates, returns to the hospital, average length of stay, average cost by case, or post discharge surveillance data, all compared to peer group comparisons and adjusted where possible for acuity.

(b) Review of participants Peer Review experience, grievances, incident reports, litigation/claims, patient satisfaction data,[95] and CMS Core Metric report cards.

(c) Evaluation of the Practitioner's, LP's, or APP's professional conduct at the Hospital.

(4) The information gathered during the OPPE process will be factored into decisions to maintain, revise, or revoke any existing Clinical Privilege.[96] OPPE may be performed concurrent with the reappointment cycle but must meet the timelines as set forth by the Medical Staff Ongoing Professional Practice Evaluation Policy. The data obtained through OPPE will be presented to the Department Chair, the Chief Medical Officer, and the CCMS in advance of reappointments and renewal of Clinical Privileges.

D. For Cause Focused Professional Practice Evaluation[97]

(1) In selected circumstances, the Medical Staff, through the Department Chair, Division Head, CCMS, ECMS or an appointed ad hoc Investigating Committee, or the CME in collaboration with the Chair of the ECMS may require that an individual Practitioner, LP, or APP, undergo For Cause FPPE in accordance with the Medical Staff Focused Professional Practice Evaluation Policy.[98]

(2) For Cause FPPE may occur when a concern is raised regarding a Practitioner's, LP's, or APP's professional performance, competence, or ability to provide safe, quality patient care.[99] Criteria for conducting a For Cause FPPE may include without limitation:

(a) A return from a leave of absence or period of clinical inactivity, except for parental leave, at the discretion of the Department Chair, the Chair of CCMS, the Chair of ECMS, or the CME;

(b) Concerning trends or findings obtained through OPPE;

(c) Professional practice or behavior that impacts the quality of care or patient safety;

[94] MS.08.01.03, EP 2.
[95] MS.03.01.01, EP 5.
[96] MS.08.01.03, EP 3.
[97] MS.08.01.01, EP 3.
[98] MS.08.01.01, EP 4.
[99] MS.08.01.01, EP 2.

(d) Formal complaints or issues that may arise through quality reporting channels; or

(e) Any other indications identified in the Medical Staff Focused Professional Practice Evaluation Policy.

(3) Methods for conducting For Cause FPPE include without limitation:

(a) Retrospective medical chart review;

(b) Discussion with, or survey of, colleagues and staff members who have personal knowledge of the Practitioner's, LP's, or APP's professional competence and conduct;

(c) Discussion with, or survey of, patients who have been treated by the Practitioner, LP, or APP;

(d) Non-concurrent proctoring, including without limitation completion of a written or oral case simulation, periodic one-on-one case review, and prospective proctoring defined as presentation of actual cases to a proctor with outline of diagnostic and treatment plan; and

(e) Concurrent proctoring, defined as completion of a skill or Clinical Privilege while supervised by a proctor.

(4) For Cause FPPE shall not constitute a formal investigation, restriction of Clinical Privileges, or grounds for any formal hearing or appeal rights under these Bylaws

11.2 Collegial Intervention.

A. Objectives. Medical peer review and/or professional review activity are conducted on an ongoing basis, with primary responsibility for implementation of medical staff peer review processes placed on the Department Chairs for medical staff members within their Department. The objectives of the medical staff Peer Review process, which includes FPPE and OPPE, are to assess the quality of patient care, treatment, and services and the professional competence and/or conduct of Practitioners, LPs, and Advanced Practice Providers, and determine if improvement is indicated.

These collegial intervention efforts are intended to be implemented on a voluntary and collegial basis within the Departments without triggering mandatory reporting requirements. If necessary, changes cannot be implemented on a voluntary basis, matters may be referred for corrective action in accordance with this Article, which process may trigger mandatory reporting requirements depending on the type of action implemented.

B. It is the intent of the Medical Staff and MD Anderson administration to initially use collegial intervention to reach a voluntary resolution with the affected Practitioner, LP, or APP with Clinical Privileges regarding an issue, unless it is serious in nature.

C. All collegial intervention efforts are part of MD Anderson's performance improvement and professional peer review activities. Collegial efforts involve reviewing and following up on questions raised about the clinical practice and/or professional conduct of Practitioners, LPs, and APPs, including but not limited to the following:

(1) advising colleagues of all applicable policies/procedures, including but not limited to policies/procedures regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

(2) counseling, monitoring, consultation, and proctoring;

(3) education;

(4) letters of guidance, counseling, or reprimand;

(5) conduct and/or performance improvement agreements, and/or

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

The appropriate Department Chairs, Medical Staff leader(s), and/or MD Anderson administration shall document collegial intervention efforts in a Practitioner's, LP's, or APP's confidential file. If documentation is included in a Practitioner's, LP's, or APP's file, the Practitioner, LP, or APP will have an opportunity to review it and respond in writing. The response shall be maintained in that Practitioner's, LP's, or APP's file along with the original documentation.

Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and/or MD Anderson administration. Department Chairs, Medical Staff leaders, and/or MD Anderson administration may also handle these matters using other applicable policies and/or procedures.

D. Corrective Action. Nothing above shall limit the ability to request or refer a matter directly to the ECMS for consideration of an Investigation for purposes of possible corrective action as provided in Section 11.3 below or require that certain procedures, such as implementation of the For Cause FPPE, be undertaken prior to such referral. Implementation of For Cause FPPE or a performance improvement plan does not preclude corrective action in accordance with these Medical Staff Bylaws.

11.3 Corrective Action.[100]

A. Grounds. When there is concern that the activities and/or professional conduct of a Practitioner, LP, or APP is below the standards of the Medical Staff, or disruptive to the operations of MD Anderson, a formal request for an investigation may be submitted to the ECMS. Grounds for initiation of an investigation include, but are not limited to:

(1) whenever concerns arise regarding the clinical competence or clinical practice of any Practitioner, LP, or APP, or that any Practitioner, LP, or APP has exhibited activities or professional conduct disruptive to the orderly operations of MD Anderson or lower than the acceptable professional standards of the Medical Staff, including the inability to work harmoniously with others;

[100] MS.09.01.01, EP 1; MS.09.01.01, EP 2

(2) whenever a Practitioner, LP, or APP is known to have violated or is suspected of violating these Medical Staff Bylaws or any other supplemental document or policy of the Medical Staff and/or MD Anderson;

(3) upon receipt of notice that a Practitioner, LP, or APP is under investigation by the state professional licensing body;

(4) upon receipt of notice that a Practitioner's, LP's, or APP's license or other legal credential authorizing practice in this state has been subject to any type of corrective action (see Section 11.5 in the event of suspension or revocation of license); or

(5) upon receipt of notice that a Practitioner's, LP's, or APP's license or other legal credential authorizing practice in any other state has been revoked, suspended, or subject to any other type of corrective action.

B. Authority to Request.

(1) Initiation of an Investigation for purposes of possible corrective action may be requested by any Member of the Medical Staff or the Governing Body. The request must be in writing, directed to the ECMS, and set out the specific concerns that are the basis for the request.

(2) The ECMS in its discretion may:

(a) Determine that no disciplinary action be taken;

(b) Refer the matter for For Cause FPPE in accordance with Section 11.1.D above;

(c) Refer the matter to the Department Chair or Division Head for an expedited initial review of the matter to make sufficient initial inquiry to determine whether the concern is credible. If referred for an expedited initial review, such review shall be completed within fourteen (14) days of the referral; or

(d) Initiate an Investigation in accordance with Section 11.3.C below.

C. Initiation of Investigation.

(1) Upon a determination by the ECMS that a request for initiation of an Investigation merits review, the ECMS shall initiate an Investigation and provide the Practitioner, LP, or APP with Special Notice of the request, the general nature of the concern, the initiation of an Investigation, and a copy of this Article XI. The Practitioner, LP, or APP is not entitled to access the request for initiation of the Investigation or to be advised of the identity of the requestor.

(2) After an Investigation is initiated, the Chair of the ECMS shall appoint an ad hoc committee (hereinafter referred to as the "Investigating Committee") composed of at least three (3) Members of the Medical Staff, one of whom shall be designated by the Chief Medical Executive as chair. The members of the Investigating Committee may also be members of the ECMS. The following persons shall not be appointed to the Investigating Committee: (a) any individual requesting the investigation; (b) a relative of the Practitioner, LP, or APP under review; and (c) a direct competitor of the Practitioner, LP, or APP under review. If the request involves issues more appropriately handled by the Practitioner Peer

Assistance Committee, the Chief Medical Executive may appoint that committee (or a subcommittee with a designated chair) to serve as the Investigating Committee.

D. Investigation. From the date the Investigating Committee is formed, the Investigating Committee shall have thirty (30) working days to conduct an Investigation, which may include without limitation a review of medical records and the results of any OPPE or FPPE, witness interviews, and External Review if appropriate. The Investigating Committee shall not be limited to review of the specific event(s) referred, but may expand the scope of the review, provided that the Practitioner, LP, or APP is given Special Notice of the expansion. The Investigating Committee may be granted an extension for a specific time period by the Chair of the ECMS if necessary, to complete the Investigation.

(1) The Investigating Committee shall have available to it the full resources of the Medical Staff and MD Anderson, as well as the authority to use outside consultants, when the Investigating Committee deems it appropriate. The Investigating Committee may conduct interviews of persons it believes have knowledge of the issues being investigated and review all relevant documents. The Investigating Committee may also require a physical and/or mental examination of the Practitioner, LP, or APP by a physician or physicians or practitioner satisfactory to the Investigating Committee, and shall require the Practitioner, LP, or APP to execute an appropriate release or consent so that the results of such examination are available for the Investigating Committee's consideration and that of the Hospital's other medical peer review committees.

(2) On conclusion of the Investigation, the Investigating Committee shall prepare a written report of its findings and recommendations as a result of the Investigation to present to the ECMS. Prior to making the report, the Practitioner, LP, or APP being investigated shall have an opportunity for an interview with the Investigating Committee. The Practitioner, LP, or APP shall be notified in writing of the time, date, and place of the interview and the general nature of the claims made against the Practitioner, LP, or APP by Special Notice and their opportunity to discuss them. The interview shall not constitute a hearing, shall be preliminary in nature, and shall be exempt from the procedural rules provided in the Fair Hearing Manual. For example, a Practitioner, LP, or APP does not have the right to have his/her attorney present during the interview. A record of such interview shall be made by the Investigating Committee and included with the report to the ECMS.

E. ECMS Consideration. The chair of the Investigating Committee shall present the Investigating Committee's report and recommendation to the ECMS for action at its next regular meeting or a special meeting called for such purpose.

(1) The Practitioner, LP, or APP shall be requested to be available during the time that the ECMS meets in the event the committee has questions for the Practitioner, LP, or APP but shall not be entitled to attend the meeting unless requested by the ECMS.

(2) The ECMS's actions or recommendations on a request for possible corrective action may include without limitation:[101]

(a) Rejection or modification of the request for corrective action;

[101] MS.01.01.01, EP 30

(b) Issuance of a letter of guidance, a letter of warning, a letter of admonition, or a letter of reprimand;

(c) Require additional education, training, or experience;

(d) Change Medical Staff category or limit Medical Staff prerogatives;

(e) Imposition of probation;

(f) Recommend denial of initial Medical Staff appointment or reappointment;

(g) Recommend revocation of Medical Staff membership;

(h) Recommend denial of an initial request for particular Privileges;

(i) Reduction of privileges for a period in excess of thirty (30) days;

(j) Recommend suspension of Privileges for more than thirty (30) days;

(k) Recommend revocation of Privileges;

(l) Recommend terms of proctoring that could be in place for more than thirty (30) days if the terms of proctoring could materially restrict the Practitioner's, LP's, or APP's exercise of Privileges. Proctoring that requires a proctor, who practices in the same or similar specialty as the Practitioner, LP, or APP, to be present during the surgery, procedure, or treatment materially restricts the Practitioner's, LP's, or APP's Privileges;

(m) Immediate imposition of a proctoring requirement for a period of more than thirty (30) days that materially restricts the Practitioner's, LP's, or APP's exercise of Privileges. The imposition of proctoring which requires a proctor, practicing in the same or similar specialty as the affected Practitioner, LP, or APP, to be present during the surgery, procedure, or treatment materially restricts the Practitioner's, LP's, or APP's Privileges; and/or

(n) Immediate imposition of a consultation requirement, for more than thirty (30) days that materially restricts the Practitioner's, LP's, or APP's Privileges; and/or

(o) Any other recommendation that it deems necessary or appropriate.

(3) The ECMS may also defer action on the request for a stated period of time if necessary, to obtain additional information or conduct further Investigation.

(4) If the Practitioner's, LP's, or APP's Privileges are summarily suspended under Section 11.4 of these Bylaws, the Investigating Committee shall submit a written report to the ECMS within fourteen (14) days after having received the request for investigation or as soon as the report may reasonably be made. If the Investigating Committee cannot complete an investigation within the time periods designated herein, the Investigating Committee shall notify the Chair of the ECMS and conclude the investigation within a reasonable amount of time.

F. Further Procedures. The Chair of the ECMS shall provide the Practitioner, LP, or APP with Special Notice of the ECMS's recommendation within fifteen (15) Days of the recommendation.

(1) If the recommendation of the ECMS is an Adverse Recommendation or Action:

(a) A Practitioner shall be entitled to the hearing and appeal procedures in Article XII and all further procedures shall be in accordance with the Fair Hearing Manual before the matter is considered by the Governing Body.

(b) A LP or APP shall be entitled to the hearing and appeal procedures set forth in the Licensed Professional & Advanced Practice Provider Fair Hearing Process Policy *[CLN0996]* before the matter is considered by the Governing Body.

(2) If the recommendation of the ECMS is to not take any corrective action or to impose corrective action that is not an Adverse Recommendation or Action (and, therefore, does not entitle the Practitioner, LP, or APP to a hearing or any further procedures pursuant to Article XII of the Medical Staff Bylaws), the recommendation shall be forwarded to the Governing Body for a final decision. The Governing Body will provide the CME with Notice of the Governing Body's final decision within fifteen (15) Days of the final decision.

(a) If the decision of the Governing Body is not an Adverse Recommendation or Action (and, therefore, does not entitle the Practitioner, LP, or APP to a hearing or any further procedures pursuant to Article XII of the Medical Staff Bylaws), that decision shall be final and the Chief Medical Executive shall provide the Practitioner with Special Notice of the decision within twenty (20) Days thereof.

(b) If the decision of the Governing Body is an Adverse Recommendation or Action, the Chief Medical Executive shall provide the Practitioner, LP, or APP with Special Notice of the decision within twenty (20) Days thereof, and:

i. A Practitioner shall be entitled to the hearing and appeal procedures in Article XII and all further procedures shall be in accordance with the Fair Hearing Manual.

ii. A LP or APP shall be entitled to the hearing and appeal procedures set forth in the Licensed Professional & Advanced Practice Provider Fair Hearing Process Policy *[CLN0996]*.

(3) Except as provided below, pending compliance with the procedures in the Fair Hearing Manual or the Licensed Professional & Advanced Practice Provider Fair Hearing Process Policy, as applicable, the Adverse Recommendation or Action shall be held in abeyance unless summary action is imposed pursuant to Section 11.4.

(4) If a Practitioner, LP, or APP is due for reappointment while the applicable hearing and appeal procedures are pending, and the Adverse Recommendation or Action is a termination of Medical Staff Membership and/or Clinical Privileges, the application for reappointment shall not be processed until there has been a final decision on the Adverse Recommendation or Action.

G. Mandatory Meeting. The CCMS, ECMS, or an Investigating Committee may, at any time during the corrective action or investigation process, require a Practitioner, LP, or APP to attend

a mandatory meeting in accordance with Section 3.10. Failure of the Practitioner, LP, or APP to attend a mandatory meeting will result in automatic suspension of Membership and/or Clinical Privileges as set forth in Section 11.5 below.

11.4 Summary Action.[102]

A. Grounds. All or certain Clinical Privileges of a Practitioner, LP, or APP may be summarily suspended or restricted when there is a reasonable belief that the failure to take such an action may result in an imminent danger to the health or safety, of any individual including patients, MD Anderson personnel, and others. Such action shall become effective immediately upon imposition.[103]

B. Authority to Impose. Summary action may be taken by (i) the ECMS; (ii) the Governing Body; (iii) the Chief Medical Executive; or (iv) at least two (2) of the following individuals: the Practitioner's, LP's, or APP's Department Chair, the Practitioner's, LP's, or APP's Division Head, the Chair or Chair Elect of the ECMS, and the Chief Medical Executive.

C. Initiation of Investigation. Unless summary action is imposed during an ongoing Investigation for purposes of possible corrective action under Section 11.3, the taking of summary action shall automatically constitute the initiation of an Investigation for possible corrective action under Section 11.3.

D. Notice. The Practitioner, LP, or APP shall be notified in writing by Special Notice that their Privileges have been suspended or restricted. The Special Notice shall include a summary of the statement of the reasons for the action and a listing of pertinent medical records as applicable. The notice shall state that the Practitioner, LP, or APP shall be afforded an opportunity to meet with the ECMS and provide written evidence to the ECMS solely on the issue of whether there are reasonable grounds for the belief that immediate action must be taken to protect the life of or to reduce the likelihood of injury or damage to the health or safety of patients, MD Anderson personnel, or others, or if other measures may be appropriate to address concerns. The Chief Medical Executive shall be notified immediately of any summary action and shall advise the Practitioner's, LP's, or APP's Department Chair and Division Head, the Chair of the ECMS, and the Chief Medical Executive of the summary action, as well as the Practitioner Peer Assistance Committee chair and Employee Health and Well-being director if appropriate due to the reason for the summary action.

E. Alternate Coverage. Immediately upon imposition of summary action, if needed due to the type of action taken, the Practitioner's, LP's, or APP's Department Chair, or Chief Medical Executive in the absence of the Department Chair, shall assist the Practitioner's, LP's, or APP's inpatients to secure alternative medical coverage.

F. ECMS Review. Within fourteen (14) working days of imposition of the summary action, the ECMS shall review the reasons for the summary action and determine whether to continue, terminate, or modify the summary action.

[102] MS.01.01.01, EP 32
[103] MS.01.01.01, EP 29

(1) Prior to the ECMS's determination, the Practitioner, LP, or APP shall be invited to meet with the ECMS. In advance of the meeting, the Practitioner, LP, or APP may submit a written statement and other information to the ECMS.

(2) At the meeting, the Practitioner, LP, or APP may provide information to the ECMS and should respond to any questions that may be raised by the ECMS. The Practitioner, LP, or APP may provide information to the ECMS, including alternatives to the summary action which will protect patients, employees, or others while the matter is being reviewed.

(3) This meeting shall not constitute a hearing and shall not be subject to the procedures in the Fair Hearing Manual. No counsel is permitted to attend the meeting. Minutes of the meeting shall include documentation of the purpose of the meeting, that the meeting is part of the corrective action process, and that the Practitioner, LP, or APP has been so informed.

(4) After considering the reasons for the summary action and the Practitioner's, LP's, or APP's response, if any, the ECMS will determine whether the summary action should be continued, modified, or lifted. The ECMS may also determine whether to refer the matter for further inquiry or investigation in accordance with these Bylaws, Section 11.3.

The Chair of the ECMS shall provide Special Notice to the Practitioner, LP, or APP of the ECMS's recommendation within three (3) working days of the recommendation. The ECMS's recommendation shall be forwarded to the Governing Body for a final decision. If the ECMS's recommendation is to terminate the summary action, the summary action shall be terminated effective immediately pending a final decision by the Governing Body. The President shall provide the Practitioner, LP, or APP with Special Notice of the final decision of the Governing Body pursuant to this section within three (3) working days of the decision. Any summary action approved by the Governing Body under subsection E above shall remain in effect pending compliance with the procedures in the Fair Hearing Manual.

G. Further Procedures. Following compliance with the procedures in subsection E above, the Practitioner, LP, or APP shall not be entitled to any further review or any procedures in the Medical Staff Bylaws or the Fair Hearing Manual as to the summary action itself. If the recommendation pursuant to Section 11.3 is an Adverse Recommendation or Action, the Practitioner, LP, or APP shall be entitled to the procedural rights as set forth in that Section 11.3.

H. Reporting. Timelines for purposes of reporting a summary action as a professional review action pursuant to the Health Care Quality Improvement Act and/or state law shall commence when and if the ECMS approves the summary action pursuant to subsection E above.

11.5 Automatic Action.

A. Automatic Suspension. A Practitioner's Medical Staff Membership and/or Clinical Privileges will be automatically suspended for up to sixty (60) days for failure to continuously maintain any of the qualifications for Medical Staff Membership as set forth in Section 3.3 of these Bylaws, unless previously waived by the Governing Body, including without limitation any of the following:[104]

[104] MS.01.01.01, EP 28; MS.01.01.01, EP 31

(1) Suspension of, or failure to continuously possess, a current and unrestricted professional license.

(2) Suspension of, or failure to continuously hold a federal controlled substances authorization if the Practitioner's Clinical Privileges contemplate prescribing controlled substances.

(3) Failure to obtain or maintain board certification as required for the Practitioner's Medical Staff Category, specialty and Privileges, unless exempted in accordance with these Medical Staff Bylaws and Hospital policy.

(a) A Practitioner will be granted a sixty (60) day grace period before the automatic suspension for board certification becomes effective to provide evidence of current board certification, provided the Practitioner has completed or submitted all requirements for the board certification and is only awaiting confirmation of successfully attaining the board certification.

(b) The Chief Medical Executive may, for good cause and in the Chief Medical Executive's sole discretion, grant a Practitioner a temporary waiver of the board certification requirement while the Practitioner completes and submits the requirements to obtain or maintain board certification. The waiver, if granted, may set a waiver period and/or any additional conditions associated with such waiver. If the waiver is granted and the Practitioner does not meet any of the conditions associated with the waiver by any time period or deadline, then the Practitioner's Clinical Privileges shall be automatically suspended as of the date the Practitioner fails to meet such condition(s).

i. If a waiver is granted, the Chief Medical Executive will forward it to the Governing Body. The waiver will take effect immediately and will continue as granted by the Chief Medical Executive unless rejected or modified by the Governing Body.

ii. There is no obligation to grant any such waiver, and Practitioners have no right to have a waiver considered and/or granted. A Practitioner who is denied a waiver or consideration of a waiver shall not be entitled to any hearing and appeal rights under these Bylaws.

(4) Failure to comply after thirty (30) days prior notice to the Practitioner with any vaccination program requirements in accordance with Federal or state law, or policies adopted by the Hospital.

(5) Failure to complete after thirty (30) days prior notice to the Practitioner any continuing medical education, training, or maintenance of certification required by federal or state law or regulation, as a condition of accreditation, or by policies adopted by the Hospital, unless exempted or granted a waiver under Section 3.3.

(6) Material Misstatement of information on an application for Medical Staff membership, reappointment, and/or Clinical Privileges in accordance with Section 3.3.F discovered after the application has been processed.

(7) Failure to update or immediately disclose (no later than the end of the next business day after request by or on behalf of the Medical Staff) any information as required in accordance with Section 3.4.B.

B. Automatic Termination.

(1) If a Practitioner remains subject to an automatic suspension under Section 11.5.A above for more than sixty (60) days, the Practitioner's Medical Staff Membership and Clinical Privileges (or the affected Clinical Privileges if the suspension is a partial suspension) shall be automatically terminated.

(2) A Practitioner's Medical Staff membership and/or Clinical Privileges will be automatically terminated as set forth in these Bylaws, including without limitation any of the following:

(a) Loss, termination, or resignation of required Faculty Academic Appointment required for the applicable Medical Staff category.

(b) Revocation of a Practitioner's professional license.

(c) Revocation of a Practitioner's federal controlled substances authorization if the Practitioner's Clinical Privileges contemplate prescribing controlled substances.

(d) Conviction of or entering a plea of guilty or no contest to any felony.

(e) Conviction of or entering a plea of guilty or no contest to any misdemeanor involving (a) insurance or health care fraud or abuse, (b) violence, physical abuse, or exploitation directed at a person, or (c) violation of law pertaining to controlled substances or illegal drugs, unless the Applicant is enrolled and satisfactorily participating in, or has successfully completed, a treatment program approved by the ECMS.

(f) Exclusion of the Practitioner by the U. S. Department of Health and Human Services' Office of Inspector General from Medicare, Medicaid, or any other state or federal health care program.

(g) Debarment, disqualification, or otherwise declared ineligible as an investigator by a federal agency, or restricted from conducting clinical research by the FDA pursuant to the Generic Drug Enforcement Act of 1992 or any other equivalent or successor statutes.

C. Automatic Expiration. Failure of a Practitioner to timely submit a completed application for reappointment in accordance with Section 3.7.G of these Bylaws will result in the automatic expiration of the Practitioner's Medical Staff Membership and Clinical Privileges on the date the Practitioner's then-current appointment and Clinical Privileges expire.

D. Procedural Rights for Automatic Actions.

(1) A Practitioner who is subject to automatic suspension, automatic termination, or automatic expiration of their Medical Staff Membership or Privileges under these Bylaws is not entitled to any procedural rights, including any hearing or appeal under Article XII of these Bylaws.

(2) To the extent consistent with applicable law, automatic suspension, automatic termination, and automatic expiration of Medical Staff Membership or Clinical Privileges are not reportable to the National Practitioner Data Bank. Notwithstanding the foregoing, voluntary resignation of Faculty Academic Appointment required for the applicable Medical Staff category while under Investigation or to avoid Investigation or other peer review activity shall be considered a voluntary resignation of Medical Staff Membership or Clinical Privileges.

(3) The automatic suspension, termination, or expiration of Medical Staff Membership and Clinical Privileges does not prohibit a Practitioner from submitting an application for initial appointment or for new Privileges, which will be reviewed in accordance with these Bylaws.

E. Automatic Reinstatement. A Practitioner who is subject to automatic suspension under Section 11.5.A will be automatically reinstated to Medical Staff Membership and Clinical Privileges, as applicable, if, prior to expiration of the sixty (60) day period, the Practitioner furnishes documented proof of compliance with the qualification for Medical Staff Membership, Clinical Privileges, or Hospital policy that formed the basis for the automatic suspension. The Practitioner must submit the documented proof to Medical Staff & Credentialing Services.

F. ECMS Action. Nothing in this section is intended to limit the ability of the ECMS and/or the Governing Body to take corrective action as may be appropriate using the procedures under Section 11.3 or 11.4 above.

11.6 Time Periods as Guidelines. The time periods in this Article XI are guidelines and are not directives that create any rights for a Practitioner or APP to have an Investigation completed or any other action taken within these precise periods, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

11.7 LPs and Advanced Practice Providers. Corrective action review and appeal involving a LP or Advanced Practice Provider shall be handled pursuant to written policy. *[Licensed Professional & Advanced Practice Provider Fair Hearing Process Policy CLN0996]*

ARTICLE XII. PROCEDURAL RIGHTS OF REVIEW

12.1 Right to Hearing and Appeal.

A. Entitlement. Only Practitioners are entitled to the procedural rights of review set forth in this Article XII and the Fair Hearing Manual.[105]

(1) ECMS Action. A Practitioner that is the subject of an Adverse Recommendation or Action by the ECMS shall be entitled to a hearing on such action before a Hearing Committee,[106] as such term is defined in the Fair Hearing Manual.[107] The Hearing Committee's report shall be forwarded to the ECMS which shall consider the report and either affirm, reverse, or modify the Adverse Recommendation or Action that resulted in the hearing. If the ECMS's decision is an Adverse Recommendation or Action, the Practitioner may appeal to the Governing Body (or an ad hoc committee appointed for that purpose) prior to a final decision by the Governing Body on the matter.

(2) Governing Body Action. A Practitioner that is the subject of an Adverse Recommendation or Action by the Governing Body following a recommendation of the ECMS that was not an Adverse Recommendation or Action shall be entitled to a hearing on such action before a Hearing Committee, as such term is defined in the Fair Hearing Manual. The Hearing Committee's report shall be forwarded to the ECMS which shall consider the report and either affirm, reverse, or modify the Adverse Recommendation or Action that resulted in the hearing. If the ECMS's decision is an Adverse Recommendation or Action, the Practitioner may appeal to the Governing Body (or an ad hoc committee appointed for that purpose) prior to a final decision by the Governing Body on the matter.

B. Definition of Adverse Recommendation or Action. Only the following recommendations and actions by the ECMS or the Governing Body, as set forth in subsection A above, shall be considered an Adverse Recommendation or Action and shall entitle a Practitioner to the procedural rights afforded by this Article and the Fair Hearing Manual:

(1) Denial of membership on the Medical Staff at the time of initial credentialing or reappointment;

(2) Suspension or revocation of Medical Staff membership for more than 30 days;

(3) Denial of a requested change in Medical Staff category, unless the Member does not meet the threshold criteria for the category as set forth in the Medical Staff Bylaws;

(4) Suspension, revocation, reduction, or limitation of Clinical Privileges for more than 30 days;

(5) Denial or restriction of requested Clinical Privileges at the time of initial credentialing or reappointment for more than 30 days;

[105] MS.10.01.01, EP 1
[106] MS.01.01.01, EP 35
[107] MS.10.01.01, EP 3

(6) Imposition of consultation, monitoring, or supervision requirements pursuant to which Clinical Privileges may not be exercised without first obtaining the approval of a consultant, monitor, or supervisor for more than 30 days; or

(7) Denial of return from leave of absence as set forth in Article III, Section 3.8, if the reasons relate to professional competence or conduct.

(a) No other recommendation or action will entitle the individual to a hearing.

(b) If the Governing Body determines to take any of these actions without an adverse recommendation by the ECMS, an individual is entitled to request a hearing. For ease of use, this Fair Hearing Manual refers to adverse recommendations of the ECMS. When a hearing is triggered by an adverse proposed action of the Governing Body, any reference in this Fair Hearing Manual to the "ECMS" will be interpreted as a reference to the "Governing Body".

C. None of the following actions constitute grounds for a hearing. These actions take effect without hearing or appeal. The individual is entitled to submit a written statement regarding these actions for inclusion in their file:

(1) a letter of guidance, counsel, warning, or reprimand;

(2) a lapse, withdrawal of, or decision not to grant Temporary Privileges;

(3) automatic termination of Membership or Clinical Privileges;

(4) a requirement for additional training or continuing education;

(5) suspension, restriction, or reduction of Clinical Privileges for a period of less than 30 days or when such action is not based on competence or conduct;

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

(7) activation of a leave of absence on behalf of a practitioner in accordance with the Medical Staff Bylaws;

(8) removal from the on-call roster or any reading or rotational panel;

(9) the voluntary acceptance of a performance improvement plan;

(10) determination that an Application is not a Completed Application;

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

(12) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of MD Anderson need, or resources, or because of an exclusive contract;

(13) changes to Medical Staff Membership prerogatives (e.g., voting rights, eligibility for committee membership);

(14) any Automatic Action described in Section 11.5 of the Medical Staff Bylaws; or

(15) any other recommendation or action not listed in Section 2.1 of this Fair Hearing Manual.

12.2 Required Hearing Procedures.[108]

A. Minimum Rights. All hearing and appeals shall be in accordance with the procedural safeguards set forth in the Fair Hearing Manual and shall include at least the following rights:

(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 Panel or Hearing Officer upon receipt of a timely request from the Practitioner;[109]

(3) preparation of a record of the hearing with a copy of the transcript made available to the Practitioner on payment of any reasonable costs;

(4) the right of each party to present evidence, call and cross-examine witnesses, be represented at the hearing by an attorney or other individual of the party's choice, and submit a written statement at the close of the hearing;

(5) the right to receive the written recommendation of the Hearing Committee and the reasons for the recommendation;

(6) the right to appeal to an appellate review committee appointed by the Governing Body; and

(7) the right to receive the written decision of the Governing Body and the reasons for the decision.

12.3 Mediation Prior to a Hearing. The parties may agree to utilize mediation but must do so prior to proceeding with a hearing. Mediation requirements may be found in the Fair Hearing Manual, Section 1.0. If the Practitioner fails to submit a timely request for mediation prior to a hearing in accordance with the Fair Hearing Manual, the Practitioner will be deemed to have waived the Practitioner's right to a mediation. If a mutually agreed upon written statement is reached at the mediation and subsequently approved by the ECMS and Governing Body, the matter will be closed and the Practitioner will be deemed to have waived all their remaining rights including, the right to hearing and appeal under the Medical Staff Bylaws and Fair Hearing Manual. If no settlement is reached, or if the settlement is not approved by the ECMS and Governing Body, the hearing related timeline as outlined in the Fair Hearing Manual will resume as of the date of conclusion of mediation. The Practitioner will have no further rights to mediation. Under no circumstances may the mediation settlement agreement require any action not permitted by law or require MD Anderson, the Medical Staff, or Governing Body to violate any legal or accreditation requirements.

12.4 Appeal Procedure.[110]

[108] MS.01.01.01, EP 34; MS.10.01.01, EP 3
[109] MS.10.01.01, EP 2
[110] MS.01.01.01, EP 34; MS.10.01.01, EP 5

A. Time for Appeal. Within ten (10) days of receiving the decision of the hearing panel, either party (the Practitioner or the body whose decision prompted the hearing) may request an appellate review in accordance with the Fair Hearing Manual. If appellate review is not requested within this period, the Practitioner and/or body whose decision prompted the hearing shall have waived any right of appeal, respectively. If there is no appeal, the recommendation of the hearing panel shall be the final recommendation and action of the Medical Staff, and shall be forwarded to the Governing Body for final action.

B. Grounds for Appeal. The grounds for appeal shall be limited to the following:

(1) there was substantial failure by the hearing panel or the presiding officer to comply with these Bylaws or the Fair Hearing Manual, so as to deny a fair hearing; or

(2) the recommendations of the hearing panel are arbitrary, capricious, or unreasonable or were not supported by credible evidence.

C. Time, Place, and Notice.

(1) If an appellate review is requested in a timely manner, the Governing Body will, within thirty (30) days after receiving the Special Notice of a request for an appellate review, schedule and arrange for the appellate review. Each side will be given Special Notice of the time, place, and date of the appellate review at least twenty (20) days before the appellate review, unless otherwise agreed to by the parties and the Governing Body.

(2) The appellate review shall commence within sixty (60) days from the date the transcript of the hearing is available or the date the Governing Body received the Special Notice requesting an appellate review, whichever is later, provided, however, when a request for appellate review concerns a Practitioner who is under suspension that is then in effect, the appellate review should, to the extent possible, commence within forty-five (45) days from the date of the Special Notice requesting an appellate review. The time for appellate review may be extended by the Appellate Officer or Appeal Board for good cause.

D. Nature of Appellate Review.

(1) The Governing Body may serve as the appellate review committee, or may appoint an appellate review committee, which shall be composed of at least three (3) members of the Governing Body or independent third parties designated by the Governing Body.

(2) The proceeding by the appellate review committee shall be an appellate hearing based upon the record of the hearing before the hearing panel, including the hearing transcripts and exhibits, post-hearing statements, and the findings and recommendations of the ECMS and hearing panel, the memoranda submitted by the parties, the oral arguments of the parties, and any other information the appellate review committee deems relevant.

(3) Each party shall have the right to be represented by an attorney or other representative designated by that party in connection with the appeal.

(4) Each party shall have the right to present a written memorandum in support of the party's position on appeal in accordance with the Fair Hearing Manual.

(5) The appellate review committee may, at the appellate review committee's sole discretion, consider evidence not available at the hearing in accordance with the Fair Hearing Manual.

(6) The appellate review committee shall provide a written recommendation to the Governing Body for final action in accordance with the Fair Hearing Manual.

12.5 Failure to Appear. Failure, without good cause, of the Practitioner to appear and proceed at the hearing may be deemed by the Hearing Panel or Hearing Officer to constitute (1) a waiver of the Practitioner's right to a hearing and appeal and (2) a voluntary acceptance of the pending Adverse Action or recommendation as a final action, which shall be forwarded to the Governing Body for final determination.

12.6 Medical Staff Bylaws Control. In the event of any conflict between these Medical Staff Bylaws and the Fair Hearing Manual, the Medical Staff Bylaws shall control.

12.7 Limitations. Notwithstanding any other provision of the Medical Staff Bylaws, a Practitioner shall be entitled to only one (1) hearing and appellate review on any matter which shall have been the subject of action by the ECMS or the Governing Body.

ARTICLE XIII. ADOPTION AND AMENDMENT OF SUPPLEMENTAL DOCUMENTS

13.1 Authority. The Medical Staff shall adopt and amend such Supplemental Documents, including without limitation an Organizational Manual, a Fair Hearing Manual, and policies as may be necessary to implement the process and principles set out in these Medical Staff Bylaws (collectively, the "Supplemental Documents"), using the procedures below.

13.2 Adoption and Amendment. The Medical Staff delegates responsibility for the review, initiation, adoption and amendment of the Supplemental Documents to the ECMS. Adoption of a Supplemental Documents or amendment of any such documents/policies may occur at a regular meeting (or a special meeting called for such purpose) of the ECMS. Adoption or amendment must be preceded by at least ten (10) working days written notice sent by regular mail or email to all voting Members of the Medical Staff, which written notification shall include copies of (or provisions for accessing electronically) the proposed Supplemental Documents and/or amendments for review prior to the meeting. Members may provide written comments on the proposed adoption or amendment to Medical Staff & Credentialing Services within those ten (10) working days, which comments will be provided to the ECMS at the meeting at which the voting will occur. Adoption or amendment of a Supplemental Documents shall require the affirmative vote of two-thirds (2/3rd) of the voting members present at a meeting of the ECMS and shall be effective on approval by the Governing Body.[111]

13.3 Direct Proposal. Adoption or amendments to the Supplemental Documents may also be proposed directly to the Medical Staff by written petition signed by at least twenty percent (20%) of the voting Members of the Medical Staff. Notice of such petition will be provided to the ECMS at least thirty (30) days prior to the vote by the Medical Staff.[112] The ECMS may comment on the proposed amendment before it is forwarded to the voting Members of the Medical Staff by electronic or paper ballot, in accordance with the processes in Section 13.2.

The proposed amendments to the Supplemental Documents are approved by the affirmative vote of a majority of the voting Members of the Medical Staff who submit a timely electronic or paper ballot by the date specified by the Executive Committee of the Medical Staff, which date is no sooner than twenty-one (21) days from Notice of the proposed amendments. There is no quorum or minimum number of ballots to be submitted by voting Members of the Medical Staff in order for a proposed amendment to be approved. The Medical Staff's approval of the amendments to the Supplemental Documents will be forwarded to the Governing Body as a recommendation of the Medical Staff.

13.4 Urgent Amendment. In cases of a documented need for an urgent amendment to the Supplemental Documents in order to comply with a law or regulation, the ECMS may provisionally adopt such amendment and forward it to the Governing Body for approval and immediate implementation without prior notification of the voting Members of the Medical Staff.[113] The voting Members of the Medical Staff will be notified by the ECMS of the provisionally approved amendments as soon as feasible. The voting Members of the Medical Staff will then have the opportunity for retrospective review of and comment on the provisional amendment. The Medical Staff may, by written petition signed by at least twenty percent (20%) of the voting Members of the Medical Staff require that the amendment be reconsidered; provided, however, the

[111] MS.01.01.01. EP 24, MS.01.01.01. EP 25
[112] MS.01.01.01. EP 9
[113] MS.01.01.01, EP 8

amendment will remain effective until such time as the Supplemental Document is retired or a superseding amendment meeting the requirements of the law or regulation has been approved.[114]

13.5 Governing Body Approval. Adoption or amendment of Supplemental Documents become effective only after approval by the Governing Body.[115]

13.6 Technical Corrections. Corrections that are strictly limited to correcting typographical or inadvertent errors or updating references in supplemental document/policies, such as titles of positions or names of policies, that do not involve a substantive change may be made by the Medical Staff & Credentialing Services without the necessity of compliance with the procedures in this Article.

13.7 Prohibition on Unilateral Amendment. None of the ECMS, the Medical Staff, or the Governing Body may unilaterally adopt or amend supplemental document/policies.

13.8 Medical Staff Bylaws Control. Any Supplemental Documents shall be subject to and governed by these Medical Staff Bylaws. The definitions in these Medical Staff Bylaws shall be applicable to the Supplemental Documents, although the Supplemental Documents may include additional definitions. In the event of a conflict between Supplemental Documents and these Medical Staff Bylaws, these Medical Staff Bylaws shall control.

[114] MS.01.01.01. EP 11
[115] MS.01.01.01. EP 2

ARTICLE XIV. ADOPTION AND AMENDMENT OF MEDICAL STAFF BYLAWS

14.1 Adoption and Amendment Procedures.

The Medical Staff has the responsibility to initiate, review, adopt and amend Medical Staff Bylaws.[116] The Medical Staff's responsibility for Medical Staff Bylaws and Supplemental Documents (defined below) shall be exercised in good faith and in a reasonable, responsible and timely manner. Medical Staff Bylaws and Supplemental Documents will be effective only after approval by the Governing Body.[117]

The ECMS may recommend adoption of or amendments to the Medical Staff Bylaws to the Medical Staff.[118]

A recommendation to adopt or amend these Medical Staff Bylaws may also be made a written petition of twenty percent (20%) of the Members of the Active Staff without a prior recommendation of the ECMS.

The Medical Staff may vote to adopt Medical Staff Bylaws or approve amendments to these Medical Staff Bylaws at the annual meeting or a special meeting of the Medical Staff, or by mail or electronic ballot as set forth below. Medical Staff Bylaws or amendments to these Medical Staff Bylaws shall be effective upon approval by the Governing Body.[119]

14.2 Amendment at Annual or Special Meeting.

Written notice with copies or electronic access to the proposed amendments to these Bylaws will be sent to the voting Members of the Medical Staff by regular email at least ten (10) business days before the Medical Staff meeting.

The Medical Staff may vote to approve the proposed amendments to the Medical Staff Bylaws at the annual or special meeting of the Medical Staff, subject to the quorum and voting requirements in Article VIII.

14.3 Amendment Electronic Ballot.

The Medical Staff may vote to approve amendments to the Medical Staff Bylaws by electronic ballot. A ballot shall be electronically transmitted to each Member of the Active Staff who is eligible to vote and have specify a return date that is at least ten (10) working days, unless the Chair of the ECMS determines a shorter return date is needed based on exigent circumstances. Electronic voting is subject to the quorum and voting requirements in Article VIII.

The electronic ballot shall be accompanied by the proposed amendments. The affirmative vote of a majority of the voting members of the Medical Staff who are eligible to vote and return their votes within the ten (10) working days or the shorter return date by the Chair of the ECMS. The ballots shall be counted by the Chair of the ECMS, the CME or their respective designees.

14.4 Technical Corrections. Corrections that are strictly limited to correcting typographical or inadvertent errors or updating references in the Medical Staff Bylaws, such as titles of positions

[116] MS.01.01.01. EP 8
[117] MS.01.01.01, EP 7
[118] MS.01.01.01, EP 9
[119] MS.01.01.01, EP 2

or names of policies, that do not involve a substantive change may be made by the ECMS without the necessity of compliance with the procedures in this Article.

14.5 Prohibition on Unilateral Amendment. Neither the Medical Staff nor the Governing Body may unilaterally amend these Medical Staff Bylaws.[120]

[120] MS.01.01.03, EP 1

ARTICLE XV. ADOPTION OF MEDICAL STAFF BYLAWS

These Medical Staff Bylaws shall become effective and shall replace any previous Medical Staff Bylaws when approved by the Medical Staff and the Governing Body. Upon approval, the Medical Staff and the Governing Body shall comply with these Medical Staff Bylaws and any Supplemental Documents adopted as provided herein.

Adopted as revised by the Medical Staff of The University of Texas MD Anderson Cancer Center, 2/19/2025.

Lara Bashoura MD

Lara Bashoura, M.D.
Chair Executive Committee of the Medical Staff
Confirmed vote of approval of the Medical Staff on 2/19/2025 | 11:19 AM CST.

Jeffrey E. Lee, M.D.

Jeffrey Lee, M.D.
Chief Medical Executive
Reviewed on 2/19/2025 | 1:03 PM CST.

Peter WT Pisters, M.D.
President/Governing Body
Approved on 02/19/2025.

FAIR HEARING MANUAL
OF THE MEDICAL STAFF BYLAWS
OF THE UNIVERSITY OF TEXAS MD ANDERSON CANCER CENTER

TABLE OF CONTENTS

HEARING AND APPEAL PROCEDURES[1]

GENERAL STATEMENT

The procedures set forth in this Fair Hearing Manual apply only to Practitioners of the Medical Staff who have been granted Clinical Privileges. The definitions in the Medical Staff Bylaws, as well as any additional ones set out below, shall be applicable herein and this Fair Hearing Manual is subject to and governed by the Medical Staff Bylaws. Procedures applicable to Licensed Professionals and Advanced Practice Providers are set forth in the Licensed Professional & Advanced Practice Provider Fair Hearing Process Policy CLN0996. Procedures applicable to Allied Health Professionals are set forth in Section 4.8 of the Medical Staff Bylaws.

PURPOSE

The purpose of this Fair Hearing Manual is to describe the process and the guidelines for the Medical Staff's peer review hearings and appeals. These hearings and appeals procedures are intended to promote due process and a fair review of decisions that adversely affect Practitioners, while promoting immunity for the Peer Review participants, witnesses, Medical Staff leaders, committees, and the Hospital from liability to the fullest extent permitted by applicable law.

The Medical Staff, the Governing Body, and their officers, committees, and agents have constituted themselves as Peer Review committees under the federal Health Care Quality Improvement Act of 1986 and the Texas Medical Practice Act, and claim all privileges and immunities to the fullest extent afforded by applicable federal and state laws.

This Fair Hearing Manual is incorporated into the Hospital Medical Staff Bylaws and is subject to the approval process set forth therein.

SECTION 1.0 MEDIATION PRIOR TO A HEARING

A Practitioner who requests mediation based on being subject to a professional review action that may adversely affect their medical staff membership or Clinical Privileges for more than 30 days, entitling the Practitioner to a hearing under this Fair Hearing Manual, shall be provided with an opportunity for mediation. If the requirements of Tex. Health & Safety Code Section 241.101(d) are not met, MD Anderson shall have no obligation to offer mediation to the Practitioner.

(1) The Practitioner must submit a written request for mediation within 14 Days of receipt of a letter from the ECMS advising of a recommendation which would adversely affect their clinical privileges. Submission of a valid request for mediation temporarily suspends any hearing related timeline in the Fair Hearing Manual except as to a continued suspension. If the Practitioner fails to submit a timely request for mediation prior to a hearing in accordance with the Fair Hearing Manual, the Practitioner will be deemed to have waived the Practitioner's right to a mediation.

(2) The Practitioner and MD Anderson shall cooperate in scheduling mediation within 20 Days of receipt of the Practitioner's request and mediation shall be completed within 75 Days of

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[1] MS.10.01.01; MS.01.01.01, EP 34

receipt of the request, unless extended for good cause. If mediation is not completed within 75 Days and MD Anderson has used reasonable efforts to complete the mediation, the mediation shall be waived. In all cases in which mediation is requested (except continued suspension) mediation must be completed before a hearing is scheduled.

(3) The Practitioner and MD Anderson will share the costs of the mediator equally and the mediator will be selected by mutual agreement. The mediator shall have health care peer review mediation experience. The mediation shall be limited to one half day unless otherwise mutually agreed upon. MD Anderson shall be represented in the mediation by the Chief Medical Executive or designee. MD Anderson's Chair of the ECMS, President, or other designee of the President may also attend and participate in the mediation. MD Anderson's attorney and individual's attorney may attend and participate in mediation.

(4) If a mutually agreed upon written settlement is reached at the mediation and subsequently approved by the ECMS and Governing Body, the matter will be closed and the Practitioner will be deemed to have waived all of their remaining rights including, the right to hearing and appeal under the Medical Staff Bylaws and this Fair Hearing Manual. If no settlement is reached, or if the settlement is not approved by ECMS and Governing Body, the hearing related timeline as outlined in the Fair Hearing Manual will resume as of the date of conclusion of mediation. The Practitioner will have no further rights to mediation. Under no circumstances may the mediation settlement agreement require any action not permitted by law or require MD Anderson, the Medical Staff, or Governing Body to violate any legal or accreditation requirements.

SECTION 2.0 INITIATION OF HEARING.

2.1. Grounds for Hearing

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

(a) denial of membership on the Medical Staff at the time of initial credentialing or reappointment;

(b) suspension or revocation of Medical Staff membership for more than 30 days;

(c) denial of a requested change Medical Staff category, unless the Member does not meet the threshold criteria for the category as set forth in the Medical Staff Bylaws;

(d) suspension, revocation, reduction, or limitation of Clinical Privileges for more than 30 days;

(e) denial or restriction of requested Clinical Privileges at the time of initial credentialing or reappointment for more than 30 days;

(f) imposition of a consultation, monitoring, or supervision requirements pursuant to which Clinical Privileges may not be exercised without first obtaining the approval of a consultant, monitor, or supervisor for more than 30 days; or

(g) denial of return from a leave of absence as set forth in Article III, Section A 3.8, if the reasons relate to professional competence or conduct.

(2) No other recommendation or action will entitle the individual to a hearing.

(3) If the Governing Body determines to take any of these actions without an adverse recommendation by the ECMS, an individual is entitled to request a hearing. For ease of use, this Fair Hearing Manual refers to adverse recommendations of the ECMS. When a hearing is triggered by an adverse proposed action of the Governing Body, any reference in this Fair Hearing Manual to the "ECMS" will be interpreted as a reference to the "Governing Body."

2.2. Actions Not Grounds for Hearing.

None of the following actions constitute grounds for a hearing. These actions take effect without hearing or appeal. The individual is entitled to submit a written statement regarding these actions for inclusion in their file:

(1) a letter of guidance, counsel, warning, or reprimand;

(2) a lapse, withdrawal of, or decision not to grant Temporary Privileges;

(3) automatic termination of Membership or Clinical Privileges;

(4) a requirement for additional training or continuing education;

(5) suspension, restriction, or reduction of Clinical Privileges for a period of less than 30 Days or when such action is not based on competence or conduct;

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

(7) activation of a leave of absence on behalf of a practitioner in accordance with the Medical Staff Bylaws;

(8) removal from the on-call roster or any reading or rotational panel;

(9) the voluntary acceptance of a performance improvement plan;

(10) determination that an Application is not a Completed Application;

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

(12) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of MD Anderson need or resources, or because of an exclusive contract;

(13) changes to Medical Staff Membership prerogatives (e.g., voting rights, eligibility for committee membership);

(14) any Automatic Action described in Section 11.4 of the Medical Staff Bylaws; or

(15) any other recommendation or action not listed in Section 2.1 of this Fair Hearing Manual.

2.3. Notice of Recommendation.

The Chair of the ECMS will, within fifteen (15) days of the ECMS's recommendation, give Special Notice of a recommendation which entitles an individual to request a hearing, with a copy to the Chief Medical Executive.[2] This Special Notice will contain:

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

(2) a statement that the individual has the right to request a hearing on the recommendation within thirty (30) Days of receipt of this Special Notice;[3]

(3) a statement that the Practitioner has the right (i) to be represented by an attorney or other person of the Practitioner's choice at the hearing, (ii) to have a record made of the proceedings, copies of which may be obtained by the Practitioner upon payment of any reasonable charges associated with the preparation thereof; (iii) to call, examine and cross-examine witnesses at the hearing, (iv) to present evidence determined to be relevant by the Presiding Officer and (v) to submit a written statement at the close of the hearing;

(4) a statement that the Practitioner has the right to receive the written recommendation of the Hearing Panel or Presiding Officer, along with the bases of the recommendation and the final written decision of MD Anderson, including a statement of the basis for the decision;

(5) a statement that if the Practitioner does not request a hearing within the time and within the manner stated in the Notice Letter, the Practitioner shall have waived the hearing and any appeal and be deemed to have accepted the adverse recommendation as a final action, effective immediately upon final Governing Body action; and

(6) a copy of this Fair Hearing Manual.

2.4. Request for Hearing.

An individual has thirty (30) Days following receipt of the Special Notice to request a hearing, in writing, to the Chief Medical Executive, including the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing within the required time frame will constitute waiver of the right to a hearing, and the recommendation will be transmitted to the Governing Body for final action. That determination shall become effective immediately upon final Governing Body action. A Practitioner may not ask for a hearing after expiration of the time to request a hearing, absent good cause, if MD Anderson has made a good faith effort to notify the Practitioner of his/her right to request a hearing. The Practitioner shall not ignore the Notice Letter or avoid receipt of the Notice Letter.

2.5. Notice of Hearing and Statement of Reasons.

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[2] The Health Care Quality Improvement Act, 42 U.S.C. §11112(b)(1)
[3] MS.06.01.09, EP 5 & MS.10.01.01, EP 2

(1) The Chief Medical Executive will schedule the hearing and provide to the individual requesting the hearing, by Special Notice, the following:[4]

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

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

(c) the names of the Hearing Panel Members and Presiding Officer (or Hearing Officer) if known;

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

(i) Prior to thirty (30) days before the hearing, the statement of specific reasons for the adverse recommendation and the list of relevant patient record numbers and other supporting information, may be revised or amended or supplemented at any time.

(ii) Within thirty (30) days of the hearing date, by approval of the Presiding Officer or with the Practitioner's agreement in writing or on the hearing record, this statement and supporting patient records numbers and information may be amended or supplemented through the hearing process, so long as the additional material is relevant to the initial appointment or continued appointment or Clinical Privileges of the Practitioner. The Presiding Officer shall provide the Practitioner and his/her counsel reasonable time, up to thirty (30) days, to study this additional information and rebut it, unless Practitioner agrees in writing or on the hearing record to a shortened time period.

(2) The hearing will begin as soon as practicable, but no sooner than 30 Days after Special Notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

2.6. Hearing Panel, Presiding Officer, and Hearing Officer.:[5]

(1) Hearing Panel:[6]

[4] The Health Care Quality Improvement Act, 42 U.S.C. §11112(b)(2)
[5] The Health Care Quality Improvement Act, 42 U.S.C. §11112(b)(3)
[6] MS.01.01.01, EP 35 & MS.10.01.01, EP 4

(a) The Chief Medical Executive will appoint a Hearing Panel in accordance with the following guidelines:

(b) The Hearing Panel will consist of at least three Members, one of whom will be designated as Chair. The Chair will serve as the Presiding Officer when one has not been appointed.

(c) The Hearing Panel may include any combination of:

(i) Practitioners; and

(ii) Physicians, health care professionals, or laypersons not connected with MD Anderson.

(d) Knowledge of the underlying peer review matter, in and of itself, will not preclude the individual from serving on the Hearing Panel.

(e) Employment by, or other contractual arrangement with, MD Anderson will not preclude an individual from serving on the Panel.

(f) The Hearing Panel will not include any individual who:

(i) is in direct economic competition with the individual requesting the hearing;

(ii) is professionally associated with, a relative of, or involved in a referral relationship with, the individual requesting the hearing;

(iii) has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or

(iv) actively participated in the matter at any previous level.

(2) Presiding Officer:

(a) The Chief Medical Executive may appoint an attorney to serve as Presiding Officer. The Presiding Officer will not act as an advocate for either side at the hearing.

(b) The Presiding Officer will:

(i) schedule and conduct a pre-hearing conference;

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

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

(iv) maintain decorum throughout the hearing;

(v) determine the order of procedure;

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

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

(c) The Presiding Officer may be advised by legal counsel to MD Anderson with regard to the hearing procedure.

(d) The Presiding Officer may participate in the private deliberations of the Hearing Panel, may be a legal advisor to it, and may draft the report of the Hearing Panel's decision based upon the findings and discussions of the Panel, but will not vote on its recommendations.

(3) Hearing Officer:

(a) As an alternative to a Hearing Panel, in matters in which the underlying recommendation is based upon concerns involving behavior, sexual harassment, or failure to comply with rules, regulations or policies and not issues of clinical competence, knowledge, or technical skill, the Chief Medical Executive may appoint a Hearing Officer. The Hearing Officer, who should preferably be an attorney, will perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing.

(b) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Fair Hearing Manual to the "Hearing Panel" or "Presiding Officer" will be deemed to refer to the Hearing Officer.

(4) Objections:

(a) Any objection to any Member of the Hearing Panel, to the Hearing Officer, or to the Presiding Officer, will be made in writing, within 10 Days of receipt of Notice, to the Chief Medical Executive. The objection must include reasons to support it. A copy of the objection will be provided to the Chief Medical Executive. The Chief Medical Executive will be given a reasonable opportunity to comment. The Chief Medical Executive will rule on the objection and give Notice to the parties. The Chief Medical Executive may request that the Presiding Officer make a recommendation as to the validity of the objection.

2.7. Counsel.

The Presiding Officer, Hearing Officer, and counsel for either party may be attorneys at law licensed to practice, in good standing, in any state.

SECTION 3.0 PRE-HEARING PROCEDURES.

3.1. General Procedures.

The pre-hearing and hearing processes will be conducted in an informal manner. Formal rules of evidence or procedure will not apply.

3.2. Witness List.

(1) At least fifteen (15) Days before the pre-hearing conference, the parties will exchange a written list of the names of witnesses expected to offer testimony on their behalf.

(2) The witness lists will include a brief summary of the anticipated testimony.

(3) The parties' witness lists shall be finalized at the time of the pre-hearing conference. However, the witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that Notice of the change is given to the other party and the Presiding Officer provides the Practitioner, the ECMS and their attorneys with reasonable time, up to thirty (30) days, to prepare for the additional witnesses. The Presiding Officer shall have the authority to limit the number of witnesses, especially character witnesses or witnesses whose testimony is merely cumulative.

3.3. Time Frames

The following time frames, unless modified by mutual written agreement of the parties, will govern the timing of pre-hearing procedures:

(1) the pre-hearing conference will be scheduled at least fourteen (14) Days prior to the hearing;

(2) the parties will exchange proposed exhibits at least ten (10) Days prior to the pre-hearing conference; and

(3) any objections to witnesses and/or proposed exhibits must be provided at least 5 Days prior to the pre-hearing conference.

3.4. Provision of Relevant Information.

There is no right to discovery in connection with the hearing. The provision of the information below is not intended to waive any privilege.

(1) Prior to receiving any confidential documents, the individual requesting the hearing must agree in writing that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that their counsel and any expert(s) have executed Business Associate Agreements in connection with any patient Protected Health Information contained in any documents provided.

(2) Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with a copy of the following:

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

(b) reports of experts, if any, which the ECMS intends to rely upon at the hearing to support the adverse recommendation;

(c) Copies of any other documents which the ECMS intends to rely upon at the hearing to support the adverse recommendation.

(3) The individual will have no right to discovery beyond the above information. No information will be provided regarding other Practitioners. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.

(4) Ten Days prior to the pre-hearing conference, or on dates set by the Presiding Officer or agreed upon by both sides, each party will provide the other party with its proposed exhibits.

(5) Neither the individual, nor any other person acting on behalf of the individual, may contact MD Anderson employees or Practitioners whose names appear on the ECMS's witness list or in documents provided pursuant to this Section concerning the subject matter of the hearing, until MD Anderson has been notified and has contacted the individuals about their willingness to be interviewed. MD Anderson will advise the individual who requested the hearing once it has contacted such employees or Practitioners and confirmed their willingness to meet. Any employee or Practitioner may agree or decline to be interviewed by or on behalf of the individual who requested a hearing. In the event MD Anderson schedules, a time and place by which the Practitioner and/or his/her counsel may interview an MD Anderson employee, MD Anderson's counsel shall also have the right to be present at the interview.

3.5. Pre-Hearing Conference.

(1) The Presiding Officer will require the individual and the ECMS (or a representative of each, who may be counsel) to participate in a pre-hearing conference.

(2) All objections to exhibits or witnesses will be submitted, in writing, 5 Days in advance of the pre-hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(3) At the pre-hearing conference, the Presiding Officer will resolve all procedural questions, including any objections to exhibits or witnesses.

(4) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for Membership or the relevant Clinical Privileges will be excluded.

(5) The Presiding Officer will establish the time to be allotted to each witness's testimony and cross-examination.

3.6. Stipulations.

The parties will use their best efforts to develop and agree upon stipulations to provide for a more efficient hearing.

3.7. Provision of Information to the Hearing Panel.

The following documents will be provided to the Hearing Panel in advance of the hearing:

(1) a pre-hearing statement that either party may choose to submit;

(2) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and

(3) stipulations agreed to by the parties.

SECTION 4.0 CONDUCT OF HEARING.

4.1. Time Allotted for Hearing.

The Presiding Officer will determine the length of the hearing at the pre-hearing conference. As a general rule, it is expected that the hearing will last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing will be concluded after a maximum of 15 hours. Considering the complexity of the case and fundamental fairness, the Presiding Officer may, after considering any objections, modify the time frame for the hearing.

4.2. Record of Hearing

A stenographic reporter will be present to make a record of the hearing. The cost of the reporter will be borne by MD Anderson. Copies of the transcript will be available at the individual's expense. Oral testimony will be taken on oath or affirmation administered by any authorized person.

4.3. Rights of Both Sides and the Hearing Panel at the Hearing.:[7]

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

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

(b) to introduce relevant exhibits;

(c) to cross-examine any witness present at the hearing on any matter relevant to the issues and to rebut any evidence;

(d) to have representation by counsel who may make opening and closing statements, call, examine, and cross-examine witnesses, to the extent the witnesses are available, and present at the hearing on any relevant matter and to rebut any evidence, and present the case;

[7] The Health Care Quality Improvement Act, 42 U.S.C. §11112(b)(3)

(e) to submit a written statement at the close of the hearing; and

(f) to submit proposed findings, conclusions, and recommendations to the Hearing Panel.

(2) If the individual who requested the hearing does not testify, he or she may be called and questioned as if under cross-examination.

(3) The Hearing Panel may question witnesses.

(4) The Presiding Officer may admit evidence not introduced by either party by the mutual agreement of the parties, stipulated in writing or on the hearing record.

4.4. Order of Presentation and Burden.

The ECMS will first present evidence in support of its recommendation. Thereafter, the burden will shift to the individual who requested the hearing to present clear and convincing evidence that the recommendation that prompted the hearing was arbitrary, capricious, or unreasonable, or not supported by credible evidence.

4.5. Admissibility of Evidence.

The hearing will not be conducted according to rules of evidence. Evidence will not be excluded merely because it is hearsay. Any evidence that is relevant to the individual's qualifications for Membership and Clinical Privileges will be admitted if it is the sort of evidence on which responsible persons are accustomed to relying on in the conduct of serious affairs.

4.6. Persons to Be Present.

The hearing will be restricted to those individuals involved in the proceeding. The presence of the individual who requested the hearing is mandatory. Administrative personnel may be present as requested by the Chief Medical Executive.

4.7. Presence of Hearing Panel Members.

A majority of the Hearing Panel will be present throughout the hearing. In unusual circumstances when a Hearing Panel Member must be absent from any part of the hearing, that Hearing Panel Member must certify that he or she read the entire transcript of the portion of the hearing from which he or she was absent.

4.8. Failure to Appear.

Failure, without good cause, of the Practitioner to appear and proceed at the hearing shall be deemed by the Hearing Panel or the Hearing Officer to constitute (1) a waiver of the Practitioner's right to a hearing and appeal and (2) a voluntary acceptance of the pending adverse recommendation as a final action, which shall be forwarded to the Governing Body for final determination.

4.9. Postponements and Extensions.

Postponements and extensions of time may be requested by anyone but will be permitted only by the Presiding Officer or the Chief Medical Executive (prior to the commencement of the hearing), on a showing of good cause, for a reasonable period of time and on a showing of good cause.

Either party or any member of the Hearing Panel or the Presiding Officer may request postponements and extensions of deadlines set forth in this Fair Hearing Manual. Only the Presiding Officer, or the Chief Executive Officer (prior to the commencement of the hearing), on a showing of good cause, shall grant such requests.

4.10. Hearing Conclusion, Deliberations, and Recommendations.

4.10.1. Basis of Hearing Panel Recommendation.:

Consistent with the burden set forth in Section 4.4, as well as the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial Membership, renewed Membership, and Clinical Privileges, the Hearing Panel will recommend in favor of the ECMS unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

(1) The recommendation of the Hearing Panel or Presiding Officer shall be based on the hearing record ("Hearing Record.") The Hearing Record shall consist of the following:

(a) Oral testimony of witnesses;

(b) Exhibits admitted into evidence at the hearing;

(c) Any information regarding the Practitioner so long as that information has been admitted into evidence at the hearing and the Practitioner had the opportunity to address it;

(d) Any and all applications for appointment or reappointment and references introduced into evidence at the hearing;

(e) Other documented evidence, including medical records introduced into evidence at the hearing;

(f) Any other evidence that has been presented at the hearing with the approval of the Hearing Officer or Hearing Chair or the Presiding Officer; and

(g) Each party's memorandum of points and authorities presented in connection with the hearing.

4.10.2. Deliberations and Recommendation of the Hearing Panel.:

The Hearing Panel and Presiding Officer shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of the deliberations, the hearing shall be finally adjourned. Within thirty (30) days of the final adjournment, the Hearing

Panel or Presiding Officer shall render a report, including recommendations, which shall contain a concise statement of the basis for the decision ("Hearing Report"). In the event the Hearing Panel or Presiding Officer is considering an already imposed summary suspension or restriction, including mandatory consultation, or mandatory proctoring, the Hearing Panel or Presiding Officer shall render the Hearing Report as promptly as reasonably practicable.

4.10.3. Disposition of Hearing Report.:

The Hearing Panel will deliver the Hearing Report to the Chief Medical Executive. The Chief Medical Executive will send by Special Notice a copy of the report to the individual who requested the hearing and the Chair of the ECMS.

SECTION 5.0 APPEAL PROCEDURE.[8]

5.1. Time for Appeal.

(1) Within 10 Days after Notice of the Hearing Panel's recommendation, either party may request an appeal. The request will be in writing, delivered to the Chief Medical Executive by hand delivery, overnight mail, or certified mail, return receipt requested, and will include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.

(2) If an appeal is not requested within 10 Days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation will be forwarded to the Governing Body for final action.

5.2. Grounds for Appeal.

The grounds for appeal shall be limited to the following:

(1) there was substantial failure by the Hearing Panel or the Presiding Officer to comply with this Fair Hearing Manual, so as to deny a fair hearing; or

(2) the recommendations of the Hearing Panel are arbitrary, capricious, or unreasonable or were not supported by credible evidence.

5.3. Time, Place, and Notice.

(1) If an appellate review is requested in a timely manner, the Governing Body will, within thirty (30) days after receiving the Special Notice of a request for an appellate review, schedule and arrange for the appellate review. Each side will be given Special Notice of the time, place, and date of the appellate review at least twenty (20) days before the appellate review, unless otherwise agreed to by the parties and the Governing Body.

(2) The appellate review shall commence within sixty (60) days from the date the transcript of the hearing is available or the date the Governing Body received the Special Notice

[8] MS.10.01.01, EP 5

requesting an appellate review, whichever is later, provided, however, when a request for appellate review concerns a Practitioner who is under suspension that is then in effect, the appellate review should, to the extent possible, commence within forty-five (45) days from the date of the Special Notice requesting an appellate review. The time for appellate review may be extended by the Appellate Officer or Appeal Board for good cause.

5.4. Nature of Appellate Review.

(1) The Governing Body may serve as the Appellate Review Committee or may appoint three individuals to an Appellate Review Committee, composed of members of the Governing Body or others, including but not limited to reputable persons outside MD Anderson.

(2) The Appellate Review Committee may consider the record upon which the recommendation was made, the Hearing Record, including the hearing transcripts and exhibits, post-hearing statements, the findings and recommendations of the ECMS and Hearing Panel and any other information that it deems relevant, and recommend final action to the Governing Body.

(3) Each party will have the right to present a written statement in support of its position on appeal. The party requesting the appeal will submit a statement first and the other party will then have 10 Days to respond. In its sole discretion, the Appellate Review Committee may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

(4) When requested by either party, the Appellate Review Committee may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Additional evidence will be accepted only if the Appellate Review Committee determines that the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied.

SECTION 6.0 GOVERNING BODY ACTION.

6.1. Final Decision of the Governing Body.

(1) The Governing Body will take final action within 30 Days after it (i) considers the appeal as an Appellate Review Committee, (ii) receives a recommendation from a separate Appellate Review Committee, or (iii) receives the Hearing Panel's report when no appeal has been requested.

(2) The Governing Body may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the ECMS, Hearing Panel, and Appellate Review Committee (if applicable).

(3) Consistent with its ultimate legal authority for the operation of MD Anderson and the quality of care provided, the Governing Body may adopt, modify, or reverse any recommendation that it receives or refer the matter for further review.

(4) The Governing Body will render its final decision in writing, including the basis for its decision, and will send Special Notice to the individual. A copy will also be provided to the Chief Medical Executive.

(5) Except where the matter is referred by the Governing Body for further review, the final decision of the Governing Body will be effective immediately and will not be subject to further review.

6.2. Right to One Hearing and One Appeal Only.

No individual will be entitled to more than one hearing and one appeal on any matter.

SECTION 7.0 GOVERNING BODY'S ULTIMATE AUTHORITY.

Notwithstanding any provision in this Fair Hearing Manual to the contrary, in regards to any recommendation in Section 2 of Fair Hearing Manual which triggers the Practitioner's right to request a hearing, the Governing Body shall be the ultimate authority regarding Practitioner's privileges and membership at MD Anderson, whether the Practitioner does or does not request a hearing or whether the Practitioner or the ECMS appeals the recommendations contained in the Hearing Report. In the event the Practitioner does not request a hearing, the Governing Body shall have access to the adverse recommendation which triggered Practitioner's right to a hearing, the basis for the adverse recommendation, and the documents that form the bases of the adverse recommendation.

In the event the Practitioner requests a hearing and neither the Practitioner nor the ECMS appeals the Hearing Report or recommendation(s) contained therein, the Governing Body shall have access to the Hearing Record, the hearing transcript and the Hearing Report, along with any correspondence between MD Anderson and the Practitioner about the hearing and the appeal. The Governing Body may be advised by counsel during its deliberations regarding the Practitioner's privileges and membership. The Governing Body may accept the recommendation of any committee who has considered the Practitioner's peer review, reject them all, may combine different elements of the recommendations or make a determination that is different from all other recommendations. The Chief Medical Executive shall provide to Practitioner the Governing Body's final decision and the bases for the final decision, by Special Notice. The Chief Medical Executive shall provide the same document to the ECMS.

SECTION 8.0 REPORTS TO THE NATIONAL PRACTITIONER DATA BANK AND TEXAS MEDICAL BOARD.

MD Anderson shall report actions taken against a Practitioner's Privileges and/or Membership as required by applicable state and federal laws.

SECTION 9.0 DUTY TO EXHAUST REMEDIES.

Each Practitioner agrees to follow and complete the procedures set forth in this Fair Hearing Manual, including appellate procedures, before attempting to obtain judicial relief related to any issue or decision, procedural or substantive, which may be related to or the subject of the Hearing and Appeal Procedures set forth in this Fair Hearing Manual.

Adopted as revised by the Executive Committee of the Medical Staff of the University of Texas MD Anderson Cancer Center, 12/17/2024.

Lara Bashoura MD

Lara Bashoura, M.D.
Chair, Executive Committee of the Medical Staff
Confirmed vote of approval of the ECMS on 12/18/2024.

Jeffrey E. Lee, M.D.

Jeffrey Lee, M.D.
Chief Medical Executive
Reviewed on 12/18/2024.

Peter WT Pisters, M.D.
President/Governing Body
Approved on 12/23/2024.

ORGANIZATIONAL MANUAL
OF THE MEDICAL STAFF BYLAWS
UNIVERSITY OF TEXAS MD ANDERSON CANCER CENTER

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ORGANIZATIONAL MANUAL
OF THE MEDICAL STAFF BYLAWS
THE UNIVERSITY OF TEXAS MD ANDERSON CANCER CENTER

SECTION 1.0 GENERAL

This Organizational Manual expands upon the provisions of Articles V, VII, and VIII in the Medical Staff Bylaws. It details the composition, duties, and meeting requirements for the standing committees of the Medical Staff other than those addressed in the Medical Staff Bylaws, and lists the Divisions and Departments approved by the ECMS and the Governing Body and subject to the Medical Staff Bylaws and this Organizational Manual.

The definitions in the Medical Staff Bylaws, as well as any additional definitions set out below, shall be applicable herein and this Organizational Manual is subject to and governed by the Medical Staff Bylaws. In the event of a conflict between this Organizational Manual and the Medical Staff Bylaws, the Medical Staff Bylaws shall control.

Advanced Practice Providers (APPs) at MD Anderson will be appointed to those Medical Staff committees, subcommittees, advisory committees, ad hoc committees, or task forces pertaining to clinical services and patient care, such as the Medical Practice Committee, the Medical Record Committee, and the Infection Control Committee, and others.

SECTION 2.0 STANDING COMMITTEES OF THE MEDICAL STAFF

2.1. Committees Generally

2.1.1. Committee Chairs.

a. Qualifications & Appointment. Unless otherwise provided in the Medical Staff Bylaws or this Organizational Manual, the committee chair for each standing committee (other than the ECMS and CCMS) shall be a voting Member of the Medical Staff in good standing appointed and removed by the Chair of the ECMS, in consultation with the Chief Medical Executive. Committee Chairs shall vote only in the event of a tie. All committee chairs must maintain the above qualifications throughout the term of their office.

b. Term. Unless otherwise provided in the Medical Staff Bylaws or this Organizational Manual, committee chairs shall serve for a term of three (3) years, and may serve no more than two consecutive terms without an intervening period of at least one year.

c. Vacancy. If a committee chair fails to continuously possess the above qualifications, they shall be automatically removed from their position, creating an automatic vacancy. A vacancy in a committee chair shall be filled in accordance with subsection 2.1.1(a) above.

2.1.2. Committee Members.

a. Appointment. Unless otherwise provided in the Medical Staff Bylaws or this Organizational Manual, members of the Medical Staff committees (other than the ECMS and CCMS) shall be appointed by the committee chair in consultation with the Chair of the ECMS and the Chief Medical Executive. All members of the Medical Staff committees will be appointed as voting members unless otherwise stated in the Medical Staff Bylaws or this Organizational Manual.

   i. The Chair of the ECMS and the Chief Medical Executive will maintain and periodically review Medical Staff committee membership and voting rosters.

b. Attendance at Meetings. All voting members appointed to a Medical Staff committee are required to attend at least fifty (50%) percent of the Medical Staff committee meetings on which they are assigned to serve. Committee attendance is recorded and reviewed annually. Committee members whose attendance falls below the required fifty (50%) percent benchmark may be replaced and their committee appointments terminated as set forth in Subsection (d) below.

c. Term. Unless otherwise provided in the Medical Staff Bylaws or this Organizational Manual, committee members shall serve for a term of three (3) years and may serve consecutive terms.

d. Removal. Unless otherwise provided in the Medical Staff Bylaws or this Organizational Manual, members of the Medical Staff committees (other than the ECMS and CCMS) may be removed by the committee chair in consultation with the Chair of the ECMS and the Chief Medical Executive, or by the Chair of the ECMS in consultation with the Chief Medical Executive.

e. Ex Officio Members. Unless otherwise provided in the Medical Staff Bylaws or this Organizational Manual, the Chair of the ECMS, the President, and the Chief Medical Executive shall serve as an Ex Officio member of all Medical Staff committees, without a vote.

f. Clinical Trainees. Unless otherwise provided in the Medical Staff Bylaws or this Organizational Manual, the Chair of the ECMS in consultation with the applicable committee chair may appoint one (1) or more resident, fellow, or intern (each a "Clinical Trainee") to serve as a non-voting member on a committee whose actions affect Clinical Trainee education or patient care. Clinical Trainee members will serve a term of not more than three (3) years and may be removed in accordance with Section 2.1.2(c) above. Clinical Trainees may not be appointed to the following Medical Staff committees:

   i. Executive Committee of the Medical Staff (ECMS);

   ii. Credentials Committee of the Medical Staff (CCMS);

   iii. Bylaws Committee; or

   iv. Practitioner Peer Assistance Committee.

2.1.3. Committee Meetings.

a. Regular Committee Meetings. Unless otherwise provided in the Medical Staff Bylaws or this Organizational Manual, each Standing and Advisory Committee of the Medical staff shall meet at least nine (9) times per year and maintain a record of its proceedings and actions.

b. Ad Hoc Committee and Task Force Meetings. Unless otherwise provided in the Medical Staff Bylaws or this Organizational Manual, each Ad Hoc Committee and Task Force shall schedule meetings as often as necessary to address specific Medical Staff and institutional needs, but shall meet not less than annually.

c. Special Meetings. Special meetings of a standing Medical Staff committee may be called at any time by the committee chair, the Chair of the ECMS, or the Chief Medical Executive. Notice of the special meeting shall be sent to all committee members and shall state the purpose of the special meeting. No business shall be transacted at any special meeting, except that stated in the Notice of such meeting.

d. Electronic Meetings. At the discretion of the committee chair, a Medical Staff committee meeting may be conducted by telephone or video conference or other reliable virtual or electronic means the committee chair deems appropriate, which shall be deemed to constitute a meeting of the committee for the matters discussed and action taken during such electronic meeting.

e. Quorum and Voting. Quorum and voting requirements for the standing committees of the Medical Staff shall be as set forth in Section 7.3 of the Medical Staff Bylaws.

2.2. Bylaws Committee

2.2.1. Composition. The Bylaws Committee shall include at least three (3) members of the ECMS and at least three (3) additional Members of the Medical Staff, one of whom shall also be a member of the CCMS. The committee shall also include two (2) non-physician clinical professionals, a representative from MD Anderson's Department of Legal Services, and a representative from Medical Staff Services, all of whom shall be voting members.

2.2.2. Duties. The Bylaws Committee shall be responsible to:

a. periodically review the Medical Staff Bylaws and the supplemental documents for necessary changes or modifications;

b. review any requests for amendments or for adoption of new bylaws or supplemental documents from the ECMS or the Chief Medical Executive;

c. assist in coordinating any changes to Medical Staff or other policies that may become necessary as a result of changes made to the Medical Staff Bylaws or supplemental documents; and

d. make recommendations to the ECMS and the Governing Body as to the types of issues that should be addressed in the Medical Staff Bylaws, supplemental documents, or policies, and the criteria and standards to be used to make such determinations.

2.2.3. Meetings. The Bylaws Committee shall schedule meetings as needed and meet at least annually.

2.2.4. Reporting. The Bylaws Committee shall report and make recommendations to the ECMS.

2.3. Clinical Ethics Committee (CEC)

2.3.1. Composition. The Clinical Ethics Committee shall have multidisciplinary representation to serve as a resource for patients, families, faculty, staff, trainees and administration regarding patient care-related ethical conflicts. The committee shall include a minimum of eighteen (18) active voting members to include nine (9) physicians, three (3) nurses, three (3) other ancillary staff, two (2) community members and one (1) Clinical Trainee.

Membership to the committee shall be staggered so that one-third of the membership will rotate off the CEC each year. No alternates may be designated.

Ex-officio non-voting members may include Legal Counsel.

2.3.2. Duties. The CEC shall be charged with managing the Medical Review process when conflicts arise between or among clinicians regarding patient care management, and when conflicts arise between an attending physician and a patient regarding life-sustaining treatment, in accordance with the Clinical Ethics Consultation Policy (MD Anderson Institutional Policy #CLN0461. The committee will additionally review, revise, and/or make recommendations regarding ethically sensitive policies and procedures that impact the care of patients. The committee will also aid in identifying and addressing ethical issues in clinical practice by measuring and monitoring outcomes of ethics interventions, collecting descriptive data relating to ethics, and by tracking trends to identify educational opportunities or policy needs.

2.3.3. Meetings. The CEC shall meet as needed on call of the committee chair, but not less than quarterly.

2.3.4. Reporting. The CEC shall report and make recommendations to the ECMS.

2.4. Credentials Committee of the Medical Staff (CCMS)

The Composition, duties, meetings and reporting, and standards and procedures of the Credentials Committee of the Medical Staff (CCMS) shall be as set forth in Article VII, Section 7.6 of the Medical Staff Bylaws.

2.5. Executive Committee of the Medical Staff (ECMS)

The Composition, duties, meetings and reporting, and standards and procedures of the Executive Committee of the Medical Staff (ECMS) shall be as set forth in Article VII, Section 7.5 of the Medical Staff Bylaws.

2.6. Infection Control Committee

2.6.1. Composition. The Infection Control Committee shall have multidisciplinary membership as follows:

a. at least three (3) Members each from the Divisions of Internal Medicine and Surgery, one (1) Member each from the Divisions of Anesthesiology, Critical Care, and Pain Medicine, Diagnostic Imaging, Cancer Medicine, Cancer Prevention and Population Sciences, Infection Control, Radiation Oncology, Pediatrics, and Pathology/Laboratory Medicine, all with voting rights;

b. the Infection Preventionists, those individuals designated as Infection Control Practitioners, and the Associate Vice President, EHSSEM, all with voting rights;

c. ex-officio, voting representatives from the departments of Nursing, Employee Health Services (either a Physician or registered nurse), and Environmental Health and Safety; and

d. ex-officio, non-voting members may include the Chief Administrative Quality Officer, the Chief Quality Officer, and representatives from Clinical Operations, Medical Informatics, Facility Management, Clinical Engineering, Environmental Health & Safety, High-Level Disinfection & Sterilization, Institutional Compliance, Patient Safety & Accreditation, Respiratory Care, Sterile Processing Department, Transportation, Operating Room, Pharmacy, Materials Management, Dietary and Food Service, and Safety and Quality Improvement.

2.6.2. Chair.

a. The institution's Chief Infection Control Officer (CICO) will be appointed by the Chief Administrative Quality Officer (CAQO) in conjunction with the Chief Operating Officer (COO) and approved by a majority vote of the Executive Committee of the Medical Staff (ECMS).

b. The CICO will function as the Chair of the Infection Control Committee.

c. The CICO may be removed as Chair of the Infection Control Committee by the affirmative vote of at least two-thirds (2/3rd) of the voting members of the ECMS without impact to their institutional appointment as CICO.

d. If the CICO fails to continuously meet the qualifications of a committee chair as outlined in Section 2.1.1 above, they shall be automatically removed from their position as outlined in Section 2.1.1 above, without impact to their institutional appointment as CICO.

e. A vacancy in the position of Chair of the Infection Control Committee shall be filled in accordance with Section 2.1.1 above. The Member appointed to fill the vacancy shall serve until a new CICO is appointed and approved by a majority vote of the ECMS or until removed in accordance with Section 2.1.1 above.

f. The Chair of the Infection Control Committee may serve consecutive terms without limit.

2.6.3. Duties. The Infection Control Committee has the responsibility and authority to:

a. maintain a continuing survey of infectious risks within the MD Anderson facilities;

b. determine the type of surveillance, reporting, and intervention programs to be utilized within the facilities, and evaluate and make recommendations as to the effectiveness of those programs;

c. provide standard criteria for reporting all types of infections, including without limitation respiratory, gastrointestinal, surgical wound, skin, urinary tract, and those relating to intravascular catheters and septicemias; and

d. review, evaluate, and recommend policies and procedures designed to minimize infection within the facilities.

2.6.4. Reporting. The Infection Control Committee shall report its findings, interventions, results, and recommendations to the ECMS, and the Quality Assessment and Performance Improvement (QAPI) Council. In addition, the committee may forward its findings and recommendations as necessary and appropriate to the Chief Medical Executive, the Head of the Division of Nursing as pertinent to the quality of care provided by employees within that division, or to the applicable the Division Heads or Department Chairs for use in medical peer review and/or professional review activity.

2.7. Medical Practice Committee

2.7.1. Composition. The Medical Practice Committee shall be composed of at least five (5) Members of the Active Staff. The Chief Quality and Value Officer, Chief Patient Safety Officer, and Senior Vice-President & Chief Nursing Officer shall be Ex-officio members without vote. Other members with or without voting rights may be appointed by the committee chair in accordance with Section 2.1.2 above, contingent on the needs of the committee.

2.7.2. Duties. The Medical Practice Committee shall be advisory to the ECMS in the overall planning and recommendations of policies, programs, services, and facilities to advance the quality of patient care, treatment, and services rendered by Practitioners and others holding Clinical Privileges at the Hospital. The Medical Practice Committee shall address concerns of the Medical Staff relating to Practitioner-delivered care, especially in those areas where two (2) or more disciplines are involved. It shall recommend policies and procedures to the ECMS and the CCMS to promote the most efficient utilization of professional services. The Medical Practice Committee shall oversee the advisory committees further detailed below.

2.7.3. Advisory Committees. The Medical Practice Committee may utilize the following Advisory Committees:

a. Acute and Critical Care Advisory Committee. The Acute and Critical Care Advisory Committee shall have multidisciplinary membership composed of at least one (1) physician member from the Department of Pediatrics, the Divisions of Internal Medicine, Surgery, Anesthesiology, Critical Care and Pain Medicine, and Cancer Medicine. Other members will include at least one (1) Advanced

Practice Provider, the Nursing Director of the ICU, and representatives from Cardiac Monitoring Services, Diagnostic Imaging, the Acute Cancer Care Center, Laboratory Medicine, Pharmacy, the Nocturnal Program and the Hematology and Oncology Fellowship program. The Director of the Nocturnal Program, the Director of Cardiac Monitoring, and the VP Inpatient Medical Operations shall serve as Ex-officio members without a vote. Other members may be appointed as needed in accordance with Section 2.1.2 above.

The Acute and Critical Care Advisory Committee reviews and approves policies and procedures pertaining to admission and discharge guidelines, bed allocation, and patient care processes of the acute and critical care services for the institution. It also provides direction in matters dealing with acute and critical care quality improvement processes, evaluates outcomes of critical care, prioritizes and recommends opportunities for improvement.

The Acute and Critical Care Advisory Committee shall report and make recommendations as to operations and quality of patient care, treatment, and services in the acute and critical care areas to the ECMS through the Medical Practice Committee.

b. Operating Room Advisory Committee. The Operating Room Advisory Committee shall have multidisciplinary membership to include without limitation representation from the Division of Anesthesiology, Critical Care, and Pain Medicine, and the Division of Surgery. It shall report and make recommendations as to operations and the quality of care for perioperative services (the OR suite, OR materials management and sterile processing, the preoperative evaluation and management center (POEM), PACU, pre-op holding and surgical scheduling areas). The Operating Room Advisory Committee shall report its findings and recommendations to the ECMS through the Medical Practice Committee.

c. Clinical Effectiveness Advisory Committee**.** The Clinical Effectiveness (CE) Advisory Committee shall have voting representation from full-time Active Staff members representing their medical staff departments**.** The Clinical Effectiveness Advisory Committee shall also include designated leaders from Nursing and Pharmacy. Multidisciplinary Members in addition include but are not limited to: Nursing Practice Congress Chair, Advanced Practice Providers, Clinical Effectiveness, Research Library, Clinical Operations Informatics and others as deemed appropriate by the chair in accordance with Section 2.1.2 above.

Ad hoc members will be asked to participate when a question requires their expertise. Ex-officio Members include but are not limited to: Chair of Medical Practice Committee and Chief Quality and Value Officer. Non-voting members include, but are not limited to: Ex-officio members, ad hoc members and multidisciplinary members with the exception of a clinical pharmacist and nursing representative. In the event of a tie, the Chair shall have a casting vote.

The Clinical Effectiveness Advisory Committee will:

- Plan, prioritize, and maintain Algorithms and Institutional Order Sets for patient care delivery

- Review the clinical content and provide feedback to the clinicians related to the Algorithms and Institutional Order Sets

- Work with workgroups to review the evidence and national standards or core measures and develop patient care tools (Algorithms, Order Sets and/or Plans of Care) as appropriate for our patient population

- Fulfill all requirements of a "Cancer Committee" of the American College of Surgeons, including supervision of the Cancer Registry

- Approve all policies and order sets proposed by the Clinical Biomarker Oversight Task Force (CBOT), the Order Task Force, and the Pain Task Force.

- Provide oversight for pain management, safe opioid prescribing which includes development of protocols, establishing and monitoring quality metrics and review of relevant performance improvement activities and data

The Clinical Effectiveness Advisory Committee shall report and make recommendations to the ECMS through the Medical Practice Committee.

2.7.4. Reporting. The Medical Practice Committee shall report and make recommendations to the ECMS.

2.8. Medical Records Committee

2.8.1. Composition. The Medical Records Committee shall have a multidisciplinary membership composed of the following voting members:

a. One representative each from at least two-thirds of the clinical Departments set forth in Section 4.0 below, recommended by the applicable Department Chair and appointed in accordance with Section 2.1.2 above. No Department may have more than one member serving on the Medical Records Committee.

b. Two representatives from the Division of Nursing and.

c. One representative each from Inpatient Nursing, Nursing Professional Development, Pharmacy, and Social Work.

d. One Physician Assistant representative.

e. The Vice President and Chief Information Officer and/or the Vice President, Digital Operations, and the Director of Health Information Management Services, shall serve as ex-officio members with a vote.

f. Representatives from the following departments or areas shall also serve as non-voting members of the committee:

- Electronic Medical Records (Director).
- Legal Services.
- Institutional Compliance.
- Case Management.
- Management Information Systems.
- Quality Improvement.
- Rehabilitation Services.

g. Other members with or without voting rights may be appointed by the committee chair in accordance with Section 2.1.2 above, contingent on the needs of the committee.

2.8.2. Duties. The Medical Records Committee shall recommend policies and procedures designed to assure that the content of the medical record is sufficient to provide continuity of patient care and facilitate communication between health care providers, as well as compliance with documentation requirements for legal reimbursement and accreditation purposes. The committee shall recommend methods of enforcement of existing policies surrounding the medical record and shall approve forms or formats to be used in the medical record, including both the paper chart and computerized record.

2.8.3. Advisory Committees. The Medical Records Committee shall also utilize an Interdisciplinary Documentation Advisory Committee (IDC) to assist in accomplishing its duties. Membership of the IDC shall be multidisciplinary and include at least one (1) Member of the Medical Staff and representative(s) from the departments of Nursing, Health Information Management Services, Legal Services, Pharmacy, Quality Improvement, and other departments as deemed appropriate by the chair of the committee. The IDC is responsible for reviewing any new or revised patient care forms that contain patient health information that may be placed into the medical record in accordance with legal or accreditation requirements. The IDC oversees the process of ongoing medical record review. The IDC shall schedule meetings as needed to address Medical Staff and institutional needs and meet not less than annually. It shall report to the Medical Record Committee.

2.8.4. Reporting. The Medical Records Committee shall report and make recommendations to the ECMS.

2.9. Pharmacy and Therapeutics Committee

2.9.1. Composition. The Pharmacy and Therapeutics Committee shall have multidisciplinary membership with at least one (1) Member each from the Departments of:

- Anesthesiology and Perioperative Medicine

- Breast Medical Oncology
- Cardiology
- Critical Care Medicine
- Diagnostic Imaging
- Emergency Medicine
- Gastroenterology, Hepatology & Nutrition
- Gastrointestinal Medical Oncology
- General Internal Medicine
- Gynecologic Oncology & Reproductive Medicine
- Infectious Diseases, Infection Control and Employee Health
- Leukemia
- Lymphoma/Myeloma
- Laboratory Medicine
- Neuro-Oncology
- Pediatrics
- Pulmonary Medicine
- Radiation Oncology
- Stem Cell Transplantation & Cellular Therapy
- Surgical Oncology
- Thoracic/Head & Neck Medical Oncology

The Department representatives shall be voting members. Representatives of the departments of Pharmacy and Nursing shall also serve as voting members of the committee. Other members with or without voting rights may be appointed by the committee chair in accordance with Section 2.1.2 above, contingent on the needs of the committee.

2.9.2. Duties. The duty of this committee is to promote the safe, rational, and effective use of medications for the patients served at MD Anderson, including without limitation:

a. formulating policies regarding evaluation, selection, and therapeutic use of drugs and related devices;

b. overseeing the review process for medication additions to and deletions from the Pharmacy Formulary and Therapeutic Index using information based on the highest level of evidence reasonably available to include cost-effectiveness and budget impact where appropriate (this process is established in the Formulary Management System (FMS) which includes without limitation: tracking of pipeline drugs, review of potential for use in the MD Anderson patient population, clinical outcomes, patient preferences, cost, and reimbursement);

c. establishing, providing direction and oversight for, assessing the effectiveness of, and implementing the recommendations of advisory committees and task forces as required to meet the charge of the Pharmacy and Therapeutics Committee to promote safe and effective medication therapy and systems and, when indicated, to conduct additional review of safety, potential for medication errors, inappropriate use, and necessity of restriction;

d. managing the MD Anderson adverse drug reaction (ADR) reporting program, to include without limitation ADR collection, trending, intensive review, analysis of serious adverse drug events and significant medications errors, and forwarding data to appropriate committees and appropriate areas for medical peer review and/or professional review activity; and

e. initiating, directing, and evaluating other oversight activities relevant to safe and effective medication therapy and systems, including without limitation drug infusion devices, medication related policies, contracts, outcomes, and regulatory compliance.

2.9.3. Advisory Committees. The Pharmacy and Therapeutics Committee may utilize the following advisory committees:

a. Medication Use Safety Team (MUST). The MUST Advisory Committee shall have multidisciplinary membership, be chaired by a Member of the Medical Staff, and be co-facilitated by representatives from the departments of Pharmacy and Quality Improvement. The purpose of the MUST Advisory Committee is to identify, review, and address the medication use system and critical processes with the system with a focus on medication safety. The objective of the MUST Advisory Committee is to reduce the risk of adverse events related to medication use including without limitation the identification and elimination of sources of potential error in the medication process.

b. Medication-Related Clinical Decision Support Advisory Committee. The Medication-Related Clinical Decision Support Advisory Committee shall have multidisciplinary membership, be chaired by a Member of the Medical Staff, and be co-facilitated by representatives from the departments of Pharmacy and Quality Improvement. The purpose of the Medication-Related Clinical Decision

Support Advisory Committee is designing and implementing medication-related CDS content, defining which and how users interact with CDS, prioritizing the order of development for new CDS and delegation of content development. In addition, it will also monitor performance of the CDS system and determine data-driven strategies for improvements, and facilitate bidirectional communication channels to foster feedback from and disseminate information to end-users.

2.9.4. Reporting. The Pharmacy and Therapeutics Committee shall report and make recommendations to the ECMS.

2.10. Practitioner Peer Assistance Committee

2.10.1. Composition. The Practitioner Peer Assistance Committee (PPAC) shall be composed of at least five (5) voting members including at least one (1) Licensed Professional, one (1) psychiatrist or psychologist, one (1) APP, and, as feasible, one (1) individual in stable recovery (defined as at least two (2) years of abstinence). Depending on the particular circumstances membership may be expanded on an ad hoc basis by the committee chair in accordance with Section 2.1.2 above.

2.10.2. Duties. The PPAC provides education, peer support, and resources to Practitioners and others granted Clinical Privileges at the Hospital around the issues of stress and impairment. The committee shall act pursuant to written policy which shall be separate from the disciplinary action process set forth in the Medical Staff Bylaws. *[Practitioner Health and Impairment Policy CLN0619]*

2.10.3. Meetings. The PPAC shall meet as needed on call of the committee chair, but not less than annually. Members of the committee shall attend at least 75% of all meetings, or be subject to removal by the committee chair in conjunction with the Chair of the ECMS, or by the Chair of the ECMS in conjunction with the Chief Medical Executive.

2.10.4. Reporting. The committee shall report and make recommendations to the ECMS, and other committees as set forth in written policy.

2.11. Sedation and Procedures Committee

2.11.1. Composition. The Sedation and Procedures Committee shall include one (1) Member each from the Departments of:

- Anesthesiology and Perioperative Medicine
- Cardiology
- Pulmonary Medicine
- Emergency Medicine
- Gastroenterology, Hepatology, and Nutrition

- Imaging Departments: Abdominal Imaging, Breast Imaging, Musculoskeletal Imaging, and/or Thoracic Imaging
- Interventional Radiology
- Lymphoma/Myeloma
- Pediatrics
- Urology

2.11.2. Chair. The Chair or Vice-Chair of the Sedation and Procedures Committee shall be a licensed anesthesiologist who is a doctor of medicine or osteopathy qualified by education and experience in anesthesiology services and appointed in accordance with Section 2.1.1 above.

2.11.3. Duties. The Sedation and Procedures Committee shall be responsible for oversight of the quality of care and monitoring of non-minimal risk invasive procedures that are not performed in the operating room; as well as moderate or deep sedation and other anesthesia use by non-anesthesiologists, including without limitation:

a. develop and maintain a list of non-minimal risk invasive procedures (as defined in The Joint Commission Universal Protocol);

b. develop and maintain criteria (in accordance with MD Anderson policy and legal requirements) which associate a procedure with the requirement for informed consent documentation;

c. develop and implement minimum requirements for pre-procedure, intra-procedure, and post-procedure documentation associated with procedures performed outside the operating rooms;

d. track and review all reported complications resulting from moderate or deep sedation use outside of the operating room;

e. develop and implement educational programs related to the committee's work;

f. develop and recommend to the CCMS criteria for Clinical Privileges (if requested) for non-minimal risk invasive procedures which cross departments; and

g. develop and recommend to the CCMS criteria for Clinical Privileges (if requested) for moderate or deep sedation and other anesthesia use by non-anesthesiologists.

2.11.4. Reporting. The Sedation and Procedures Committee shall report its findings and make recommendations to the ECMS.

2.12. Transfusion and Patient Blood Management Committee

2.12.1. Composition. The Transfusion and Patient Blood Management Committee shall have multidisciplinary membership including Members from the following Departments or Divisions:

- Anesthesiology and Perioperative Medicine
- Benign Hematology
- Cancer Medicine – Solid Tumor
- Critical Care Medicine
- Donor Operations
- Houston Area Locations
- Information Technology
- Interventional Radiology
- Laboratory Medicine
- Leukemia
- Lymphoma/Myeloma
- Nursing – Ambulatory Treatment Center
- Nursing – Hematology nursing units
- Office of Performance Improvement
- Operations, Hospital and Clinics
- Pathology
- Pediatrics
- Pharmacy
- PLM Quality and Regulatory Management
- Stem Cell Transplantation & Cellular Therapy
- Surgical Oncology
- Thoracic & Cardiovascular Surgery

- Transfusion Service

Other ex officio members with or without voting rights may be appointed by the Transfusion and Patient Blood Management Committee chair in accordance with Section 2.1.2 above, contingent on the needs of the committee. Membership to the committee shall be staggered. Ex-officio non-voting members may include the Chief Quality Officer and representatives from clinical operations.

2.12.2. Duties. The Transfusion and Patient Blood Management Committee shall be charged with the multidisciplinary coordination of blood management practices at MD Anderson in compliance with national guidelines and regulations and best practices in health care. Coordination shall involve standardization, where possible, and include all phases of blood and blood product management including: collecting, processing, transporting, testing, ordering, distributing/dispensing, handling and administering product as well as monitoring the outcomes of transfusions and analyzing confirmed transfusion reactions and adverse events. In so doing, the Transfusion and Patient Blood Management Committee will actively promote patient safety, work to improve outcomes and optimize resource utilization.

a. Evaluate blood product utilization metrics and trends in the clinical and research services, including but not limited to the assessment of potential need for blood usage, pre-transfusion testing and evaluation, identification of pre-surgical and nonsurgical anemia, optimization of patient coagulation function.

b. Determine the type of reporting and intervention programs to be utilized for transfusion reactions, blood loss due to laboratory testing, care of patients who decline the use of blood or blood- derived products, massive transfusions and other programs.

c. Review outcomes and evidence-based metrics and collaborate with other committees and groups to educate providers.

d. Review, evaluate and recommend ordering tools, policies and procedures designed to promote compliance to regulatory guidelines.

2.12.3. Reporting. The Transfusion and Patient Blood Management Committee shall report and make recommendations to the ECMS.

2.13. Utilization Review (UR) Committee

2.13.1. Composition. The Utilization Review Committee shall be composed of:

a. At least two (2) Members of the Medical Staff;

b. Representatives from Case Management and other departments, in accordance with the Utilization Review Plan (UR Plan) and as appropriate; and

c. At least two (2) Physician Advisors, and preferably all Physician Advisors.

i. Physician Advisors must be Members of the Medical Staff in Good Standing and must have completed formal physician advisor training as approved by the Vice President of Inpatient Medical Operations.

ii. Physician Advisors will be appointed by the Vice President of Inpatient Medical Operations and approved by a majority vote of the Executive Committee of the Medical Staff (ECMS).

iii. Physician Advisors may be removed from their appointment as advisor (and hence their Utilization Review Committee membership, unless otherwise reappointed by the committee chair in conjunction with the Chair of the ECMS) by the affirmative vote of at least two-thirds (2/3rd) of the voting members of the ECMS, or by the Vice President of Inpatient Medical Operations subject to approval by majority vote of the ECMS.

2.13.2. Duties. The Utilization Review Committee shall have oversight of appropriate systems' resource utilization. In compliance with CMS and the State of Texas requirements, the multi-disciplinary membership of the UR Committee shall be responsible for the UR plan that provides for review of services provided by the institution to all patients by Practitioners and others granted Clinical Privileges at the Hospital, including patients entitled to benefits under Medicare and Medicaid and other programs. The committee is responsible for verification through review of records and reports and interviews that UR activities are being performed as described in the UR plan.

The UR plan describes the procedures for review of the medical necessity of admissions, duration of stay, the appropriateness of the setting, the medical necessity of extended stays, and the medical necessity of professional services and outlier cases.

2.13.3. Meetings. The UR Committee shall meet at least six (6) times per year.

2.13.4. Reporting. The UR Committee shall report and make recommendations to the ECMS and the QAPI Council as set forth in the UR Plan.

SECTION 3.0 DIVISIONS

The following is a list of the Clinical Divisions approved by the ECMS and the Governing Body and subject to the Medical Staff Bylaws:

- Anesthesiology, Critical Care and Pain Medicine Division *(ACCPM)*
- Cancer Medicine *(CM)*
- Cancer Prevention & Population Sciences (*CPPS*)
- Diagnostic Imaging *(DI)*
- Internal Medicine *(IM)*
- Pathology/Laboratory Medicine *(PLM)*

- Pediatrics *(P)*
- Radiation Oncology *(RO)*
- Surgery *(S)*

SECTION 4.0 DEPARTMENTS

The following is a listing of the Clinical Departments *(with the assigned Division in parenthesis using the abbreviations noted above)* approved by the ECMS and the Governing Body and subject to the Medical Staff Bylaws:

- Abdominal Imaging *(DI)*
- Anesthesiology and Perioperative Medicine (*ACCPM*)
- Behavioral Science *(CPPS)*
- Breast Imaging *(DI)*
- Breast Medical Oncology *(CM)*
- Breast Radiation Oncology (*RO*)
- Breast Surgical Oncology *(S)*
- Cardiology *(IM)*
- Clinical Cancer Prevention *(CPPS)*
- Colon & Rectal Surgery *(S)*
- Critical Care Medicine *(ACCPM)*
- Central Nervous System (CNS) Radiation Oncology *(RO)*
- Dermatology *(IM)*
- Emergency Medicine *(IM)*
- Endocrine Neoplasia & Hormonal Disorders *(IM)*
- Gastroenterology, Hepatology and Nutrition *(IM)*
- Gastrointestinal Medical Oncology *(CM)*
- Gastrointestinal Radiation Oncology *(RO)*

- General Internal Medicine *(IM)*
- General Oncology *(CM)*
- Genitourinary Medical Oncology *(CM)*
- Genitourinary Radiation Oncology *(RO)*
- Gynecologic Oncology & Reproductive Medicine *(S)*
- Head & Neck Surgery *(S)*
- Hematopathology *(PLM)*
- Hospital Medicine *(IM)*
- Imaging Physics *(DI)*
- Infectious Diseases, Infection Control and Employee Health *(IM)*
- Interventional Radiology *(DI)*
- Investigational Cancer Therapeutics *(CM)*
- Laboratory Medicine *(PLM)*
- Leukemia *(CM)*
- Lymphoma/Myeloma *(CM)*
- Melanoma Medical Oncology *(CM)*
- Musculoskeletal Imaging *(DI)*
- Neuro-Oncology *(CM)*
- Neuroradiology *(DI)*
- Neurosurgery *(S)*
- Nuclear Medicine *(DI)*
- Orthopaedic Oncology *(S)*
- Pain Medicine *(ACCPM)*

- Palliative, Rehabilitation, and Integrative Medicine *(CM)*
- Pathology *(PLM)*
- Pediatrics *(P)*
- Plastic Surgery *(S)*
- Psychiatry *(IM)*
- Pulmonary Medicine *(IM)*
- Radiation Oncology *(RO)*
- Radiation Physics (*RO*)
- Sarcoma Medical Oncology *(CM)*
- Stem Cell Transplantation & Cellular Therapy *(CM)*
- Surgical Oncology *(S)*
- Thoracic/Head & Neck Medical Oncology *(CM)*
- Thoracic & Cardiovascular Surgery *(S)*
- Thoracic Imaging *(DI)*
- Thoracic Radiation Oncology (*RO*)
- Urology *(S)*

SECTION 5.0 CATEGORIES OF ALLIED HEALTH PROFESSIONALS

The categories of Allied Health Professionals as recommended by the Executive Committee of the Medical Staff and approved by the Board are:

- Audiologists;
- Bone Marrow Aspiration Technicians;
- Licensed Clinical Social Workers;
- Licensed Professional Counselors;
- Surgical Assistants;

- Speech Language Pathologists; and
- Such other categories of AHPs approved by the ECMS and the Governing Body.

Adopted as revised by the Executive Committee of the Medical Staff of the University of Texas MD Anderson Cancer Center, 12/17/2024.

Lara Bashoura MD

Lara Bashoura, M.D.
Chair, Executive Committee of the Medical Staff
Confirmed vote of approval of the ECMS on 12/18/2024.

Jeffrey E. Lee, M.D.

Jeffrey Lee, M.D.
Chief Medical Executive
Reviewed on 12/18/2024.

Peter WT Pisters, M.D.
President/Governing Body
Approved on 12/20/2024.