BYLAWS

and

RULES and REGULATIONS

of the

Professional Staff

Kaiser Foundation Hospitals – Moanalua

Honolulu, Hawaii 96819

Published by
The Professional Staff of
Kaiser Foundation Hospital
Located at
3288 Moanalua Road
Honolulu, Hawaii 96819

PROFESSIONAL STAFF BYLAWS

KAISER FOUNDATION HOSPITALS – Moanalua

915506 v3
11/24/2014

THE BYLAWS OF THE PROFESSIONAL STAFF OF KAISER FOUNDATION HOSPITALS – Honolulu, Hawaii

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PREAMBLE

In order to establish principles and procedures to assure that acceptable standards of professional practice are maintained at Kaiser Foundation Hospitals, Honolulu, Hawaii, and in order to provide an organization through which such principles and procedures may be made effective, this Professional Staff organization is formed, and the Bylaws and the Rules and Regulations hereafter set forth are adopted.

This organization recognizes that Kaiser Foundation Hospitals, a California nonprofit public benefit corporation, is the owner and operator of the Hospital. The Board of Directors of Kaiser Foundation Hospitals, as the Governing Body of Kaiser Foundation Hospitals, Honolulu, Hawaii, has the ultimate responsibility for the proper functioning of the Hospital and for all related matters.

Providing professional medical care and treatment of patients is the responsibility of the Professional Staff. The primary reason for this organization is to promote the effectiveness of the Professional Staff in carrying out this responsibility.

The Board of Directors recognizes that the standards and effectiveness of hospital services and medical care and treatment depend largely upon the Professional Staff, and desires active Professional Staff assistance and cooperation for maintaining acceptable standards of medical care, treatment, safety and hospital services for all persons admitted to or treated in the Hospital.

The Professional Staff and the Board of Directors mutually recognize that the interests of hospital patients will be best served and protected by concerted and cooperative effort on the part of all the Professional Staff practicing at the Hospital, acting with the support and cooperation of the Board of Directors.

Kaiser Foundation Hospitals, Honolulu, Hawaii, is a community hospital, intended to and morally obligated to provide, to the best of its ability, for the hospital needs of persons in the community, without unlawfully discriminating on the basis of any person's race, creed, religion, preexisting medical condition, mental or physical disability, sex, age, color, ethnicity, sexual orientation, national origin, citizenship, insurance status, economic status or ability to pay for medical services.

The principal purpose of the Professional Staff is to maintain and improve standards of health care for all persons served by the Hospital.

ARTICLE A: NAME, PURPOSES, AUTHORITY AND DEFINITIONS

SECTION A-1. NAME.

The name of this organization shall be the "Professional Staff of Kaiser Foundation Hospitals, Honolulu, Hawaii."

SECTION A-2. PURPOSES.

The purpose of this organization shall be:

a. To foster, promote and oversee the quality of health care, toward the objective that all persons admitted to the Hospital or treated in the Emergency Department shall receive appropriate, cost-effective care of a quality consistent with acceptable standards of hospital and professional practice.

b. To promote and foster continuing education and maintain acceptable educational standards through conduct of a comprehensive staff education program, including staff and departmental meetings and conferences, conferences in clinical pathology, study of selected individual cases and groups of cases, lectures, demonstrations, instructional courses by knowledgeable persons in the profession, and maintenance of library facilities.

c. To foster and promote acceptable standards of performance of the medical administrative responsibilities of the Professional Staff, particularly with respect to the preparation and maintenance of medical records.

d. To foster, promote and maintain acceptable professional, technical and ethical standards, and in furtherance of such purpose, to review and make recommendations regarding all staff appointments and grants of hospital privileges, including delineation of hospital privileges and review of practitioners' practices within the Hospital.

e. To encourage medical knowledge and education by supporting medical research and fostering the conduct of medical research programs appropriate to the facilities of the Hospital and the interests and special abilities of members of the Professional Staff.

f. To provide a structure for Professional Staff activities and accountability to the Board of Directors.

g. To offer a means whereby problems of a medical administrative nature which have not been resolved at the hospital level may be discussed by the Professional Staff with the Board of Directors or its representatives.

SECTION A-3. AUTHORITY.

These Bylaws and the appended Rules and Regulations are adopted, and this organization is formed, under the authority of the Board of Directors.

SECTION A-4. PROFESSIONAL STAFF RELATIONSHIP WITH THE HOSPITAL ADMINISTRATOR AND BOARD OF DIRECTORS.

The Hospital Administrator, pursuant to the Bylaws of Kaiser Foundation Hospitals, shall have primary responsibility for the management and administration of the Hospital, and shall exercise such other authority and perform such other duties as the Board of Directors of Kaiser Foundation Hospitals may assign. The Professional Staff member shall have full authority with respect to the medical, dental, psychological, or podiatric care of a patient, provided, however, that he or she observes the administrative policies of the Hospital and these Bylaws and the Rules and Regulations. In administrative matters the Professional Staff, through the Chief of Staff, shall act in an advisory capacity. Professional Staff liaison with the Board of Directors shall be maintained through the Hospital Administrator and other officers of Kaiser Foundation Hospitals.

SECTION A-5. DEFINITIONS.

As used herein:

a. *"Active Staff"*

means members of the Professional Staff meeting the qualifications set forth in Section C-1.

b. *"Administrative Staff"*

means members of the Professional Staff meeting the qualifications set forth in Section C-6.

c. *"Allied Health Professional"*

means an individual, other than a licensed physician, dentist, or podiatrist, who exercises independent judgment within the areas of his or her professional competence and the limits established by the Board of Directors, the Professional Staff and the applicable State practice acts, who is qualified to render certain limited direct or indirect medical, dental, or podiatric care under the supervision or direction of a Professional Staff member possessing privileges to provide such care in the Hospital, and who may be eligible to exercise practice privileges and prerogatives in conformity with the rules adopted by the Board of Directors, these Bylaws, and the Professional Staff Rules and Regulations. Allied Health Professionals are not eligible for Professional Staff membership. "Allied Health Professional" includes, but is not necessarily limited to, physician assistants, nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, clinical psychologists, and psychiatric social workers allowed to perform psychotherapy.

d. *"Appointment Period"*

means the term of appointment of members of the Professional Staff, specifically not more than two years.

e. *"Board of Directors"*

means the Governing Body of Kaiser Foundation Hospitals.

f. *"Bylaws"*

means these Bylaws of the Professional Staff of Kaiser Foundation Hospitals, Honolulu, Hawaii.

g. *"Chief of Staff"*

means the chief officer of the Professional Staff.

h. *"Privileges"*

means the permission granted to a Professional Staff member or Allied Health Professional to render specific clinical, diagnostic, therapeutic, medical, dental, psychological, podiatric, or surgical services in the Hospital within the limits of his or her license, registration or certification.

i. *“Clinical Psychologist”*

means an individual holding a doctoral degree in psychology or a doctoral degree considered equivalent by the state licensing board and a license to practice clinical psychology in this State.

j. “*Complete Application*”

means all information an applicant for Professional Staff membership or clinical privileges has been asked to provide during the credentialing and privileging processes described in Sections B-2.b, and B-3.a.1, has been submitted to the Hospital.

k. *“Courtesy Staff”*

means members of the Professional Staff meeting the qualifications set forth in Section C-2.

l. *“Date of Receipt”*

means, as used in Section B.4 and B.5 of these Bylaws, the date that any notice or other communication was delivered personally to the addressee, the date evidenced on the return receipt or other method confirming receipt or five (5) working days after it was deposited, as postage prepaid, First Class United States mail.

m. *“Day”*

means calendar day, including weekends and holidays.

n. *“Dentist”*

means an individual holding a D.D.S. or D.M.D. degree and licensed to practice dentistry in this State.

o. *“Governing Body”*

means the Board of Directors of Kaiser Foundation Hospitals.

p. *“Hospital”*

means Kaiser Foundation Hospitals, Honolulu, Hawaii

q. *“Hospital Administrator”*

means the individual appointed by the Board of Directors to undertake primary responsibility for the management and administration of the Hospital.

r. *“House Staff”*

means doctors of medicine, podiatry and dentistry in approved training programs in the hospital. House staff are not Professional Staff members, and as such, are not entitled to any of the rights or prerogatives of

Professional Staff members.

s. *"KFH Hospitals"*

means a hospital, ambulatory surgical center or surgical clinic under the governance of the Kaiser Foundation Hospitals Board of Directors.

t. *"Medical-Administrative Officer"*

means a practitioner who is employed by or is serving the hospital in both administrative and clinical capacities under a contract or agreement with the hospital.

u. *"Medical Disciplinary Cause or Reason"*

in Section B.4 and B.5.of these Bylaws, refers to a basis for disciplinary action involving an aspect of a practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

v. *"Medical Executive Committee"*

means the Medical Executive Committee of the Professional Staff.

w. *"Nurse Executive"*

means a licensed registered nurse qualified by advanced education and management experience who has the authority and responsibility for establishing standards of nursing practice throughout the Hospital.

x. *"Oral Surgeon"*

means an individual who holds a D.D.S. or D.M.D. degree, who has successfully completed a residency in oral surgery of at least three years duration as approved by the American Dental Association Commission on Dental Accreditation, and is licensed to practice in this State.

y. *"Physician"*

means an individual who is licensed to practice medicine or osteopathy in this State.

z. *"Podiatrist"*

means an individual who holds a D.P.M. degree and who is licensed to practice podiatry in this State.

aa. *"Practitioner"*

means, unless otherwise expressly limited, a member of the Professional Staff or an Allied Health Professional exercising privileges. As used in Section B-5, "practitioner" refers to an applicant for initial membership or a member of the Professional Staff who has requested a hearing pursuant to Section B-5 and includes physicians, podiatrists, and dentists.

bb. *“Professional Staff”*

means the formal organization of all physicians, dentists, podiatrists, licensed to practice in this State and privileged to care for patients and/or participate in Professional Staff matters in Kaiser Foundation Hospitals, Honolulu, Hawaii.

cc. *“Rules and Regulations”*

means the Rules and Regulations of the Professional Staff of Kaiser Foundation Hospitals, Honolulu, Hawaii. These Bylaws describe the fundamental principles of Professional Staff self-governance and accountability to the Board of Directors. Accordingly, the key standards for Professional Staff membership, appointment, reappointment and privileging are set out in these Bylaws. Additional provisions, including, but not limited to, administrative procedures for implementing the Professional Staff standards may be set out in Professional Staff Rules and Regulations, or in policies adopted or approved as described in these Bylaws. Upon proper adoption, as described in these Bylaws, all such Rules and Regulations and policies shall be deemed an integral part of the Professional Staff Bylaws.

ARTICLE B: MEMBERSHIP

SECTION B-1. CLASSIFICATION AND MINIMUM QUALIFICATIONS.

a. Professional Staff Classifications. All members of the Professional Staff shall be assigned to a category of Professional Staff membership in accordance with the provisions of Article C.

b. Minimum Qualifications: Licensure.

No person shall be appointed to the Professional Staff unless duly licensed to practice medicine, osteopathic medicine, dentistry, or podiatry in this State. No one shall be entitled to Professional Staff membership or to enjoy hospital privileges solely because he or she meets the foregoing minimum qualifications.

c. General Qualifications for Membership.

To qualify for and continue membership on the Professional Staff a practitioner must:

1. Document and submit evidence of his or her experience, background, training, demonstrated ability, availability, and physical and mental health status, with sufficient adequacy to demonstrate to the Professional Staff and the Board that he or she will provide care to patients at the generally recognized level of professional quality taking into account patients' needs, available hospital facilities, resources and utilization standards at the Hospital;

2. Agree to cooperate in any review of a practitioner's credentials, qualifications or compliance with the Bylaws (including one's own), any review as part of the Professional Staff's performance improvement activities, and refrain from directly or indirectly interfering, obstructing or hindering any such review by any means, including by threat of harm or liability by withholding information, or by refusing to serve or participate in assigned responsibilities;

3. Demonstrate willingness to participate in the discharge of Professional Staff responsibilities, including providing for the continuous care of his or her patients;

4. Perform a sufficient number of procedures, manage a sufficient number of cases, and have sufficient patient care contact within the Hospital or another community hospital or health care setting to permit the Professional Staff to assess the applicant's current competency for all privileges, whether requested or already granted, including completion of initial evaluation and proctoring as specified in Section H-2;

5. Be free of any physical, mental or behavioral impairment that interferes with, or presents a substantial probability of interfering with patient care, the exercise of privileges, the assumption and discharge of required responsibilities, or cooperative working relationships;

6. Abide by the terms, conditions and procedures of the Bylaws and Rules and Regulations of the Professional Staff and the policies of the Professional Staff and the Hospital, including the Credentialing and Privileging Policies and Procedures of Kaiser Foundation Hospitals, Honolulu, Hawaii.

7. Demonstrate the ability to work cooperatively and professionally with the Hospital, its staff and the Professional Staff, and refrain from harassing, disruptive, or any other behavior which has interfered or could interfere with patient care or the proper operation of the Hospital and its Professional Staff;

8. Have a practice or a specialty which is consistent with the purposes, treatment, philosophy, methods and resources of the Hospital and for which the Hospital has a current need;

9. Demonstrate compliance with additional criteria imposed by the Professional Staff;

10. Maintain adequate professional liability insurance or equivalent coverage, meeting the standards established by Hospital Administration.

d. General Responsibilities of Membership

For continued membership on the Professional Staff, a practitioner must:

1. Provide his or her patients with care at the generally recognized level of professional quality and efficiency;

2. Discharge such staff, department, service, committee and Hospital functions for which he or she is responsible by appointment, election or otherwise, including where applicable, participate in the Emergency Department “on call” system to the extent required by the Hospital or applicable law and comply with policies governing supervision of House Staff;

3. Prepare and complete in a timely and legible manner the medical and other required records for all patients he or she admits or to whom he or she in any way provides care in the Hospital;

4. Abide by the ethical principles and laws governing his or her profession;

5. Maintain the confidentiality of all medical record and patient treatment information; quality improvement, risk management, and utilization management information and data; and peer review information, proceedings, and records;

6. To the extent applicable, provide services to indigent, medical assistance patients and other patients in accord with the requirements of the Professional Staff;

7. Notify the Chief of Staff or the Hospital Administrator within 30 days of the expiration, revocation, suspension, limitation, or voluntary or involuntary relinquishment of his or her professional license in any jurisdiction; the imposition of terms of probation or limitation of practice by any state licensing agency; his or her voluntary or involuntary loss of staff membership, or loss, curtailment or restriction of privileges, at any hospital or other health

care institution; the cancellation or restriction of his or her professional liability insurance coverage; the revocation, suspension, or voluntary or involuntary relinquishment, or any prior or pending challenges to his or her DEA registration or other authorization to prescribe or furnish controlled substances; adverse determinations by a Quality Improvement Organization concerning his or her quality of care; any opt out, sanction or debarment or notice of same by a government health program (e.g., Medicare); a formal investigation or the filing of charges by the Department of Health and Human Services or health regulatory agency of the United States or any State or territory of the United States; or notice of a claim or entry of a judgment or settlement against the practitioner alleging professional liability; or any other matter likely to impact or interfere with his or her ability to provide safe, quality health care;

8. Notify the Chief of Staff or the Hospital Administrator within 30 days of any investigation, filing of charges, arrest, or conviction, or notice thereof by any law enforcement agency; and

9. Notify the Chief of Staff or Hospital Administrator within 30 days if he or she no longer meets one or more of the qualifications listed above or if he or she is unable to exercise privileges or the responsibilities of membership.

e. The foregoing minimum and general qualifications and responsibilities shall apply to all Practitioners.

SECTION B-2. APPOINTMENT OF PROFESSIONAL STAFF MEMBERS.

a. Authority of Board of Directors.

It is recognized that the Board of Directors has ultimate legal and moral responsibility for health care and services rendered in the Hospital, including final authority on the granting, renewing, delineating, reducing, suspending, and terminating of Professional Staff privileges. The exercise of the Board's authority in this regard, directly or as delegated, shall follow the procedures prescribed in these Bylaws.

b. Application.

An applicant applying for membership on the Professional Staff and/or privileges shall file an application on a form approved by the Credentials and Privileges Committee, presenting the professional and other qualifications of the applicant, and additional relevant information, and documenting the applicant's agreement to abide by the Professional Staff Bylaws and Rules and Regulations and to release all persons and entities from any liability that might arise from their investigating and/or acting on the application.

c. Applicants for Closed Departments, or Administrative or Medical-Administrative Positions.

Individuals seeking medical-administrative positions in the hospital, or memberships in closed specialty departments or services, or administratively responsible capacities in the Hospital pursuant to a contract, shall be appointed and reappointed through the same procedures used for

all other applicants and members of the Professional Staff.

d. Consideration and Review.

1. It is the applicant's responsibility to provide all information required to make an application complete as defined in Section A-5.j. If a complete application is not provided within thirty (30) days after any request for information is made by the Hospital Administrator, or his or her designee, the application shall be automatically removed from consideration for membership and privileges. The application shall not be denied, but will be filed as incomplete, which action shall not entitle the applicant to the hearing and appeals procedure set forth in Section B-5.

2. The Credentials and Privileges Committee, in conjunction with the chief of the pertinent clinical department, shall review the professional competence, qualifications, and other factors that are relevant to the membership and privileges requested. The committee may request an interview with the applicant. The committee shall verify, through information provided by the applicant and other sources available to it, that the applicant meets and has established the necessary qualifications for Professional Staff membership.

3. No applicant shall be recommended for rejection because of unlawful discrimination based upon his or her race, creed, sex, age, mental or physical disability, color, religion, sexual orientation or national origin.

4. If the Credentials and Privileges Committee, upon examining the application and supporting information, has doubts regarding the privileges the applicant seeks in the Hospital, it shall make such further inquiry as it deems appropriate. However, the burden of establishing his or her qualifications and producing the requisite information shall be on the applicant. Misrepresentations, omissions, or the failure to furnish requested information are grounds for denying the application.

5. The Credentials and Privileges Committee shall make a written recommendation to the Medical Executive Committee of the Professional Staff, indicating whether the applicant should be accepted, rejected, or deferred pending reasonable inquiries into the qualifications and competence of the applicant, as appropriate. Such recommendation also shall indicate the applicant's staff classification, departmental assignment, and privileges to be granted.

6. The period of time between Medical Executive Committee recommended action on a completed application and action by the Board of Directors shall not exceed one hundred and twenty (120) days.

e. Medical Executive Committee Action.

The Medical Executive Committee, at its next regular meeting after receipt thereof, shall consider the application, supporting and related information, findings and recommendations of the Credentials and Privileges Committee. The Medical Executive Committee may arrange to

interview the applicant and request further information relative to the application as it deems desirable. The Medical Executive Committee shall:

1. Recommend that the applicant be appointed, designating the staff classification and departmental assignment, and indicating the privileges to be granted, or

2. Reject the applicant but not because of unlawful discrimination based upon his or her race, creed, religion, sex, age, color, sexual orientation or national origin, mental or physical disability, or

3. Defer action on the application pending reasonable inquiries into the qualifications and competence of the applicant as the Medical Executive Committee considers to be appropriate.

4. The recommendations of the Medical Executive Committee shall be referred to the Board of Directors for final action. Only recommendations for appointment shall be referred to the Board of Directors for final action, except that, in its discretion, the Medical Executive Committee may forward recommendations to defer or reject applications which it deems worthy of Board consideration. The applicant shall be notified of the Medical Executive Committee's recommendation within ten (10) days thereof.

f. Action by Board of Directors; Conference with Staff Representatives.

The Board of Directors, at its next regular meeting after receipt of the final report and recommendations of the Medical Executive Committee on any initial application for membership, shall consider same. If the Board determines to act contrary to the recommendation of the Medical Executive Committee, the Board shall provide written notice to the Medical Executive Committee of its intention to act contrary to the recommendation of the Medical Executive Committee. Within ten (10) days of such notification, a conference shall be arranged between an equal number of representatives of the Medical Executive Committee and of the Board to discuss the Board's proposed action. Following such conference, the Board shall make its decision at its next regularly scheduled meeting. When the Board has taken final action on any application for membership on the Professional Staff, and/or privileges, the Board shall notify the Hospital Administrator, noting the extent of privileges granted, if any, including any restrictions or limitations thereon or reduced duration of the appointment. The Hospital Administrator shall inform the applicant, the Medical Executive Committee, the Credentials and Privilege Committee and the appropriate departmental chief of the action taken.

g. Temporary Membership.

Upon the written concurrence of the Chief of Staff, and the chief of the department to which the applicant is to be assigned, the Hospital Administrator, or his or her designee, may grant temporary membership to a physician, dentist, podiatrist licensed to practice in this State. Temporary membership may only be granted to practitioners to whom temporary privileges have been awarded pursuant to Section H-6 of these Bylaws.

SECTION B-3. REAPPOINTMENTS OF PROFESSIONAL STAFF MEMBERS.

a. Request for Reappointment; Review and Recommendation.

1. Members shall be appointed to the Professional Staff for a term not to exceed two (2) years. Within six (6) months before the lapse of a two year appointment period, the member may apply for reappointment to the Professional Staff. The member shall be required to indicate the scope of privileges requested. If increased privileges are requested, appropriate supporting information shall be provided.

   The member shall promptly furnish a completed application with current information to include, but not be limited to, that specified in Section B-2.b. If the applicant has not provided a completed application within thirty (30) days of the notice of expiration of the appointment period, the application may be removed from consideration and filed as incomplete, which action shall not entitle the member to the hearing and appeals procedure set forth in section B-5. The Hospital Administrator shall notify the member that his or her application has been removed from consideration.

2. The chief of the department shall be responsible for the review of the performance of the member seeking renewal, and shall consider, but not limit review to, factors relevant to the applicant's competency as specified in Article B of these Bylaws and shall make a timely recommendation to the Credentials and Privileges Committee.

3. The Credentials and Privileges Committee shall review the information provided by the applicant for renewal of membership and privileges and the reports of the chief of the appropriate department and other pertinent information, including reports from other hospitals where the individual is a member of the Professional Staff. The Credentials and Privileges Committee shall recommend to the Medical Executive Committee for or against reappointment of each member of the Professional Staff for the ensuing appointment period (which shall not exceed two years), including the privileges to be granted and the extent thereof, and whether such privileges are to be changed.

b. Medical Executive Committee and Board Action.

The Medical Executive Committee shall follow the same procedure set forth in Section B-2(e).c. Independent Board Action or Board Action Contrary to Professional Staff Recommendation.

The Board of Directors shall follow the same procedure as set out in Section B-2(f).

SECTION B-4. CLINICAL PRACTICE MONITORING & EDUCATION, INVESTIGATION, CORRECTIVE ACTION, SUSPENSION, AND RESIGNATION.

a. Clinical Practice Monitoring and Education.

1. Responsibility. It shall be the responsibility of the Chief of Staff and the chiefs of the clinical departments, working through department committees, to design and implement an effective program (A) to monitor, informally review, conduct focused reviews as indicated,

and otherwise assess the quality of professional practice in each department, and (B) to improve the quality of practice in each department by: (1) providing education, and counseling; (2) issuing letters of admonition, warning or censure, as necessary; and (3) requiring routine administrative monitoring when deemed appropriate by department committees.

2. Procedure.

A. Informal Review.

(1) Each department committee conducts patient care reviews and studies of practice within the department in conformity with the Hospital's quality improvement processes and, where warranted, reviews complaints and practice-related incidents.

(2) Professional Staff focused review activities shall be conducted in conformity with applicable quality improvement processes and policies and procedures.

(3) Acting on their own initiative and in their leadership capacities, the Chief of Staff and the chiefs of the clinical departments may also independently review such matters.

(4) The above reviews shall not be considered a formal "investigation" as defined by the National Practitioner Data Bank nor shall such reviews be considered corrective action.

B. At the discretion of the Chief of Staff, Department Chief, committee chairperson or their designees, when a practitioner's practice or conduct is scheduled for discussion at the regular department, or a committee meeting, the practitioner may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least (7) seven days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a practitioner to appear at any meeting with respect to which he or she was given such notice, unless excused by the Medical Executive Committee upon a showing of good cause, may be a basis for separate corrective action.

C. In order to assist department members to conform their conduct or professional practice to the standards of the Professional Staff or Hospital, the Chief of Staff and department chiefs may issue informal comments or suggestions, either orally or in writing. Such comments or suggestions shall be subject to the confidentiality requirements and protections of all Professional Staff information and may be issued by department chiefs with or without prior discussion with the recipient and with or without consultation with the department committee. Such comments or suggestions shall not constitute a restriction of privileges, shall not be considered to be corrective action as provided in Section B-4, and shall not give rise to hearing review or appeal rights under Section B-5.D. Following discussion of identified concerns with any department or member, the chief of the department (or his or her designee) may issue a letter of admonition, warning or censure, or require such member to be subject to routine, administrative monitoring for such

time as may appear reasonable. Any discussion of such actions with individual members shall be informal. Such action shall not constitute a restriction of privileges, shall not be considered to be corrective action as provided in Section B4, and shall not give rise to hearing review or appeal rights under Section B-5.

D. Action taken pursuant to this Subsection need not be reported to the Medical Executive Committee.

b. Formal Investigation and Corrective Action.

1. **Initiation of Formal Investigation**. An investigation may be initiated whenever a practitioner demonstrates the inability to meet acceptable standards of care; or whenever a practitioner makes statements, exhibits demeanor or engages in conduct (either within or outside of the Hospital) that is likely to be detrimental to patient safety or the delivery of quality patient care within the Hospital, is disruptive to the operation of the Hospital, or that may result in the imposition of sanctions against the Hospital, or any person acting on behalf of the Hospital by any governmental authority. A request for an investigation may be initiated by any officer of the Professional Staff, the chief of any department in which the practitioner exercises privileges, the Credentials and Privileges Committee, the Board of Directors, or the Hospital Administrator. The request for investigation will be made in writing and may be based on a complaint or information furnished by any person.

2. **Formal Investigation**. The Medical Executive Committee may initiate a formal investigation on its own initiative, or may do so based on a written request submitted to the Medical Executive Committee, describing the specific activities or conduct that are the basis for proposing an investigation. The Medical Executive Committee may conduct the investigation itself, or appoint an ad hoc committee of Professional Staff members to conduct the formal investigation. The Medical Executive Committee or ad hoc committee may, in its discretion, interview the practitioner regarding the subject of the formal investigation. Any such interview shall be informal, shall not constitute a “hearing” as that term is used in Section B-5, and none of the procedural rights or requirements in a hearing under Section B-5 shall apply. Neither the practitioner, Medical Executive Committee, ad hoc Professional Staff Committee, nor any person in attendance during the interview shall be represented by legal counsel at the interview. The initiation of an investigation under this paragraph shall demark the point at which an “investigation” is deemed to have commenced for purposes of reporting “resignations during investigation” to the National Practitioner Data Bank.

3. **Time Frame for Formal Investigation**. Insofar as feasible under the circumstances, formal investigations should be conducted expeditiously, and should be completed no later than sixty (60) days after the formal investigation’s commencement. If additional time is needed to complete the investigation, the Medical Executive Committee may defer action and it shall so notify the affected practitioner. A subsequent recommendation for any one or more of the actions provided in Section B-4.b.4, or a decision to defer the matter further, shall be made within the time specified by the Medical Executive Committee, and if no such time is specified, then within thirty (30) days of the deferral.

4. **Medical Executive Committee Corrective Action**. The Medical Executive Committee may take corrective action after consideration of a recommendation for corrective action, or on its own initiative after consideration of a potential basis for corrective action, whether

or not the Medical Executive Committee has conducted a formal investigation. A corrective action may be requested by any officer of the Professional Staff, the chief of any department in which the practitioner exercises privileges, the Credentials and Privileges Committee, the Board of Directors, or the Hospital Administrator. A corrective action may be taken whenever a practitioner demonstrates the inability to meet acceptable standards of care; or whenever a practitioner makes statements, exhibits demeanor or engages in conduct (either within or outside of the Hospital) that is likely to be detrimental to patient safety or the delivery of quality patient care within the Hospital, is disruptive to the operation of the Hospital, or that may result in the imposition of sanctions against the Hospital, or any person acting on behalf of the Hospital by any governmental authority. The Medical Executive Committee may take corrective action including, without limitation:

A. Determining no corrective action should be taken;

B. Deferring for a reasonable time;

C. Issuing letters of admonition, censure, reprimand or warning. In the event such letters are issued, the affected practitioner may make a written response which shall be placed in the practitioner's credentialing file. Nothing herein shall preclude a Department Chief (or his or her designee) from issuing such letters as otherwise provided in these Bylaws;

D. Recommending the imposition of terms of probation or special limitation upon continued Professional Staff membership and/or the exercise of privileges including without limitation, individual requirements for co-admission, mandatory consultation or monitoring;

E. Recommending reductions of Professional Staff membership status or category, or limitation of any privileges or other prerogatives that are related to the provision of patient care;

F. Recommending suspension or revocation of Professional Staff membership and/or privileges. If suspension is recommended, the Medical Executive Committee shall state the terms and duration of the suspension and the conditions that must be met before the suspension is ended;

G. Referring the practitioner to the Professional Staff Well-Being Committee for evaluation and follow-up as appropriate;

H. Other actions appropriate to the facts developed in the course of investigation;

I. The Medical Executive Committee may implement summary suspension at any time in the exercise of its discretion pursuant to Section B-4.c.1;

J. Nothing in this section shall require the Medical Executive Committee to initiate a formal investigation prior to taking action upon a practitioner's Professional Staff membership or privileges.

5. **Interviews after Recommended Corrective Action by Medical Executive Committee.** To facilitate the resolution of inter-professional issues at an early stage, a member who is the subject of a recommendation that entitles the member to the procedural rights provided

in Section B-5 may request, in writing, an informal interview before the Medical Executive Committee in order to explain or discuss the facts relevant of the recommended corrective action. The Medical Executive Committee shall decide, in its sole discretion, whether to grant the member's request for the interview. Alternatively, the Medical Executive Committee may request, in writing, such an interview with the member. The Medical Executive Committee shall fix the time and place for the interview as soon as the Committee reasonably may be convened but, preferably, on a date within ten (10) working days after the Medical Executive Committee's receipt of the request or after the request's delivery to the member, as the case may be. This interview shall be informal, shall not constitute a "hearing" as that term is used in Section B-5, and none of the procedural rights or requirements in a hearing under Section B-5 shall apply. Neither the practitioner, Medical Executive Committee, ad hoc Professional Staff Committee, or any person in attendance during the interview shall be represented by legal counsel at the interview

6. **Board of Directors Action.** The Board of Directors shall notify the Medical Executive Committee in writing of the Board's intention to act on its own initiative, or contrary to the favorable recommendation of the Medical Executive Committee on a matter involving staff privileges. Within ten (10) days of such notification, a conference shall be arranged between an equal number of representatives of the Medical Executive Committee and of the Board to discuss the Board's proposed investigation or corrective action. Following such conference, the Board may direct the Medical Executive Committee to initiate an investigation or take corrective action. The Medical Executive Committee shall consider the Board's direction within thirty (30) days. If the Medical Executive Committee does not take action in response to the Board's direction, the Board may, in furtherance of the Board's ultimate responsibilities and fiduciary duties, initiate corrective action, but must comply with applicable provisions of these Bylaws, including Section B-5 where applicable. The Board of Directors shall give great weight to the actions of the Medical Executive Committee and, in no event, shall act in an arbitrary or capricious manner. The Board shall inform the Medical Executive Committee in writing of any action it takes under this Section.

c. Suspension.

1. Summary Suspension.

A. In cases where it is determined that failure to take action may result in imminent danger to the health of any individual, the Medical Executive Committee, the Hospital Administrator, Chief of Staff or chief of the department in which the practitioner has privileges may summarily suspend or restrict the privileges and/or membership of a practitioner. In such cases, the Hospital Administrator should consult with the Medical Executive Committee, the Chief of Staff, or Chief of the applicable department before taking action. The chief of the department shall make arrangements for other staff members to attend any inpatients of the suspended staff member.

B. The Board of Directors, or its designee may immediately suspend or restrict a member's privileges if a failure to summarily suspend or restrict such privileges or membership is likely to result in imminent danger to the health of any individual, provided that the Board has made reasonable attempts to contact the Medical Executive Committee before the suspension or restriction.

C. A summary suspension or restriction by the Board or Hospital Administrator which has not been ratified by the Medical Executive Committee within two (2) working days after the suspension or restriction, excluding weekends and holidays, shall terminate automatically.

D. Oral or written notice of the suspension or restriction, given to the member, shall suffice, provided that any member who is suspended in excess of fourteen (14) days for a medical disciplinary cause or reason shall be provided with the notice and hearing rights set forth in Section B-5. Similarly, a staff member who has been summarily suspended or restricted for a cumulative total of thirty (30) days or more within any twelve (12) month period, for a medical disciplinary cause or reason, shall be provided with the notice and hearing rights set forth in Section B5.

E. The Medical Executive Committee may, at its sole discretion, interview the suspended member in the manner and on the terms set forth in Section B-4.b.2. Whether or not such an interview occurs, the Medical Executive Committee shall schedule a meeting on the matter as soon as the Committee reasonably may be convened, but not longer than ten (10) days after the suspension or restriction is imposed. The Medical Executive Committee shall determine whether such suspension or restriction shall be continued and, if so, for how long or under what conditions restoration of privileges will occur.

F. Any challenge to the suspension or restriction, or to any recommendation for corrective action pursuant to Section B-4.c resulting from the suspension or restriction and any related investigation, shall be considered in one (1) single hearing. Any corrective action investigation related to or arising from the suspension or restriction should be completed promptly so that any hearing on the summary suspension or restriction and corrective action can be commenced within sixty (60) days after a hearing on a summary suspension or restriction is requested.

2. Administrative Suspension.

A. Incomplete Medical Records.

A suspension, effective until delinquent medical records are completed, may be imposed by the Hospital Administrator, for failure of the practitioner to complete medical records within the period of time established in accordance with

Professional Staff Rules and Regulations, hospital accreditation standards, and legal requirements. The practitioner shall be given ten (10) days' notice of the intent to suspend. The suspension shall continue until the suspended practitioner completes his or her medical records to the satisfaction of the Hospital Administrator. A suspended practitioner may not admit patients to, or perform elective surgery in, the Hospital.

B. Revocation, Suspension or Expiration of License to Practice, DEA Certificate, Other Permits and Certificates or Probation.

License to Practice. Upon notification from the appropriate state agency of the revocation or suspension of the license of a practitioner having privileges to practice his or her profession in this state, the practitioner's privileges and Professional Staff membership shall automatically terminate. Upon restoration or lifting of the revocation or suspension of the license, the practitioner may apply for Professional Staff membership and/or privileges.

If a practitioner having privileges at the Hospital is restricted or placed on probation by a state professional licensing agency, the terms of such probation or restriction shall be automatically imposed upon the practitioner's Professional Staff membership and/or privileges. Upon the expiration of the license the professional staff membership and/or privileges of the practitioner shall automatically be suspended and shall be reinstated upon verification of renewal.

DEA Registration. Any action by a government agency resulting in the revocation, limitation, or suspension of the practitioner's DEA registration shall automatically terminate the right to prescribe such medications as a member of the Professional Staff. Restoration of the DEA registration after revocation, limitation or suspension, shall not automatically restore the right to prescribe the covered medications in the Hospital without reconsideration thereof and a determination by the Medical Executive Committee to make such restoration. In the event of an adverse recommendation by the Medical Executive Committee, based on a medical disciplinary cause or reason, the member's hearing rights shall be governed by Section B-5.

Upon the expiration of the DEA registration the practitioner's right to prescribe medications subject to DEA regulation shall automatically terminate and shall be reinstated upon verification of renewal.

Other Permits and Certificates. Upon notification from an issuer of a permit or certificate of the revocation or suspension of a permit or certificate that is required for the performance of all or part of a practitioner's practice in the hospital, the practitioner's privileges shall be automatically suspended to the extent of the practice authorized by the permit or certificate. Restoration of the permit or certificate shall not automatically restore the right to resume the practice

authorized by the permit or certificate without reconsideration thereof and a determination by the Medical Executive Committee upon the recommendation of the Department Chief to make such restoration. In the event of an adverse recommendation by the Medical Executive Committee, based on a medical disciplinary cause or reason, a Professional Staff member's hearing rights shall be governed by Section B-5.

Upon the expiration of the permit or certificate the Professional Staff member's privileges shall automatically be suspended to the extent of the practice authorized by the permit or certificate and shall be reinstated upon verification of renewal.

C. Failure to Maintain Minimum Professional Liability Coverage.

A practitioner who fails to maintain the minimum professional liability coverage as established by Hospital Administration shall be subject to automatic and immediate suspension of all privileges. The chief of the department shall make arrangements for other staff members to attend any inpatients of the suspended member.

D. Conviction of a Crime.

A practitioner who has been convicted of a crime, other than a misdemeanor traffic offense, shall be automatically suspended. Such suspension shall remain in effect until removed or rescinded by the Chief of Staff with the concurrence of the Hospital Administrator, or by the Medical Executive Committee following referral under this section. Within 90 days of implementation of the suspension, the Chief of Staff and Hospital Administrator will interview the affected practitioner. Following such interview, the Chief of Staff, with the concurrence of the Hospital Administrator, will decide whether to remove or rescind the suspension, or refer the matter to the Medical Executive Committee for further review and action under Section B-4 of these Bylaws. The chief of the department shall make arrangements for other staff members to attend any patients of the suspended member.

E. Exclusion from Government Health Care Programs.

Practitioners who are currently debarred or excluded from, or sanctioned by, any health care program funded, in whole or in part, by the federal government or any state, shall be subject to automatic and immediate suspension of membership and/or all privileges. The lifting of any sanctions by or debarment or exclusion from a government health care program, shall not automatically result in a restoration of such privileges or membership unless the Medical Executive Committee finds that the practitioner meets the requirements of Professional Staff membership or is otherwise qualified to exercise privileges at the Hospital. The

Chief of the department shall make arrangements for other staff members to attend any inpatients of the suspended practitioner.

F. Procedure.

Notification of the administrative suspension to the affected practitioner, Chief of Staff and Department Chief shall be the responsibility of the Hospital Administrator. Administrative suspensions are not imposed for medical disciplinary cause or reason, therefore, no hearing under Section B-5 shall be afforded the suspended practitioner.

d. Joint Review, Investigation and Corrective Action at Multiple KFH Hospitals.

1. Notice of Pending Reviews or Investigations / Joint Reviews or Investigations.

A. Each Chief of Staff and each Hospital Administrator each shall have the discretion to notify their counterparts at other KFH Hospitals whenever a practitioner is under review or whenever corrective action has been recommended or taken.

B. In addition, the Medical Executive Committee may authorize the Hospital's review process or investigation to coordinate with another KFH Hospitals Professional Staff's review process or investigation.

C. The Chief of Staff and the Hospital Administrator are authorized to disclose to another KFH Hospitals' peer review body (or an authorized representative of that body) information from Hospital and Professional Staff records to assist in the other KFH Hospital's independent or joint review or investigation of any practitioner.

D. The results of any joint investigation shall be reported to each involved KFH Hospitals' Medical Executive Committee for its independent determination of what, if any, corrective action should be taken.

2. Notice of Actions.

In addition to the discretionary notification and joint investigation provisions set forth at Section B-4.d.1, the Chief of Staff and/or the Hospital Administrator are authorized to inform his or her counterpart at any other KFH Hospitals where the practitioner is known to hold privileges whenever any summary suspension of privileges or other corrective actions have been taken.

3. Effect of Actions Taken by Other KFH Hospitals.

Whenever the Chief of Staff or Hospital Administrator receives information about an action taken at another KFH Hospitals, the Chief of Staff or Hospital Administrator shall ensure

that there is an independent assessment of the practitioner's practice within this Hospital, as appropriate.

e. Termination and Nonrenewal of Staff Membership.

1. Termination on Expiration. Any Professional Staff membership, whether in good standing or under suspension, which is not renewed by the Board of Directors, shall terminate upon the expiration of the appointment period.

2. Medical-Administrative Officers. Professional Staff members who are directly under contract with the hospital in a medical-administrative capacity shall not be entitled to the procedural rights specified in Section B-5 except to the extent that the member's Professional Staff membership or privileges which would otherwise exist independent of the contract are to be limited or terminated under the terms of the contract for a medical disciplinary cause or reason.

f. Resignation.

A practitioner may resign at any time by written notice of such resignation submitted to the Hospital Administrator, Chief of Staff, or Department Chief. If the resignation is submitted to the Chief of Staff or Department Chief, he or she shall promptly notify the Hospital Administrator. The resignation shall be effective upon receipt if no effective date is specified, or at any later date therein specified. Formal acceptance by or on behalf of the Board of Directors shall not be required.

SECTION B-5. HEARING AND APPEALS PROCEDURE.

a. General Provisions

1. **Exhaustion of Remedies**. If adverse action described in Sections B-4 and B-5 is taken or recommended, the applicant or Professional Staff member agrees to follow and complete the procedures set forth in these Bylaws, including appellate procedures, before attempting to obtain judicial relief in any forum related to any issue or decision which may be subject to a hearing or appeal under these Sections.

3. **Individual Evaluations vs. Requests to Review Rules and Requirements**. The sole purpose of the meetings, investigations, hearings, and appeals provided in Sections B-4 and B-5 is to evaluate individual Professional Staff members on the basis of Bylaws, Rules and Regulations, and policies and standards of the Professional Staff and Hospital. The Judicial Review Committee provided for under Section B-5 has no authority to modify, limit, or overrule any established Bylaw, Rule, Regulation, policy, or requirement (collectively "rules or requirements"), and shall not entertain challenges to such rules and requirements. Any Professional Staff member wishing to challenge an established rule or requirement must first notify the Medical Executive Committee and the Board of Directors of the rule or requirement he or she wishes to challenge and of the basis for the challenge. The Board of Directors shall then consult with the Medical Executive Committee regarding the

request. No Professional Staff member shall initiate any judicial challenge to a rule or requirement until the Board of Directors, following consultation with the Medical Executive Committee, has reviewed the rule or requirement in question and has either decided not to reconsider, or has upheld, the particular rule or requirement.

3. **Substantial Compliance**. Technical non-prejudicial or insubstantial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken under Sections B-4 or B-5.

4. **Hearings Prompted by Board of Directors Action**. If the hearing is based upon an adverse action taken by the Board of Directors, the Chairman of the Board of Directors shall fulfill the functions assigned in this Section to the Chief of Staff, and the Board of Directors shall assume the role of the Medical Executive Committee under this Section. There shall be no Appellate Review of the decisions resulting from such hearings.

b. Basis for Request for Hearing.

1. A practitioner may request a hearing when notified in writing that the Medical Executive Committee has reached a final decision to recommend any of the following actions for a medical disciplinary cause or reason that requires reporting to the applicable licensing authority:

   A. that the practitioner's application for membership or request for privileges be rejected,

   B. that the scope of privileges the practitioner has requested be denied,

   C. that the practitioner's membership or privileges be terminated or not renewed,

   D. that there be a reduction in the practitioner's existing privileges,

   E. that the practitioner's privileges or membership or both, be suspended pursuant to Section B-4.c.

   F. that any other action be taken that would require that a report be filed regarding the practitioner with the applicable licensing authority.

2. Notice of Adverse Action. The notice of adverse action provided under Section B-5.b.1 shall advise the practitioner of the action that has been proposed, a brief indication of the reasons for the proposed action, his or her right to request a hearing under Section B-5 of these Bylaws, the time limit within which to request such a hearing, and that the proposed action is one for which a report must be filed with the state licensing board in accordance with applicable legal requirements. A copy of the notice of adverse action shall be hand-delivered to the practitioner, or sent by First Class mail, or certified mail, return receipt requested, or other method confirming receipt to his or her latest address as shown in the practitioner's credentials file.

3. <u>Request for Hearing</u>. The request for a hearing shall be submitted in writing to the

Hospital Administrator within thirty (30) days of receipt by the practitioner of notification of the Medical Executive Committee's action.

Failure to make such timely request shall constitute a waiver of the right to a hearing and appeal as well as acceptance by the practitioner of the recommendation and action of the Medical Executive Committee.

c. Pre-Hearing Procedure.

1. Judicial Review Committee. The hearing shall be held before an ad hoc Judicial Review Committee appointed by the Chief of Staff. The Chief of Staff shall appoint an ad hoc Judicial Review Committee consisting of a chairperson and two additional members of the Professional Staff who shall gain no direct financial benefit from the outcome, who have not acted as accusers, investigators, fact finders, or initial decision makers in the same matter, and who have not previously taken an active part in the consideration of the matter contested. The Chief of Staff shall also appoint alternate members of the Judicial Review Committee, as the Chief of Staff deems necessary. The Chief of Staff may in his or her discretion appoint any practitioner with privileges to practice at any Kaiser Foundation Hospitals' facility to serve on the Judicial Review Committee. Where feasible, the Committee shall include an individual practicing the same specialty as the staff member or applicant. In addition to the other authority and responsibilities set forth in Section B-5, the Judicial Review Committee shall serve as the initial finder of fact in this hearing and appeal process and shall have such authority as necessary to discharge its responsibilities.

2. Hearing Officer.

A. Appointment and Qualifications. A Hearing Officer shall be appointed by the Chief of Staff to preside at the hearing. The Hearing Officer shall be an attorney at law qualified to preside over a formal hearing and preferably shall have experience in medical staff disciplinary matters. He or she shall not be biased for or against the practitioner, and shall not be an attorney who regularly advises the Professional Staff on legal matters. The Hearing Officer shall gain no direct financial benefit from the outcome, and shall not act as a prosecuting officer or advocate for either side.

B. Authority and Duties.

(1) The Hearing Officer may participate in the deliberations and act as a legal advisor to the Judicial Review Committee, but he or she shall not be entitled to vote. He or she shall act to assure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence, and that proper decorum is maintained. He or she shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing, and to set reasonable schedules for timing and/or completion of all matters related to the hearing.

(2) He or she shall have the authority and discretion, in accordance with these Bylaws, to grant continuances, to rule on disputed discovery requests, to decide when evidence may or may not be introduced, to rule on witness issues, including disputes regarding expert witnesses, to rule on challenges to Judicial Review Committee members, to rule on challenges to himself or herself serving as a Hearing Officer, and to rule on questions which are raised prior to or during the hearing pertaining to matters of law, procedure, or the admissibility of evidence.

(3) If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as seems warranted by the circumstances, including, but not limited to, limiting the scope of examination and cross-examination and setting fair and reasonable time limits on either side's presentation of the case. Under extraordinary circumstances, where a party's failure to cooperate in the proceedings interferes with the Judicial Review Committee's ability to evaluate the evidence and reach a conclusion such that further proceedings are ineffectual, the Hearing Officer may recommend to the Judicial Review Committee, or the Judicial Review Committee may initiate on its own, termination of the hearing. If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as seems warranted by the circumstances, including, but not limited to, limiting the scope of examination and cross-examination and setting fair and reasonable time limits on either side's presentation of the case. Under extraordinary circumstances, when the Hearing Officer deems that termination of the hearing is necessary and orders termination, if the order is against the Medical Executive Committee, the charges against the practitioner will be deemed to have been dropped. If, instead, the order is against the practitioner, the practitioner will be deemed to have waived his/her right to a hearing. The party against whom termination sanctions have been ordered may appeal the matter to the Board of Directors.

(4) In all matters, the Hearing Officer shall act reasonably under the circumstances and in compliance with applicable legal principles and these Bylaws. In making rulings, the Hearing Officer shall endeavor to promote a less formal, rather than more formal, hearing process and also to promote the swiftest possible resolution of the matter, consistent with the standards of fairness set forth in these Bylaws. When no attorney is accompanying any party to the proceedings, the Hearing Officer shall have authority to interpose any objections and to initiate rulings necessary to ensure a fair and efficient process.

3. **Notice of Hearing and Notice of Charges**. After consultation with the members of the Judicial Review Committee and the practitioner, the Chief of Staff shall fix the place and

time of the hearing, on a date within sixty (60) days of the Professional Staff's receipt of the practitioner's request for hearing. The Chief shall send by First Class mail, or by certified mail, return receipt requested, or other method confirming receipt, or hand deliver a notice to the practitioner of such date, time and place not less than thirty (30) days prior to the hearing. Together with the notice stating the place, time, and date of the hearing, the Chief of Staff shall include a notice of charges, prepared by the Medical Executive Committee, which shall state clearly and concisely in writing the reasons for the action, including the specific acts or omissions with which the practitioner is charged and a list of any charts on which the Medical Executive Committee is relying in support of the charges. The Medical Executive Committee may amend the notice of charges at any time so long as the practitioner is provided with reasonable notice of any amendment prior to the next hearing session. The practitioner's sole remedy for inadequate notice of any such amendment shall be a continuance of the hearing as determined by the Hearing Officer pursuant to Section B-5.c.2.B. The scope of the hearing shall be limited to determining whether the adverse action described in the Notice of Adverse Action, for the reasons described in the Notice of Changes, is reasonable and warranted.

4. **Failure to Appear and Proceed**. Failure of the practitioner to appear personally and to proceed at such hearing without good cause shall be deemed to constitute voluntary acceptance of the prior recommendations of the Medical Executive Committee, which shall become the Medical Executive Committee's final report and recommendation to the Board of Directors.

5. **Discovery**.

    A. Each side shall have a right to inspect and copy, at its own expense, any documentary information relevant to the charges which the other party has in its possession or under its control, as soon as reasonably practicable after the receipt of the request for a hearing. However, the right to inspect and copy information does not extend to confidential information referring solely to individually identifiable practitioners, other than the practitioner. The Hearing Officer shall consider and rule upon any request for access to information and may impose any safeguards that the protection of the peer review process and justice require. When ruling upon requests for access to information and determining the relevancy thereof, the Hearing Officer shall, among other factors, consider: (1) whether the information sought may be introduced to support or defend the charges; (2) the exculpatory or inculpatory nature of the information sought, if any; (3) the burden imposed on the party in possession of the information sought, if access is granted; and (4) any previous requests for access to information submitted or resisted by the parties to the same proceeding.

B. The failure by either party to provide access to the information specified in B-5.c.2. at least thirty (30) days before the hearing, shall constitute good cause for a continuance.

C. At the request of either side, each side shall disclose to the other copies of documents which it intends to introduce and a list of witnesses who are expected to testify or to provide evidence at the hearing, not less than ten (10) days prior to the hearing. Each side shall have the duty to notify the other side of any change in its witness list promptly after that party learns of the change. The failure to provide a copy of a document or to provide the name of a witness, as required above, shall constitute good cause for a continuance.

D. It shall be the duty of the practitioner and the Medical Executive Committee, or its designee, to exercise reasonable diligence in promptly notifying the Hearing Officer of any anticipated disputes regarding requests for access to information or other procedural disputes in advance of the hearing. Objections to any prehearing decisions may be made at the hearing.

d. Hearing Procedure

1. Representation.

A. The parties may be represented at the hearing by anyone of their choice, including an attorney at law. The representative of the Medical Executive Committee shall not be accompanied by an attorney if the staff member or applicant is not so accompanied. The foregoing shall not be deemed to deprive any party of its right to the assistance of legal counsel for the purpose of preparing for or participating in the hearing.

B. If attorneys are not present in the hearing pursuant to this Section, the practitioner and the Medical Executive Committee may be represented at the hearing by a practitioner licensed to practice in the State of California who is not also an attorney at law.

2. **Conduct of Hearing.** The hearing will be closed, informal, and conducted in accordance with the rules of this Section B-5.

3. **Rights of the Parties**. At a hearing, both sides shall have the following rights:

A. to ask Judicial Review Committee members and/or the Hearing Officer questions which are directly related to determining whether they meet the qualifications set forth in these Bylaws and to challenge such members.

B. to call and examine witnesses;

C. to introduce relevant documents and other evidence;

D. to receive all information made available to the Judicial Review Committee;

E. to cross-examine any witness who testified orally on any matter relevant to the issues, and otherwise to rebut any evidence;

F. to submit written statements in support of its position, both no later than ten (10) days prior to the start of the hearing and within five (5) days after the close of the hearing, or at such other times as the parties may agree or the Hearing Officer may order;

G. the practitioner may be called by the Medical Executive Committee and examined as if under cross-examination;

H. the Judicial Review Committee may question the witnesses or call additional witnesses if it deems such action appropriate;

I. the Judicial Review Committee may request each party to submit a written statement in support of his or her position both prior to the start of the hearing or at the close of the hearing.

4. **Rules of Evidence**. The Judicial Rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses and presentation of evidence shall not apply in any hearing conducted hereunder. Any relevant evidence, including hearsay, shall be admitted by the Hearing Officer if it is the sort of evidence upon which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

5. **Burdens of Presenting Evidence and Proof**. The Medical Executive Committee shall have the initial duty to present evidence which supports the charge or action. An initial applicant shall have the burden of persuading the Judicial Review Committee by a preponderance of the evidence of his or her qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning his or her current qualifications for staff privileges or membership. He or she shall not be permitted to introduce information not produced upon on the request of the Medical Executive Committee, or Credentials and Privileges Committee, as applicable, during an appointment, reappointment or privilege application review or during corrective action, unless he or she establishes that such information could not have been produced previously in the exercise of reasonable diligence. Except as provided above for initial applicants, the Medical Executive Committee shall bear the burden of persuading the Judicial Review Committee by a preponderance of the evidence that the action or recommendation is reasonable and warranted.

6. **Record of Hearing**. The Judicial Review Committee Arbitrator shall maintain a record of the hearing by using a certified shorthand reporter. The party requesting a transcript shall pay the cost of preparing the transcript prior to receiving it. The other party may obtain a photocopy of the transcript for the cost of preparing one. The Hearing Officer may, but is not required to, order that oral evidence shall be taken only on oath administered by any person designated by the Judicial Review Committee and entitled to notarize documents in this State or by affirmation under penalty of perjury to the Hearing Officer.

7. **Continuances**. The parties shall exert their best efforts to assure that the hearing is completed within a reasonable time after the practitioner's receipt of notice of a final proposed action or an immediate suspension or restriction of privileges. Continuances shall be granted by the Hearing Officer upon the agreement of the parties or for good cause, including failure of either party to comply with Section B-5.e.5.

8. **Adjournment and Conclusion**. The Hearing Officer may adjourn the hearing and reconvene it as agreed to by the parties or as he or she deems proper in consultation with the Judicial Review Committee. When the presentation of evidence and arguments is concluded, the Hearing Officer may declare the hearing to be closed. The Judicial Review Committee then shall deliberate privately and make a recommendation and report to the Board in accordance with Section B-5.d.1. above.

9. **Decision of the Judicial Review Committee and Report to the Board**.

   A. Within thirty (30) days of conclusion of the hearing, the Judicial Review Committee shall make a report and decision in writing to the Board, with a copy to the Medical Executive Committee and to the Hospital Administrator. The hearing shall be considered concluded when the Judicial Review Committee has concluded its deliberations.

   B. The Judicial Review Committee's report and decision to the Board shall be based on the evidence presented at the hearing, including oral testimony, written statements, hospital and medical record information, documents introduced at the hearing and other admissible evidence made available to the Judicial Review Committee.

   C. The written report shall include findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. If the Judicial Review Committee decides the Medical Executive Committee's action is reasonable and warranted, the Judicial Review Committee's report to the Board shall affirm the action, and state the reasons for the Judicial Review Committee's decision. If the Judicial Review Committee decides the action is not reasonable and warranted, the Judicial Review Committee's report should modify or reject of the action, and state the reasons for the Judicial Review Committee's decision. The Judicial Review Committee also may remand the matter to the Medical Executive Committee for further consideration of specified issues.

   D. The Judicial Review Committee shall also send a copy of its written report to the staff member or applicant who requested the hearing, by First Class, or certified mail, return receipt requested, or other method confirming receipt and shall include a written explanation of the procedure for appealing the decision.

e. Appellate Review.

1. **Time For Appeal**. Within forty (40) days after the date of receipt of the Judicial Review Committee decision, either the practitioner or the Medical Executive Committee may request an appellate review by the Board. Said request shall be delivered to Chairman of the Board, in writing either in person, or by First Class or certified mail, return receipt requested, or other method confirming receipt at Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals, One Kaiser Plaza, Oakland, California 94612. The request shall briefly state the reasons for the appeal. Reasons for appeal shall be procedural failure so as to deny a fair hearing, that the decision of the Judicial Review Committee was not reasonable and warranted, or that the decision was made arbitrarily or capriciously. If appellate review is not requested within this period, both sides shall be deemed to have accepted the action involved and it shall thereupon become the final recommendation of the Medical Executive Committee. The Board shall give that recommendation great weight, but the recommendation shall not be binding on the Board.

2. If appellate review is timely requested by the appellant practitioner or the Medical Executive Committee, the Chairman of the Board of Directors shall appoint a three member Appellate Review Panel, at least one of whom shall be a member of the Professional Staff of the Hospital who was not a witness at the prior hearing or a member of the Judicial Review Committee at which the hearing was conducted] and who had no prior involvement in the same matter as an initial fact-finder, accuser, witness, or decision-maker. The Chairperson of the Panel shall be selected by the Chairman of the Board of Directors. The appellate Review Panel shall have such authority as necessary to discharge its responsibilities. The Appellate Review Panel shall have such authority as necessary to discharge its responsibilities.

3. **Appeal Procedure.** The Appellate Review Panel shall review the record of the hearing before the Judicial Review Committee, and may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence, or that the evidence was improperly excluded at the hearing before the Judicial Review Committee, and subject to the same rights of cross-examination or confrontation provided at the Judicial Review Committee hearing. The Appellate Review Panel may remand the matter to the Judicial Review Committee for the taking of further evidence and for decision. Each party has the right to be represented by an attorney or any other representative the party chooses. The Appellate Review Panel may select an unbiased attorney to assist it by fulfilling the duties of a Hearing Officer; as described in Section B-5.d.2.

   A verbatim record shall be made of the appellate hearing by a court reporter. The parties may obtain a transcript or a copy thereof in the same manner as provided in Section B-5.f.6 above.

   Each party has the right to present a written statement in support of its position on appeal, in a length and format determined by the Hearing Officer in consultation with the Appellate Review Panel, and to appear personally and present oral argument. At the conclusion of

oral argument, the Appellate Review Panel may thereupon conduct, at a convenient time, deliberations outside the presence of the parties and their representatives.

Failure of the practitioner to appear personally and to proceed at such proceeding without good cause, shall be deemed to constitute voluntary acceptance of the report and decision of the Judicial Review Committee. If the practitioner requested appellate review, the report and decision of the Judicial Review Committee**,** that report and decision shall be considered the final recommendation of the Medical Executive Committee and shall then be forwarded to the Board for review. The Board shall give that recommendation great weight, but the recommendation shall not be binding on the Board. If the Medical Executive Committee requested appellate review, the Appellate Review Panel shall proceed under this Section B-5.f and reach a decision based on the record of the prior hearing and information and argument submitted by the Medical Executive Committee under this Section.

4. **Decision.** The Appellate Review Panel shall exercise its independent judgment in determining whether a practitioner appellant was afforded a fair hearing, whether the decision is reasonable and warranted, and whether any Professional Staff Bylaws' provision, Rule or Regulation relied upon by the Judicial Review Committee is reaching its decision is reasonable and warranted. The panel, after reviewing the record and arguments of the parties, may affirm, modify or reverse the recommendation. The panel also may remand the matter for further consideration of designated issues. In such instance the recommendation as to the designated issues may be reviewed by the Appellate Review Panel, in accordance with the procedures of this subsection, but following an expedited time frame, if feasible. The decision shall specify the reasons for the action taken and provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal (if any), and the decision reached, if such findings and conclusions differ from that of the Judicial Review Committee.

The Appellate Review Panel shall deliver copies of the decision to the Board, the practitioner and to the Medical Executive Committee and Hospital Administrator, by personal delivery, by First Class mail or by certified mail, return receipt requested or other method confirming receipt.

f. **Right to One Hearing.** Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one judicial, evidentiary hearing and one appellate review on any matter which shall have been the subject of any action or recommendation giving rise to a hearing under Section B.5.

g. Joint Hearing and Appeal for KFH Hospitals.

Joint Hearing.

Whenever a practitioner is entitled to a hearing at this Hospital and one or more other KFH Hospitals based on the same or substantially similar acts, events, or circumstances, a single joint

hearing may be conducted, at the sole discretion of the Medical Executive Committees of the involved KFH Hospitals. The hearings shall be conducted in accordance with the hearing procedures set forth in these Bylaws, to the extent that these provisions are consistent with the other KFH Hospitals' Bylaws. If the Bylaws are not consistent on an aspect of hearing procedure, then the parties shall agree on which bylaws provisions shall apply to that procedural aspect. If the parties cannot reach agreement, then the Hearing Officer shall determine which hearing procedure applies. The Chief of Staff at this Hospital and at each participating KFH Hospital shall appoint one member of the Judicial Review Committee, which shall consist of representatives of members of the Professional Staff of this Hospital and of other KFH Hospitals whose action is the subject of the hearing. The Judicial Review Committee shall in all cases consist of an odd number of members to avoid deadlocked recommendations. The Chiefs of Staff of the Professional Staff of this Hospital and participating KFH Hospitals shall agree on additional appointments to reach an odd number of members on the Judicial Review Committee. The Chiefs of Staff shall also agree on alternate members of the committee, as they deem necessary. The Judicial Review Committee shall otherwise be subject to the qualifications for membership set forth in these bylaws.

In the event there is such a joint hearing, the Judicial Review Committee shall report: its recommendation to the Board on behalf of this Hospital and other KFH Hospitals that participate in the joint hearing.

Joint Appeal.

Should the practitioner or the Medical Executive Committees of one or more KFH Hospitals wish to request appellate review, the provisions of section B-5.g shall apply. In the case of an appellate review of a joint hearing, the Appellate Review Panel must include at least one member of the Professional Staff of the Hospital and each participating KFH Hospitals. The Appellate Review Panel may consist of more than three members to meet this requirement, but must consist of an odd number of members to avoid deadlock.

h. Reapplication After End of Hearing Procedure. Upon completion of the hearing and appeals procedure, or upon waiver thereof, the practitioner whose membership and/or privileges have been terminated shall be ineligible to apply for staff membership for at least thirty-six (36) months, unless the Medical Executive Committee chooses to consider the reapplication at an earlier date.

i. Exceptions to Hearing Rights.

1. Actions based on failure to meet the Minimum Qualifications.

   A practitioner shall not be entitled to any formal hearing or appellate review rights if his or her membership, application or request is denied, suspended, or terminated, because of his or her failure to meet minimum requirements for membership or privileges as established under these Bylaws.

2. Administrative Suspension. A practitioner shall not be entitled to any formal hearing for any matter related to an administrative hearing as defined in Section B-4.c.2 except as otherwise specified.

3. Allied Health Professionals. The provisions of Section B-5 shall not apply to the Allied Health Professionals, except where required by law.

ARTICLE C: CLASSIFICATIONS, PREROGATIVES, AND OBLIGATIONS OF THE PROFESSIONAL STAFF

SECTION C-1. ACTIVE STAFF.

a. Qualifications.

The Active Staff shall consist of practitioners who:

1. Meet the requirements set forth in Sections B-1 through 3.
2. Are engaged in the practice of their professions in the vicinity of this Hospital.
3. Regularly care for patients in this hospital; or are otherwise regularly involved in the care of in excess of six (6) patients a year in the Hospital; or are regularly involved in Professional Staff functions, as determined by the Professional Staff.
4. Have satisfactorily completed appointment in the Provisional Staff Category. (This provision shall not apply to individuals with current Professional Staff membership on effective date of this Bylaws)

b. Prerogatives.

The prerogatives of an Active Professional Staff member, unless otherwise limited by these Bylaws and Rules and Regulations, shall be to:

1. Exercise privileges as provided in Article H,
2. Be eligible to hold office in the Professional Staff and in the department of which he or she is a member, and to serve on committees.
3. Vote on all matters presented at general and special meetings of the Professional Staff and of the department and committees of which he or she is a member.
4. Attend all scientific and educational meetings.

c. Obligations.

The obligations of Active Staff members include the following:

1. Each member of the Active Staff, attend not less than one third of the regular meetings of his or her primary department or section, and of Professional Staff committees of which he or she is a member.
2. Each member of the Active Staff, within the areas of his or her professional competence, shall actively participate in and regularly assist the Hospital in fulfilling its obligations related to patient care, including, but not limited to, consultative emergency services.

3. Each member of the Active Staff shall actively participate in peer review and be available to participate in other performance improvement activities, including utilization review, quality evaluation and related monitoring activities, proctoring other Professional Staff members and Allied Health Professionals, and in performing other related functions as may be required.

SECTION C-2. COURTESY STAFF.

a. Qualifications.

The Courtesy Staff shall consist of practitioners who:

1. Meet the requirements set forth in Section B-1 through 3.

2. Do not regularly care for patients or are not regularly involved in Professional Staff functions as determined by the Professional staff.

b. Prerogatives:

The prerogatives of a Courtesy Staff member, unless otherwise limited by these Bylaws and Rules and Regulations shall be to:

1. Exercise his or her privileges as provided in Article H

2. Be eligible for appointment to any committee;

3. Have the privilege of the floor at any business meeting, but not to vote; and

4. Attend all scientific, educational, and business meetings.

c. Obligations.

Courtesy Staff members shall use their best efforts to attend a reasonable number of department, business, scientific and educational meetings.

d. Have satisfactorily completed appointment in the Provisional Staff Category. (This provision shall not apply to individuals with current Professional Staff membership on the effective date of this Bylaws.)

SECTION C-3. CONSULTANT STAFF.

a. Qualifications.

The Consultant Staff shall consist of practitioners who:

1. Meet the requirements set forth in Section B-1 through 3.

2. Provide consultative services at this Hospital.

b. Prerogatives:

The prerogatives of a Consultant Staff member, unless otherwise limited by these Bylaws and Rules and Regulations shall be to:

1. Provide consultative services patients consistent with his or her privileges as provided in Article H;
2. Be eligible for appointment to any committee;
3. Have the privilege of the floor at any business meeting, but not to vote; and
4. Attend all scientific, educational, and business meetings.
5. Members of the Consultant Staff shall not admit patients.

c. Obligations.

Consultant Staff members shall use their best efforts to attend a reasonable number of department, business, scientific and educational meetings.

d. Have satisfactorily completed appointment in the Provisional Staff Category. (This provision shall not apply to individuals with current Professional Staff membership on the effective date of this Bylaws.)

SECTION C-4. PROVISIONAL STAFF.

a. Qualifications.

The Provisional Staff shall consist of practitioners who:

1. Meet the requirements set forth in Sections B-1 through 3.
2. Immediately prior to their application and appointment to the Professional Staff were not members (or were no longer members) in good standing of this Professional Staff.

b. Prerogatives.

The prerogatives of an Provisional Staff member, unless otherwise limited by these Bylaws, Rules and Regulations, shall be to:

1. Be eligible for appointment to any committee;
2. Have the privilege of the floor at any business meeting, but not to vote; and
3. Attend all scientific, educational, and business meetings;

4. Provisional Staff members who desire assignment to and meet the qualifications for the Active and Courtesy staff categories may have the privilege to admit and discharge patients.

c. Provisional Staff members shall use their best efforts to attend a reasonable number of department, business, scientific and educational meetings.

d. The Medical Executive Committee may award additional prerogatives and assign additional obligations to individual members of the Provisional Staff.

e. Term: A member shall remain in the Provisional Staff category until completion of the Initial Evaluation as defined in Section H-2, for a period of one year, not to exceed a total of two years.]

SECTION C-5. HONORARY STAFF.

a. Qualifications.

The Honorary Staff shall consist of individuals recognized for their outstanding reputation, their noteworthy contributions to the health and medical sciences, or their previous long-standing service to the Hospital.

b. Prerogatives.

Honorary Staff members are not eligible to admit patients to, or exercise privileges in, the Hospital. They may serve upon committees with or without vote at the discretion of the Medical Executive Committee. They may attend staff and department meetings and any staff or Hospital educational meetings. An Honorary Staff member may not vote on any Professional Staff matter or hold an office of the Professional Staff.

c. Obligations.

Each Honorary Staff member shall abide by the Professional Staff Bylaws and Rules and Regulations.

SECTION C-6. ADMINISTRATIVE STAFF.

a. Qualifications.

The Administrative Staff shall consist of practitioners who:

1. Are members of the Professional Staff and perform the obligations set forth herein.

2. Possess adequate training, experience, and demonstrated competence to provide general supervision of the medical care of Hospital patients.

3. Otherwise satisfy the qualifications of the officer position pursuant to Article D of these Bylaws.

4. Do not provide care for patients in the Hospital but otherwise satisfy the qualifications of Sections B-1 through 3.

b. Prerogatives.

The prerogatives of an Administrative Professional Staff member, unless otherwise limited by these Bylaws and Rules and Regulations, shall be to:

1. Be eligible to hold office in the Professional Staff and to serve on committees.

2. Vote on all matters presented at general and special meetings of the Professional Staff and of the committees of which he or she is a member.

3. Attend all scientific and educational meetings.

c. Obligations.

The obligations of Administrative Staff members include the following:

1. Each member of the Administrative Staff shall attend not less than one third of the regular meetings of Professional Staff committees of which he or she is a member.

2. Each member of the Administrative Staff shall be available to participate in other performance improvement activities, including peer review, utilization review, quality evaluation and related monitoring activities, and in performing other related functions.

Membership on the Professional Staff shall automatically terminate when the practitioner no longer serves in the administrative role which qualified them for the Administrative Staff category.

Nothing in this Section shall preclude a practitioner who is a member of the Administrative Staff from applying for other Staff categories pursuant to these Bylaws if the practitioner otherwise satisfies the requirements of those categories.

ARTICLE D: OFFICERS

SECTION D-1. OFFICERS.

Only members of the Active or Administrative Staff shall serve as officers. The officers of the Professional Staff and their terms of office shall be:

a. The Chief of Staff: six (6) years

b. The Assistant Chief of Staff: three (3) years

c. If the Executive Committee so recommends, the Professional Staff may elect such other officers as needed.

SECTION D-2. SELECTION OF OFFICERS.

The officers of the Professional Staff shall be selected as follows:

a. Chief of Staff.

The Chief of Staff shall be a physician member of the Professional Staff who is a member of the Active or Administrative Staff. The Chief of Staff shall have sufficient clinical training, experience, and demonstrated competence to provide general supervision of the Professional Staff. The Chief of Staff shall be elected by the Active Staff, and shall take office commencing January 1 of the following calendar year, or earlier if the previous Chief of Staff did not complete his or her term. Candidates may be nominated by the Medical Executive Committee or by written petition of forty percent (40%) of the members of the Active Staff. The Chief of Staff shall hold office until December 31 of the year in which his or her term expires or until his or her successor shall be elected and accepts office. This paragraph becomes effective at the completion of the term of office of the Chief of Staff holding office when this paragraph is adopted.

b. The Assistant Chief of Staff shall be a physician member of the Professional Staff appointed by the Chief of Staff with the approval of the Medical Executive Committee, and shall hold office until his or her successor is appointed.

Upon the death, permanent incapacity, termination or resignation of the Chief of Staff, the Assistant Chief of Staff shall serve until a Chief of Staff is elected and takes office.

c. Election of Officers

Ballots for election of officers shall be mailed by hard copy or electronic means to each Active or Administrative Staff member within sixty (60) days after the officer(s) is/are nominated by the Medical Executive Committee. In order to be counted, a ballot must be received by the Professional Staff office no later than thirty (30) days after the date the ballots were mailed by hard copy or electronic means. A Professional Staff officer or designee shall supervise the counting of

the ballots. The affirmative vote of a majority of the voting members casting valid ballots shall be required for the election of officers.

SECTION D-3. DUTIES OF PROFESSIONAL STAFF OFFICER.

a. Chief of Staff.

The Chief of Staff shall be responsible for the general supervision of the medical care of Hospital patients. He or she shall be an ex officio member, with voice and vote, of all committees and shall perform such other duties as the Professional Staff or the Medical Executive Committee shall designate. He or she shall act in coordination and cooperation with the Hospital Administration in matters of mutual concern within the hospital. He or she shall serve as the Chairperson of the Medical Executive Committee. He or she shall appoint, with Medical Executive Committee approval, the chairpersons and committee members of all standing and special Professional Staff committees, except where otherwise provided by these Bylaws and Rules and Regulations. He or she shall represent the views, policies, needs and grievances of the Professional Staff to the Hospital Administrator and the Board of Directors. He or she shall impart the policies of the Board of Directors to the Professional Staff. He or she shall be spokesman for the Professional Staff in professional and public relations. The Chief of Staff shall supervise the enforcement of these Bylaws and Rules and Regulations.

b. Assistant Chief of Staff.

The duties of the Assistant Chief of Staff shall be as follows: 1) those functions delegated by the Chief of Staff, and 2) to serve as Chief of Staff in his or her temporary absence.

SECTION D-4. REMOVAL OF STAFF OFFICER.

a. The Assistant Chief of Staff shall be subject to removal from office by two-thirds vote of the Medical Executive Committee, or by vote of two-thirds of the Active and Administrative Staff members at a special staff business meeting convened for that purpose. Action for removal may be initiated by the Medical Executive Committee or upon written request of twenty-five percent (25%) of the members eligible to vote for officers.

b. Removal of the Chief of Staff prior to completion of his or her appointed term may be accomplished by a two-thirds majority vote of the Active and Administrative Staff members. Voting on removal of a Chief of Staff shall be by secret written mail ballot. The written mail ballots shall be sent to each voting member at least twenty-one (21) days before the voting date and the ballots shall be counted by the Assistant Chief of Staff.

c. An officer who has been removed from office is not entitled to a hearing pertaining to such action.

d. Cause for removal of an officer shall be any of the following: (1) failure to perform the duties of the office, as described herein; or (2) failure to meet or continue to meet the qualifications of an officer, as described herein; or (3) the inability to serve effectively in the role as an officer.

ARTICLE E: COMMITTEES

SECTION E-1. GENERAL.

a. Designation and Approval of Actions.

The committees described in this Article shall be the standing committees of the Professional Staff. Unless otherwise specified, the members of such committees and the Chairpersons of such committees shall be appointed by the Chief of Staff, subject to the Medical Executive Committee's approval. All committee actions require Medical Executive Committee approval except as otherwise designated in these Bylaws.

b. Composition of Committees: Quorum.

Except for the Medical Executive Committee, the composition of which is specified in Section E-2, each committee shall consist of such number of members as the Chief of Staff shall appoint, but ordinarily not less than three, a majority of whom shall be selected from the Active and Administrative Staff. The Chief of Staff and the Hospital Administrator or their designees shall serve ex officio on all committees with voice and vote. Committees reviewing clinical performances or related records shall include representation of the Nursing Department. Other non-physician committee members shall consist of departmental representatives serving on those committees concerned with their respective areas of concentration. They shall be appointed by the Hospital Administrator, confirmed by the Medical Executive Committee, and shall have voice and vote.

A quorum of fifty percent of the voting membership shall be required for Executive and Credentials and Privileges Committee meetings. For other committees, a quorum shall consist of one-third of the voting members of a committee but in no event less than two (2) voting members.

Unless otherwise specified, meetings should be conducted according to Robert's Rules of Order Newly Revised. Technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

c. Appointment and Term of Office.

Committee Chairpersons shall be members of the Active or Administrative Professional Staff. They shall be appointed by the Chief of Staff with Medical Executive Committee approval. Other members of standing committees, excluding members of the Medical Executive Committee, shall be appointed or reappointed annually by the Chief of Staff subject to Medical Executive Committee approval. Committee appointments may be terminated by the Chief of Staff upon recommendation of the committee chairperson, for cause. Participation by all committee members shall be reviewed annually by the Chief of Staff. Unless otherwise specified, vacancies on any committee shall be filled in the same manner in which original appointment to such committee is accomplished.

d. Committee Minutes.

Each committee shall keep permanent minutes of its proceedings, of the persons attending each

meeting and the result of the vote on each matter upon which a vote is taken. Committee minutes shall be kept in such manner and form as the Chief of Staff shall designate. Committees shall report relevant concerns and findings to the various departments. As specified by Section E-2., all committee minutes shall be provided to the Medical Executive Committee for review and approval of all recommendations and actions taken.

e. Voting.

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members. Any action taken must be approved by at least a majority of the required quorum for such meeting. Committee action may be taken by telephone or video conference or electronic mail which shall be deemed to constitute a meeting for the matters discussed in that telephone or video conference or electronic mail. A committee may act without a meeting if a written description of the action is signed by a majority of members entitled to vote. All committee members, including those not members of the Professional Staff, shall have voice and vote.

f. Provision for Committees.

The functions of two or more standing committees of the Professional Staff may be combined upon approval of the Medical Executive Committee. Committees shall submit reports to the Board of Directors, through the Medical Executive Committee, as requested.

The standing committees of the Professional Staff shall be:

1. Medical Executive Committee
2. Accreditation Committee
3. Bioethics Committee
4. Credentials and Privileges Committee
5. Health Information Management Committee
6. Infection Control Committee
7. Resource Stewardship-Utilization Management Committee
8. Cancer Committee
9. Pharmacy and Therapeutics Committee
10. Professional Education Committee
11. Professional Staff Well-Being Committee

12. Quality, Risk Service, and Safety Committee

13. Special Care Units Committee

SECTION E-2. MEDICAL EXECUTIVE COMMITTEE.

The Medical Executive Committee shall consist of the Chief of Staff, who shall be chairperson of the committee; other Professional Staff officers as applicable; Department Chiefs as defined in Section G-2, the Hospital Administrator or designee and the Nurse Executive. Ex officio members may be appointed by the Chief of Staff with approval of the Medical Executive Committee. Ex officio members shall be members of the Professional Staff or Hospital Administration. The Medical Executive Committee is responsible to ensure the proper functioning of all departments, committees and other activities of the Professional staff and to monitor the effectiveness of Professional staff activities. The committee shall coordinate the activities and general policies of the various departments, implement Professional Staff policies, and act for the Professional Staff as a whole in the intervals between Professional Staff meetings under such limitations as may be imposed by the Professional Staff with respect to both business and clinical matters. It shall receive and act upon reports and recommendations of departments, and committees and other groups performing services under the Bylaws of the Professional Staff. It shall be responsible for the organization of the performance improvement and patient safety activities of the Professional Staff as well as the mechanisms used to conduct, evaluate and revise such activities. It shall make recommendations to the Board of Directors on the organization of the Professional Staff, Staff appointments, reappointments, requests for privileges, disciplinary action, and the mechanism for the review of the foregoing, including the processes used to review credentials and delineate privileges. The Medical Executive Committee shall establish, as necessary, such ad hoc committees that will fulfill particular functions for a limited time and will report directly to the Medical Executive Committee. In general, the Medical Executive Committee shall meet at approximately once a month during ten (10) months of the year, and maintain a permanent record of its proceedings and actions. It shall report at each regular General Staff meeting and submit periodic reports to the Board of Directors at least quarterly and as requested.

SECTION E-3. ACCREDITATION COMMITTEE.

The Accreditation Committee shall meet at least quarterly. It shall review current standards and regulations of accreditation and licensing organizations, and shall recommend to the Medical Executive Committee actions necessary or desirable for obtaining and maintaining desired accreditation and licensure.

SECTION E-4.BIOETHICS COMMITTEE.

The Bioethics Committee shall meet at least quarterly, and more often as needed to respond to requests for consultation. It shall (a) provide Professional Staff, Allied Health Professionals, and other individuals or groups with education concerning ethical issues in health care, as requested by the Board of Directors, the Hospital Administrator, the Medical Executive Committee, and others, (b) draft or review policies which involve ethical issues, and (c) respond to requests for reflection and advice concerning ethical issues arising in connection with the care of an individual patient. A summary of its activities shall be presented to the Medical Executive Committee periodically. The membership shall be interdisciplinary, consisting of physicians and non-physicians with backgrounds and experience sufficiently diverse to carry out the committee's responsibilities.

SECTION E-5. CREDENTIALS AND PRIVILEGES COMMITTEE.

The Credentials and Privileges Committee shall meet as frequently as necessary and at least quarterly, and shall review, investigate, and evaluate the credentials of all applicants for membership and/or clinical privileges, and maintain a continuing review of the qualifications and performance of all members of the Professional Staff and Allied Health Professionals. It shall consider and make recommendations regarding appointment, proctoring, renewal, classification, and delineation of privileges and changes therein, as required by these Bylaws. In addition the committee shall investigate and report on matters involving any breach of professional standards by Professional Staff members or Allied Health Professionals.

SECTION E-6. HEALTH INFORMATION MANAGEMENT COMMITTEE.

The Health Information Management Committee shall meet at least quarterly to ensure the quality, recording, maintenance, duplication, and retrieval, and timely completion of medical records and other clinical information whether in electronic, hardcopy, photographic, or other medium. The Committee shall strive to assure compliance with hospital policies, and accrediting and regulatory rules and regulations regarding the completeness, accuracy, and legibility of hospital medical records. The committee shall be responsible for the review and approval of the content, form, and structure of the medical record including authorizing any necessary symbols and abbreviations. Additionally, the Committee may assume the role of coordinating and prioritizing requests for enhancements to application systems, hardware, and end-user technologies. Committee membership shall include members of the Professional Staff, the Director of Health Information Management, and representatives of Quality Metrics, outpatient medical records, information technology, hospital systems, nursing, and other ancillary services as deemed appropriate.

SECTION E- 7. INFECTION CONTROL COMMITTEE.

The Infection Control Committee shall meet at least quarterly. It shall develop a system for surveillance, prevention and control of infections, identifying, and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analysis of such data, as well as for required follow-up action. The committee shall develop and implement a preventive and corrective infection control program designed to minimize infection hazards, including establishing, reviewing, and evaluating aseptic, isolation, and sanitation techniques; provide advice on all proposed hospital construction; develop written policies defining special indications for isolation requirements in relation to the medical condition involved; and review and/or act upon findings from such review of clinical use of antibiotics. The committee chairperson shall have authority to institute any appropriate control measure or studies when there is reason to conclude that there exists within the hospital a danger to patients and/or others from infection. The committee membership shall include, but not be limited to, the Hospital Infection Control Manager and/or Epidemiologist, members of the Professional Staff, and representatives from Nursing. Representatives from the Operating Room, Environmental Services, Dietary, Engineering/Maintenance, and Pharmacy shall participate at least on a consultative basis.

SECTION E-8. RESOURCE STEWARDSHIP-UTILIZATION MANAGEMENT COMMITTEE.

The Resource Stewardship-Utilization Management Committee shall meet at least quarterly. The committee shall oversee all utilization review activities in the hospital and region; identify high-volume, high cost and high variation areas in care delivery; prepare reports for all utilization review activities; analyze internal and external data associated with quality, regulatory and accrediting agencies and recommend practice changes; identify opportunities and support improvement efforts that will support optimal use of health care resources; and measure medical services within KPHI in order to differentiate cost on outside contracted services The Team shall establish, follow, periodically evaluate, and update a Resource Stewardship Program Description and Work Plan which shall be approved by the Medical Executive Committee. The committee shall submit reports to the Medical Executive Committee summarizing the results of review activities, including recommendations and actions taken.

SECTION E-9. CANCER COMMITTEE.

The Cancer Committee shall meet at least quarterly. The committee is responsible for cancer program management and administration in accordance with the accreditation standards of the American College of Surgeons. The Cancer Committee responsibilities include the following:

- Develops and evaluates the annual goals and objectives for the clinical, educational, and programmatic activities related to cancer;
- Promotes a coordinated, multidisciplinary approach to patient management;
- Ensures that educational and consultative cancer conferences cover all major sites and related issues;
- Ensures that an active supportive care system is in place for patients, families, and staff;
- Monitors quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes;
- Promotes clinical research;
- Supervises the cancer registry and ensures accurate and timely abstracting, staging, and follow-up reporting;
- Performs quality control of registry data;
- Encourages data usage and regular reporting;
- Ensures content of the annual report meets the requirements of the American College of Surgeons' Commission on Cancer; and
- Upholds medical ethical standards.

The Cancer Committee shall develop and evaluate annual cancer program goals toward the promotion of an active, coordinated, interdisciplinary approach to patient management, promote clinical research, provide an annual summary, and uphold medical ethical standards.

SECTION E- 10. PHARMACY AND THERAPEUTICS COMMITTEE.

The Pharmacy and Therapeutics Committee shall meet at least quarterly and shall be responsible for the development, endorsement, and surveillance of the drug therapy and utilization policies and practices in the Hospital in order to promote satisfactory drug therapy outcomes and clinical results, while minimizing the potential for hazards. The committee membership shall consist of representatives of the Professional Staff, one of whom shall be the chairperson, the Director of Pharmaceutical Services, a representative from Nursing, and a

representative from Hospital Administration. Members of the Professional Staff shall provide leadership for patient safety and the development of quality measurement, assessment, and improvement activities, regarding the use of medications. Other performance improvement activities related to the use of medications shall include activities for (a) prescribing, ordering, preparing, dispensing, and the administration of medications; and (b) monitoring the effects of medications on patients. The committee shall assist in the formulation of broad professional policies regarding the evaluation, selection, storage, distribution, use, safety procedures, administration, and other matters relating to drugs and diagnostic testing materials in the Hospital; advise the Professional Staff on matters pertaining to the choice of available drugs; define and evaluate all significant untoward drug reactions; make recommendations concerning drugs to be stocked throughout the Hospital; evaluate all standardized drug procedures and pre-printed drug orders; develop and maintain a current formulary or drug list for use in the Hospital; evaluate clinical data concerning new drugs; coordinate and conduct drug usage evaluation activities; and establish standards and approve protocols concerning the use and control of investigational drugs and of research in the use of approved drugs; and approve pre-printed/electronic order sets and protocols.

SECTION E-11. PROFESSIONAL EDUCATION COMMITTEE.

The Professional Education Committee shall meet at least quarterly and shall organize a Continuing Education Program coordinated with the Quality Management and Clinical Risk Programs and designed to keep the Professional Staff informed of significant new developments in medicine. The committee shall act upon continuing education recommendations from Professional Staff clinical departments, Medical Executive Committee, or other committees responsible for patient care review and other quality review, evaluation, monitoring, and patient safety functions. The committee shall maintain records of education activities including individual participation and submit reports to the Medical Executive Committee of such education activities.

SECTION E-12. PROFESSIONAL STAFF WELL BEING COMMITTEE.

The Professional Staff Well Being Committee shall meet at least quarterly to promote the recognition and treatment of Professional Staff members and Allied Health Professionals impaired by chemical dependency or other physical or mental illness. The committee shall assist such members to obtain necessary treatment and/or rehabilitation services. It shall monitor the progress of such therapy and adherence to the treatment program.

The committee shall invite self referrals and referrals from others. It shall also consider general matters related to the health and well being of the members of the Professional Staff, and develop educational programs or related activities for staff.

The activities of the committee shall be confidential. Reports shall summarize the general activities of the committee, but shall not divulge the names or specific treatment programs of any individuals who are being or have been monitored by the committee. The confidentiality of the physician seeking referral or referred for assistance shall be maintained except as limited by law, ethical obligation, or when the safety of a patient is threatened. When these exceptions occur, that information shall be referred to the appropriate clinical department Chief, Chief of Staff, Hospital Administrator, and the Chair of the Credentials and Privileges Committee.

If a participant does not comply with the treatment program, or if information received by the committee indicates that the health or known impairment of a Professional Staff member poses a risk of harm to patients, staff, or others, that information shall be referred to the appropriate.

The committee shall not include members of the Professional Staff who serve on the Medical Executive Committee. Committee membership will be encouraged from physicians who treat chemical dependency patients, Professional Staff members who have been successful in their own recovery from chemical dependency, and other interested and compassionate members of the Professional Staff.

SECTION E-13. QUALITY, RISK SERVICE, AND SAFETY COMMITTEE.

The Quality, Risk Service, and Safety Committee shall meet at least quarterly, and shall develop and implement a hospital wide Quality Improvement Program, subject to Medical Executive Committee approval, to assure the provision of quality patient care through ongoing monitoring and evaluation of such care. Committee functions shall include, but are not limited to, overseeing departmental quality activities, collecting and analyzing appropriate data, identifying problem areas in health care or clinical performance, recommending changes in practices and processes, monitoring and evaluating the effectiveness of corrective actions taken, and overseeing follow-up activities. The committee shall be multidisciplinary. Membership shall include physician representatives of clinical departments, nursing, patient safety, quality management, risk quality metrics, pharmacy, lab, diagnostic imaging, and other departments/services as deemed necessary. The committee shall develop and submit reports to the Board of Directors at least quarterly through the Medical Executive Committee.

SECTION E-14. SPECIAL CARE UNITS COMMITTEE.

The Special Care Unit Committees for the Operating Room, Perinatal, Critical Care and Pediatric Inpatient Services shall meet at least quarterly. They shall monitor the operations, facilities, and equipment of the Units and shall evaluate the quality, safety, and appropriateness of care provided within the Units. A director of a special care unit shall chair the committee. The membership shall include, but not be limited to, members of the Professional Staff, nursing, and ancillary services deemed appropriate.

SECTION E-15. OTHER COMMITTEES.

a. Special committees may be appointed by the Chief of Staff, the Hospital Administrator, the Medical Executive Committee, or may be created by majority vote of the Active and Administrative Staff at any Professional Staff meeting, to aid in carrying out the duties of the Professional Staff. Such committees shall confine their work to the purposes for which they are appointed.

b. Medical-administrative problems ordinarily shall be resolved by the Hospital Administrator and representatives of the Professional Staff. That failing, issues are presented to the Board of Directors by the Joint Liaison Committee composed of the Chief of Staff, Hospital Administrator, one person chosen by the Active and Administrative Staff, and two representatives of the Board of Directors. The committee shall convene upon authorization of the Board of Directors. A chairperson shall be elected for each meeting. Reports of the committee’s deliberations or recommendations shall be made to the Board of Directors and to the Medical Executive Committee.

ARTICLE F: STAFF MEETINGS

SECTION F-1. ANNUAL MEETING.

There shall be an annual meeting of the Professional staff. The Chief of Staff shall present reports on actions taken during the preceding year and on other matters of interest and importance to the members. Notice of this meeting shall be given to the members at least fifteen (15) days prior to the meeting.

SECTION F-2. AGENDA.

The agenda at the Annual Staff Meeting shall include, as far as possible:

a. Reading and acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting.

b. Administrative reports, including results of quality review activities.

c. The election of officers when required by these Bylaws.

d. Recommendations for improving patient care within the Hospital.

e. New business

The agenda at regularly scheduled meetings of the Professional Staff will follow the foregoing if applicable to the business to be considered.

SECTION F-3. QUORUM.

The presence of one-third of the total membership of the Active and Administrative Staff at any regular meeting shall constitute a quorum for doing business.

SECTION F-4. SPECIAL MEETINGS.

Special meetings may be held at any time, and may be called by the Medical Executive Committee, Chief of Staff, or ten percent (10%) of the Active and Administrative Staff members may call a special meeting after notifying the Hospital Administrator or Chief of Staff not less than seven days, prior to the meeting. The notice shall state the time and place of the special meeting and describe its purpose and the nature of the business to be transacted. Notice may be sent by electronic mail or any method reasonably likely to give notice to members. If a majority of the Active and Administrative Staff is present and a majority of the total membership of the Active and Administrative Staff signifies its assent, any business, including business which would ordinarily be transacted at the annual meeting, may be transacted at a special meeting. Action on any such business shall require approval of a majority of the total number of members of the Active and Administrative Staff.

SECTION F-5. VOTING.

Except as otherwise specified in these Bylaws, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is

initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be required by these Bylaws.

a. Voting may be conducted by a show of hands, by voice vote, vote by mail, vote by electronic mail, or by secret ballot, as the Chief of Staff at his or her discretion shall designate. A secret, written ballot shall be required if duly moved and seconded prior to a vote.

b. The secretary of the committee, or a Professional Staff officer in the case of a meeting of the Active and Administrative Staff, shall be responsible for counting the votes cast and for reporting the results.

SECTION F-6. MINUTES.

Minutes of all meetings shall be prepared and shall include a record of the attendance of members and the results of votes on each matter upon which a vote is taken. The minutes shall be signed by the Secretary and forwarded to the Medical Executive Committee.

SECTION F-7. CONDUCT OF MEETINGS.

Unless otherwise specified, meetings should be conducted according to Robert's Rules of Order Newly Revised. Technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

ARTICLE G: CLINICAL ORGANIZATION

SECTION G-1. CLINICAL DEPARTMENTS.

Every member of the Professional Staff shall be assigned to a clinical department. The clinical organization of the Professional Staff shall consist of the following departments and such other departments as the Medical Executive Committee may establish.

a. Anesthesiology

b. Emergency

c. Internal Medicine

d. Obstetrics-Gynecology

e. Orthopedics

f. Pathology

g. Pediatrics

h. Psychiatry

i. Radiology

j. Surgery

k. Family Practice

l. Neuroscience

SECTION G-2. ORGANIZATION OF DEPARTMENTS.

a. Department Chiefs.

Each major department shall be administered by a Department Chief who is qualified for privileges in the department and is certified by the appropriate specialty board or has demonstrated, through the privilege delineation process, that the person possesses comparable competency. In addition, each department may have one or more Assistant Department Chiefs, similarly qualified, who are selected by and serve at the discretion of the Department Chief.

b. Term of Office.

Each Department Chief shall serve until December 31 of the year following the beginning of his term of office or until his successor shall be appointed and accept office.

c. Appointment and Removal of Department Chiefs.

The Board of Director shall appoint the Department Chiefs upon recommendation of the Medical Executive Committee and Chief of Staff. Removal of a Department Chief may be initiated by a majority vote of all Active Staff members of the clinical department effective when concurred in by the Medical Executive Committee and Board of Directors. Suspension from office for cause may be instituted at any tie by the Chief of Staff or the Medical Executive Committee, pending removal action by the Board of Directors. Such suspension action will be reviewed by the Medical Executive committee and Board of Directors and removal from office shall be acted upon by the Board of Directors. Cause for removal of a Department Chief shall be any of the following: (1) failure to perform the duties of the office, as described herein; or (2) failure to meet or continue to meet the qualifications of a Department Chief, as described herein; or (3) the inability to serve effectively in the role as Department. Chief.

d. Responsibility of Department Chief.

Each Department Chief shall be responsible to the Chief of Staff for the functioning of his or her department and its sections and shall have general supervision over the clinical work within his or her department. Specifically, each Department Chief is responsible for the professional and administrative activities within the department, including:

1. The continuing surveillance of the professional performance of all individuals who have delineated privileges within that department;

2. Requesting from a practitioner whatever information is necessary to assess the current competence of a practitioner, which shall include health information relevant to the practitioner's ability to exercise the privileges he or she has requested.

3. The continuous assessment and improvement of the quality of care and services provided;

4. Recommending the criteria for privileges in the department;

5. Recommending privileges for each practitioner having privileges in the department and others seeking privileges in the department, and periodic renewal of such privileges;

6. Recommending appointment and periodic reappointment of department members.

7. The integration of the department into the primary functions of the organization;

8. The coordination and integration of the interdepartmental and intradepartmental services;

9. The development and implementation of policies and procedures that guide and support the provision of services;

10. Recommending a sufficient number of qualified and competent persons to provide care;

11. Determining the qualifications and competence of department personnel who are not privileged and who provide patient care services;

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

13. The orientation and continuing education of all persons in the department;

14. Recommending space and other resources needed by the department;

15. Assessing and recommending to the relevant hospital authority off-site sources for needed patient care services not provided by the department or the Hospital;

16. Ensuring for department members implementation of the credentialing and privileging rules and regulations and policies of the Professional Staff of the Hospital; and

17. Continuous assessment and improvement of the quality of care, treatment, and services provided at the Hospital.

e. Responsibility of Assistant Department Chief.

Assistant Department Chiefs are responsible to and shall assist the Department Chief in the performance of his or her duties, and shall assume the duties of the Department Chief in his or her absence or during periods when he or she is unable to serve.

Membership in a clinical department is contingent upon continued qualification for Professional Staff membership. A member of the Professional Staff shall be a member of one clinical department. He or she must be well skilled in the specialty within which the major professional work of the department falls, and a substantial part of his or her medical practice shall be devoted to such specialty. A member of a clinical department shall not be required to confine his or her hospital practice to a single specialty. The practitioner shall attend the required number of meetings as stipulated in Section C.1.c.

SECTION G-3. DEPARTMENTAL MEETINGS.

Each department shall hold meetings regarding the quality and appropriateness of medical care and treatment of patients within its jurisdiction. Meetings shall be held monthly for at least ten months of the year or less frequently upon prior approval of the Medical Executive Committee. In no case shall meetings be held less than quarterly. A written record shall be kept of each departmental meeting including a record of those in attendance, any conclusions, recommendations and/or actions taken. Such written record shall be made part of the permanent record of the Professional Staff. Attendance at meetings of a clinical department shall not relieve members of their obligation to attend other meetings of the Professional Staff.

ARTICLE H: PRIVILEGES

SECTION H-1. DETERMINATION OF PRIVILEGES FOR PROFESSIONAL STAFF MEMBERS.

Each applicant for Professional Staff membership in any classification shall apply for the privileges for which he or she deems himself or herself qualified. Delineation of privileges shall be based at least upon the applicant's training, experience, demonstrated competence and health status. The applicant's credentials record shall reflect education and/or experience to support the granting of privileges. Certification by the appropriate specialty board is a factor which may be considered in the delineation of privileges. Each clinical department shall develop criteria for recommending specific privileges in that department. In considering applications, upon the recommendation of the chief of the appropriate department, the Credentials and Privileges Committee shall follow the procedure specified in Section B-2.d. Professional staff members who choose not to participate in the teaching program are not subject to denial or limitation of privileges for this reason alone.

SECTION H-2. INITIAL EVALUATION AND PROCTORING.

Practitioners who are granted privileges shall demonstrate current clinical competence by completing an initial period of monitoring consisting of observation of their practices and/or proctoring and compliance with Professional Staff Bylaws, Rules and Regulations and hospital policies. Newly granted privileges shall be evaluated in a timely manner based on criteria established by the Department and approved by the Credentials and Privileges Committee. This requirement may be fulfilled by the collection and review of information from this Hospital and other comparable healthcare organizations, to determine whether the practitioner is clinically competent to perform the privileges granted. The Department Chief or designee shall be responsible for proctoring and shall submit proctoring reports and other evidence of compliance to the Credentials and Privileges Committee for its approval. The initial evaluation shall be for a period of one year, unless extended by the Credentials and Privileges Committee for an additional period of up to one year upon a determination of good cause. The initial evaluation period shall not exceed two (2) years. Failure to successfully complete initial evaluation shall be grounds for termination of membership and/or limitation of privileges. Such termination shall not be subject to hearing and appeal rights under Section B5, unless the reason for failure to successfully complete initial evaluation was a medical disciplinary cause or reason, such that the practitioner is otherwise entitled to the hearing rights afforded under Section B-5.

SECTION H-3. RENEWAL OF PRIVILEGES.

At the time of reappointment, each staff member shall submit a written request for specific privileges. Privileges are granted for a period not to exceed two years. Following review and recommendation by the chief of the appropriate department, the Credentials and Privileges Committee shall follow the procedure specified in Section B-3.a.3.

SECTION H-4. CHANGES IN PRIVILEGES.

The chiefs of all departments shall maintain a continuing review of the qualification of staff members, and may at any time during the period for which privileges were granted recommend to the Credentials and Privileges Committee that the privileges of any member be limited or revoked. Any Professional Staff member desiring a change in privileges shall submit a written request to the Chief of his or her department

and the Credentials and Privileges Committee. If additional privileges are requested, documentation of appropriate training and clinical competence must accompany the request. Proctoring will occur by department defined criteria. Consideration and action on the request shall follow the processes described in Section B-3. The provisions for temporary privileges in Section H-6 shall apply to requests for extension of privileges.

SECTION H-5. SPECIAL CONDITIONS APPLICABLE TO DENTAL AND PODIATRIC PRIVILEGES.

Patient care and surgical procedures performed by dentists shall be under the overall supervision of the Chief of the Department of Otolaryngology. Patient care and surgical procedures performed by podiatrists shall be under the overall supervision of the Chief of the Department of Orthopedics.

SECTION H-6.TEMPORARY PRIVILEGES.

a. Granting of Temporary Privileges.

Upon the written concurrence of the Chief of Staff, (or his or her designee), and the chief(s) of the department(s) where the requested privileges may be exercised, the Hospital Administrator, (or his or her designee), may grant temporary privileges to a physician, oral surgeon, dentist, or podiatrist licensed to practice in this State. Temporary privileges may also be granted to Allied Health Professionals. Temporary clinical privileges may be granted when important patient care need mandates an immediate authorization to practice or for new applicants to the Professional Staff. In all circumstances, temporary privileges may be granted for no more than one hundred and twenty (120) days. Temporary privileges may be granted only upon a showing of current competence and in the circumstances described in subsections H-6.b, c., or d. To be considered for temporary privileges the practitioner must make information available to the Credentials and Privileges Committee which reasonably supports a favorable determination regarding the requested privileges. The granting of temporary privileges shall include the following:

1. Verification of (A) current licensure, (B) relevant training or experience; (C) current competence; and (D) ability and judgment to exercise the privileges requested;

2. Obtaining and evaluating results of queries to the National Practitioner Data Bank and state licensing Board;

3. The applicant’s filing of a complete application with the Medical Staff office;

4. The applicant has (A) no current or previously successful challenge to licensure or registration; (B) not been subject to involuntary termination of Medical Staff membership at another organization; and (C) not been subject to involuntary limitation, reduction, denial, or loss of privileges;

5. Proof of adequate professional liability protection; and

6. Other minimum credentials established by Credentialing policy.

Before temporary privileges are granted, the practitioner must acknowledge in writing that he or she agrees to be bound by the terms of the Professional Staff Bylaws, Rules and Regulations, and

Hospital policies. Any physician, dentist, oral surgeon, podiatrist, or Allied Health Professional exercising temporary privileges shall be under the supervision of the chief of the department to which he or she is assigned. Special requirements of consultation and reporting may be imposed by the department chief.

b. Pendency of Application Period.

Temporary privileges described in Section H-6.a.may be granted after verification of a complete application. In such circumstances, an applicant may be granted temporary privileges while the complete application is awaiting approval for a period not to exceed one hundred and twenty (120) days.

c. Care of Specific Patients.

Temporary privileges described in Section H-6.a. may be granted on a case-by-case basis, when an important patient care need mandates immediate authorization to practice and upon receipt of a written application for specific temporary privileges for the care of one or more specific patients. Practitioners requesting temporary privileges more than four (4) times in any 12 month period must apply for membership on the Professional Staff before being granted the requested privileges.

d. Locum Tenens.

Temporary privileges described in Section H-6.a. may be granted, upon receipt of a written application for locum tenens temporary privileges to a practitioner who is a member in good standing of the Staff of another hospital or who the Chief of the Department in which the privilege will be exercised, in consultation with the Chair of the Credentials and Privileges Committee, finds to be currently competent. Such privileges may be granted for an initial period of thirty (30) days and may be renewed for three successive periods of thirty (30) days each, the total of which may not exceed one hundred and twenty (120) days annually.

Practitioners requesting locum tenens temporary privileges after more than 120 days in a twelve (12) month period must apply for membership on the Professional Staff before being granted the requested privileges.

e. Termination of Temporary Privileges.

Temporary privileges may be terminated by the department chief or the Chief of Staff, after making arrangements for the care of patients previously admitted by the terminated practitioner. An appeal shall be available to the practitioner whose temporary privileges have been terminated pursuant to Section B-5.

SECTION H-7. DISASTER PRIVILEGES

The Professional Staff reviews and approves its role in the Disaster (“Emergency Operations”) Plan.

a. Disaster privileges may be granted to volunteer practitioners who are not currently members of the Professional Staff:

1. In accordance with the Disaster ("Emergency Operations") Plan; and

2. When the Disaster ("Emergency Operations") Plan has been activated and the hospital is unable to meet immediate patient needs with its existing staff.

b. Disaster privileges may be granted to volunteer practitioners who are not currently members of the Professional Staff on a case-by-case basis by the Hospital Administrator (or his or her designee) or the Chief of Staff (or his or her designee) in accordance with the Disaster ("Emergency Operations") Plan.

c. The Professional Staff shall be responsible for overseeing the performance of practitioners granted disaster privileges in accordance with the Disaster ("Emergency Operations") Plan.

ARTICLE I: ALLIED HEALTH PROFESSIONALS

SECTION I-1. IN GENERAL.

a. Allied Health Professionals shall be assigned to an appropriate department and shall participate in patient care under the direction of members of the Professional Staff in that department. Allied Health Professionals may take independent action affecting patient care, within the scope of their competence and authorization. Where statutes, regulations, or joint agreements govern the activities of such personnel within the hospital, these sources of authority shall limit the scope of practice. An Allied Health Professional's privileges shall automatically terminate if the Allied Health Professional is no longer under a supervision arrangement with a member of the Professional Staff in that Department. Additional guidelines may be adopted by the Medical Executive Committee upon advice of the Credentials and Privileges Committee and interested departmental chiefs.

b. Allied Health Professionals shall not be eligible for Professional Staff membership nor vote in Professional Staff elections. Their authorization to serve hospitalized patients may be terminated or curtailed without entitlement to a hearing or appeals under section B-5.

However, Allied Health Professionals shall have the right to challenge any action that would constitute grounds for a hearing under Section B-5, by filing a written notice with the Medical Executive Committee within fifteen (15) days of the action. Upon receipt of such notice, the Medical Executive Committee shall conduct an investigation that affords the Allied Health Professional an opportunity for an interview concerning the notice. The interview shall not constitute a "hearing" and need not be conducted according to the procedural rules applicable to hearings under section B-5 of these Bylaws. Before the interview, the Allied Health Professional shall be informed of the general nature of the circumstances giving rise to the action and he or she may present relevant information at the interview. A record of the interview shall be made and a decision on the action shall be made by the Medical Executive Committee

c. An applicant for privileges as an Allied Health Professional shall submit a written application, which includes information regarding professional qualifications, work history including past professional practice and hospital affiliations, current license status, professional liability protection, personal and professional references, condition of mental and physical health, and any pending or previous malpractice claims, settlements and judgments or loss of or challenge to licensure, certification, or privileges at any hospital or other health care organization. Applicants shall also agree in writing to be governed by the Bylaws and Rules and Regulations of the Hospital and of the Professional Staff. The above information, along with a request for delineated privileges within the particular category of Allied Health Professional for which application is being made, shall be reviewed and approved by the chief of the appropriate department. The Credentials and Privileges Committee, upon the recommendation of the chief of the department, shall review the application, and recommend to the Medical Executive Committee the privileges to be granted to the applicant.

The Medical Executive Committee, if it approves the application, shall make its recommendation to the Board of Directors.

d. An applicant whose request for specific Allied Health Professional privileges is pending may be granted temporary privileges as provided in Section H-6-a and b.

e. The chief of the appropriate department shall conduct a review, at least every two years, of the qualifications and performance of each Allied Health Professional and may at any time recommend to the Credentials and Privileges Committee that the privileges of the Allied Health Professional be continued, extended, limited, or revoked consistent with the Allied Health Professionals scope of practice. Such action shall be considered by the Credentials and Privileges Committee and a recommendation made to the Medical Executive Committee. The Medical Executive Committee shall determine the delineation of privileges to be granted for the subsequent two years and submit its recommendation to the Board of Directors for approval.

SECTION I-2. SUPERVISION OF CERTIFIED REGISTERED NURSE ANESTHETISTS.

Certified Registered Nurse Anesthetists (CRNAs) are under the clinical supervision of the Anesthesia Professional Staff. For the purposes of compliance with Medicare Conditions of Participation for Hospitals, Professional Staff members who have privileges to perform procedures which require anesthesia services shall be deemed to have privileges to supervise CRNAs during the performance of the procedure. For the purposes of this section, “supervision” means that the supervising physician (Anesthesiologist or Operating Practitioner) is immediately available on site to assist in an emergency.

ARTICLE J: MISCELLANEOUS PROVISIONS

SECTION J-1. RULES AND REGULATIONS.

a. In addition to these Bylaws, the Professional Staff shall adopt such Rules and Regulations as may be necessary or desirable for the proper delivery of health care in the Hospital.

b. Each department may establish policies and procedures for its specialized practice. They shall be consistent with the Bylaws and Rules and Regulations of the Professional Staff, and shall be subject to the approval of the Medical Executive Committee.

SECTION J-2. ADOPTION, REVIEW AND AMENDMENT OF THE BYLAWS AND THE RULES AND REGULATIONS OF THE PROFESSIONAL STAFF.

a. Adoption.

The Bylaws and the Rules and Regulations of the Professional Staff may be adopted at any meeting of the Professional Staff by vote of a majority of the members of the Active and Administrative Staff present, or may be adopted by a majority of all members of the Active and Administrative Staff by subscription without a meeting.

b. Effective Date.

The Bylaws and the Rules and Regulations of the Professional Staff shall become effective upon approval by the Board of Directors and shall replace all previous Bylaws and Rules and Regulations.

c. Review.

A review will be conducted by a standing or ad hoc committee designated by the Medical Executive Committee as frequently as necessary, but not less often than every three (3) years to determine the need for amendments.

d. Amendments.

Amendment of the Bylaws and Rules and Regulations may be initiated by action of the Professional Staff, or by the Medical Executive Committee, or by the Board of Directors. No amendments shall be effective until approved by the Board of Directors. Neither the Board of Directors nor the Professional Staff shall unilaterally amend the Bylaws or the Rules and Regulations.

1. Amendment of Bylaws by Professional Staff.

   A. Amendments to the Bylaws may be proposed by written petition of twenty-five percent (25%) of the members of the Active and Administrative Staff, submitted to the Medical Executive Committee.

B. If any amendment is so proposed, a special committee shall be appointed by the Chief of Staff to consider such proposal. The committee shall report at the next regular meeting or at a special meeting called for the purpose of receiving such reports. The special committee shall present its recommendations as to the proposed amendment to the Active and Administrative Staff at the meeting or in writing prior to such meeting. Written notice of any such special meeting shall be sent to all members of the Active and Administrative Staff at least 20 days in advance of the meeting.

C. The affirmative vote of a majority of the members of the Active and Administrative Staff present at the meeting shall be required before submitting the proposed amendment of the Bylaws of the Professional Staff to the Board of Directors.

2. Amendments to Bylaws and Initiated by the Medical Executive Committee.

Proposed amendment to the Bylaws or the Rules and Regulations may be initiated by the Medical Executive Committee whose proposals then shall be considered and voted upon at Professional Staff meetings or by ballot as described in subsection J-2.d,

3. Amendment of Rules and Regulations at Professional Staff Meetings.

Amendments to the Rules and Regulations may be submitted to vote at any regular meeting of the Professional Staff without prior notice, or at a special meeting duly called upon written notice containing the time and place of the meeting and the wording of the proposal, and sent to all members of the Active and Administrative Staff at least 20 days prior to the meeting. Amendments to the Rules and Regulations shall be approved for submission to the Board of Directors upon the affirmative vote of a majority of the members of the Active and Administrative Staff present at the meeting

4. Bylaws and Rules and Regulations –Procedure for Approval of Amendments by Ballot.

Proposed amendments to the Bylaws or the Rules and Regulations that are permitted by these Bylaws to be approved by hard copy mail or electronic means, shall be mailed to each Active and Administrative Staff member within sixty (60) days after the proposed changes are approved or received by the Medical Executive Committee. The notice regarding the proposed changes shall include the exact wording of the proposed amendment(s) and a secret written mail or electronic mail ballot. In order to be counted, a ballot must be received by the Professional Staff office no later than thirty (30) days after the date the ballots were mailed or electronically mailed. A Professional Staff officer shall supervise the counting of the ballots. The affirmative vote of a majority of the voting members casting valid ballots shall be required for staff approval of the amendment(s).

5. Initiation of Amendments by the Board of Directors.

Amendments to the Bylaws and Rules and Regulations may be proposed by the Board of Directors or by the Medical Executive Committee of the Board. The proposed amendment(s) shall be communicated in writing to the Medical Executive Committee of the

Professional Staff which shall notify the members of the Professional Staff of the proposal. The Medical Executive Committee shall solicit the response of the staff members and then advise the Board of Directors or its Medical Executive Committee as to the views of the staff regarding the proposed amendment(s). If the staff appears to oppose the proposed amendment(s), the Medical Executive Committee may request a conference with representatives of the Board of Directors as selected by the Chairman of the Board. If the staff appears to favor the proposed amendment, the Medical Executive Committee may arrange for a vote of the staff by ballot, as described in Section J-2.d.4. In no event, however, shall the consideration and action by the Medical Executive Committee and Professional Staff exceed ninety (90) days from receipt by the Medical Executive Committee of the amendment(s) proposed by the Board of Directors. After such ninety (90) days have elapsed, the Board of Directors may convene a joint conference between members of the Board of Directors appointed by the Chairman of the Board and members of the Professional Staff approved by the Medical Executive Committee. Notwithstanding the above, neither the Board of Directors nor the Professional Staff shall unilaterally amend the Bylaws or the Rules and Regulations.

SECTION J-3. HISTORY AND PHYSICAL EXAMINATIONS

A history and physical examination ("H&P") shall be completed by a practitioner who has been granted clinical privileges to perform the history and physical examination in this Hospital within twenty-four (24) hours after admission or registration, but prior to the performance of any procedure. If a history and physical examination has been performed within thirty (30) days prior to admission, a durable, legible copy of this report may be used in the patient's medical record to satisfy this requirement if an Interval H&P is written within 24 hours of admission or registration. The attending physician will write an update note (i.e., interval H&P) addressing an updated examination of the patient, including whether there have been any changes in the patient's status and the nature of those changes. The update note (i.e., interval H&P) must be in the medical record or filed with the report of the history and physical examination.

Operative and High Risk Procedures: A history and physical examination shall be completed and entered into the medical record prior to the initiation of an operative procedure or a procedure requiring anesthesia services (or procedural sedation). An interval assessment documenting an updated examination of the patient and the presence or absence of changes since the completion of the history and physical examination shall be performed within 24 hours prior to surgery.

Qualifications: Unless otherwise allowed in this section, the history and physical examination shall be completed by one of the following members of the Professional Staff with appropriate clinical privileges: physicians, podiatrists, or dentists.

Certified nurse midwives, physician assistants and nurse practitioners, as allowed by their scope of practice and privileges, may perform all or part of the medical history and physical examination provided that the findings, conclusions, and assessment of risk shall be countersigned or authenticated by a member of the professional staff with responsibility for the patient's care and appropriate privileges within twenty-four (24) hours after admission or registration, but prior to the performance of any procedure.

SECTION J-4. NO RETALIATION

Neither the Professional Staff, its members, committees or department heads, the Board of Directors, its chief executive officer, or any other employee or agent of the hospital or Professional Staff, shall discriminate or retaliate, in any manner, against any patient, hospital employee, member of the Professional Staff, or any other health care worker of the health facility because that person has done either of the following.

a. Presented a grievance, complaint, or report to the facility, to an entity or agency responsible for accrediting or evaluating the facility, or the Professional Staff of the facility, or to any other governmental entity.

b. Has initiated, participated, or cooperated in an investigation or administrative proceeding related to, the quality of care, services, or conditions at the facility that is carried out by an entity or agency responsible for accrediting or evaluating the facility or its Professional Staff, or governmental entity.

The foregoing Bylaws of the Professional Staff of Kaiser Foundation Hospital - Moanalua, were adopted by the Professional Staff effective:

February 10, 2021
Date

Zamir Moen, M.D.
Chief of Staff

The Bylaws were approved by the Board of Directors effective:

February 10, 2021
Date

Bernice Gould, Assistant Secretary

THE RULES AND REGULATIONS OF THE PROFESSIONAL STAFF

KAISER FOUNDATION HOSPITALS – Moanalua

THE RULES AND REGULATIONS OF THE PROFESSIONAL STAFF OF KAISER FOUNDATION HOSPITALS HONOLULU, HAWAII

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THE RULES AND REGULATIONS OF THE PROFESSIONAL STAFF

INTRODUCTION

Pursuant to Section 1-1-a, the Bylaws of the Professional Staff of Kaiser Foundation Hospitals, Honolulu, Hawaii, the following Rules and Regulations are adopted to become effective upon approval of the Board of Directors of Kaiser Foundation Hospitals.

ARTICLE I: ADMISSION AND CARE OF PATIENTS

SECTION I-A. ADMISSION AND PROVISIONAL DIAGNOSIS.

A patient shall be admitted to the Hospital only by a practitioner with admitting privileges. A provisional diagnosis shall be stated for each patient upon admission to the Hospital.

SECTION I-B. RESPONSIBILITY FOR MEDICAL CARE

A member of the Professional Staff shall be responsible for the care and treatment of each patient in the hospital, for the timeliness, completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to the patient and/or relatives of the patient.

The attending physician has the responsibility for the complete and continuing care of his or her patients. He or she is required to keep appropriate hospital personnel informed as to where he or she can be reached in case of emergency, and shall designate at least one physician or render emergency or other necessary patient care if he or she is not available. It shall be the responsibility of the Medical Executive Committee to establish policies and procedures regarding minimum requirements for rounding by the attending Professional Staff.

SECTION I-C. PROTECTION OF PATIENTS.

All practitioners responsible for admitting patients to the Hospital shall obtain and furnish, to all Hospital personnel concerned, such information as is readily available and may be reasonable required for the protection of the patient from self-harm and for the protection of others from patients who are a source of danger.

SECTION I-D. PROVISION OF SERVICES.

Appropriate services, whether available in the hospital or requiring outside referral, shall be offered to patients based on their clinical need, including patients who are mentally ill, who become mentally ill while in the hospital, or who suffer from the effects of alcohol or other substances.

SECTION I-E. PROVISION OF PATIENT CARE.

Medically indigent patients who are admitted to the Hospital shall be attended by members of the Professional

Staff. **SECTION I-F. TRANSFER OF PATIENTS.**

A patient shall be transferred to another facility only when such transfer is authorized by the attending physician and has been agreed upon by an accepting physician and facility. The patient or the patient's legal representative, when he or she is reasonably available, shall consent to the transfer.

Before transferring a patient who has been diagnosed with an emergency medical condition or is in active labor, the physician shall provide emergency services and care to prevent, to the extent possible, a material deterioration of or jeopardy to the patient's medical condition or expected chances of recovery during transfer.

Clinically unstable patients shall not be transferred unless: a) the patient is being transferred to a higher level of care and the risks of transferring the patient are outweighed by the benefits of the transfer; b) the patient insists on such transfer after being fully informed of the risks associated with the transfer.

SECTION I-G. DISCHARGE OF PATIENTS.

Patients shall be discharged from the Hospital only by a Practitioner with discharge privileges.

SECTION I-H. ATTENDANCE OF PATIENTS IN EMERGENCY SITUATIONS.

An appropriate medical screening examination within the capability of the hospital (including routinely available ancillary services) shall be provided to all individuals who come to the emergency department or labor and delivery and request (for on whose behalf a request is made) examination or treatment. Such medical screening shall be provided by qualified medical personnel. For purposes of this section, qualified medical personnel include physician members of the professional staff, physician assistants, nurse practitioners, certified registered nurse midwives, registered nurses operating under standardized procedures, resident, interns and postgraduate fellows who are enrolled in an approved postgraduate training program and others authorized to perform such examinations.

Emergency services and care shall be provided to any person in danger of loss of life or serious injury or illness whenever there are appropriate facilities and qualified personnel available to provider such services or care. Such emergency services and care shall be provided without regard to the patient's race, color, ethnicity, sexual orientation, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental disability, insurance status, economic status, or ability to pay for medical services, except to the extent such circumstances is medically significant to the provision of appropriate care to the patient.

The chief of each service shall establish policies and duty rosters of physicians, including physicians who serve on an "on call" basis, to provide coverage in emergency cases. In emergency situations, Professional Staff members are required to attend patients until appropriately relieved.

SECTION I-I. MEDICAL RESEARCH.

Medical research involving human subjects, including research utilizing confidential medical record information, shall be conducted only after review and approval of the Institutional Review Board ("IRB"). Research shall be conducted in accordance with the applicable governmental regulations. In cases involving human subjects, appropriate written consent shall be obtained after full explanation of procedures, risks, and alternatives in a form acceptable to the IRB.

SECTION I-J. INVESTIGATIONAL ARTICLES.

Use of investigational drugs, devices, and biologics ("Articles") shall be approved by the Chief of Staff and the Institutional Review Board ("IRB"). Such drugs shall be administered as part of an approved medical research study, or otherwise approved by the IRB, and only under the direct supervision of the approved Professional Staff member(s). Unexpected or significant adverse reactions shall be reported by the attending physician to the IRB, the study sponsor, and to the U.S. Food and Drug Administration, as required. Prior to administration of an investigational Article, the physician under whose direction the Article is administered shall ensure that patient written informed consent is obtained in a form approval by the IRB.

SECTION I-K. QUESTIONING OF ORDERS.

Physician orders may be questioned by nurse and other personnel in accordance with professional practice standards and established hospital and Professional Staff policies.

SECTION I-L. UTILIZATION MANAGEMENT.

The attending practitioner is required to document the need for admission and continued hospitalization after specific periods of hospital stay as identified by the Utilization Management Committee and approved by the Medical Executive Committee. This documentation must contain:

1. An adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.
2. The estimated period of time the patient will need to remain in the hospital.
3. Plans for post hospital care.

Upon the request of the Utilization Management Committee, the attending practitioner must provide written justification of the necessity for continued hospitalization of any patient including an estimate of the number of additional days of stay and the reasons therefor. This report shall be submitted promptly upon receipt of such request. Failure of compliance with this policy will be referred to the Utilization Management Committee for appropriate action.

SECTION I-M. REQUEST FOR EMERGENCY ASSISTANCE.

In the event that a member of the nursing staff requests a member of the Professional Staff to respond to a patient or an emergency, the Professional Staff member shall render appropriate emergency care and/or advice and shall assist in contacting the patient's attending physician.

ARTICLE II: MEDICAL RECORDS

SECTION II-A. GENERAL PROVISIONS.

1. Complete Medical Record: The attending practitioner(s) shall be responsible to assure that a complete, legible, dated and authenticated medical record is prepared for each patient accepted for care by the Hospital. This record shall be in such form and shall contain such information as the Medical Executive Committee and Hospital Administrator shall jointly prescribe. Entries in the medical record may be electronic or hard copy. A medical record is complete when:

   a. its contents reflect the patient's condition on arrival, diagnosis, test results, therapy, condition and in-hospital progress, and condition at discharge

   b. its contents, including any required clinical resume or final progress notes, are assembled and authenticated; and

   c. all final diagnoses and complications are recorded.

   The following minimum information shall be included, to the extent applicable:

   i. Identification data

   ii. Medical complaint(s)

   iii. History of present illness

   iv. Past medical history

v. Allergy history, including allergies noted during hospital stay

vi. Family history

vii. Social history

viii. Review of systems

ix. Physical examination

x. Special reports covering all consultations, clinical laboratory examinations, x-ray examinations and similar information

xi. Provisional diagnosis

xii. Referrals to other providers and agencies

xiii. Evidence of informed consent

xiv. Medications, assessments and treatments ordered

xv. Reports of operative and other invasive procedures

xvi. Anesthesia record, if applicable

xvii. Legal status of patients receiving Mental Health services

xviii. Emergency care provided to the patient prior to arrival, if any

xix. Evidence of known advance directives

xx. Consultation reports

xxi. Discharge instructions

xxii. Labor and delivery record, if applicable

xxiii. Medical or surgical treatment recommended and carried out

xxiv. Pathological findings

xxv. Daily progress notes

xxvi. Condition on discharge

xxvii. Discharge summary

xxviii. Post discharge plan

xxix. Autopsy report, when an autopsy is performed

xxx. At the time of discharge, final diagnosis without abbreviation.

2. Timely Completion: After discharge of the patient from the Hospital, records shall be promptly completed. No medical record shall be filed until it is complete, except at the direction of the Medical Records Committee. Records not completed within 30 days in of the patient's discharge shall be considered delinquent. The Medical Records Committee shall make recommendations to the Medical Executive Committee regarding handling of delinquent records and appropriate disciplinary action.

3. Signature and Authentication: As used in these rules and regulations, requirements for Practitioner signature may be met through handwritten signatures, signature stamps, or electronic signature.

When a signature stamp or electronic signature is used, a statement shall be on file with the hospital to the effect that the person whose name is on the stamp or electronic signature is the only person who has access to and will use the stamp or electronic signature.

Each entry in the medical record shall be signed by the person making the entry, dated and the time shall be noted. The date and time shall be the date and time the entry is made regardless of whether the contents of the note relate to a previous date and time.

4. Symbols and Abbreviations: A list of symbols and abbreviations which may not be used in the medical record shall be approved by the Medical Executive Committee

5. Progress Notes: Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity and transfer of care. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes by the attending practitioner must be written at least daily on all acute patients and all progress note entries must be dated, timed, and authenticated. Patients receiving less than acute level of care require rounding and progress notes not less frequently than once weekly..

SECTION II-B. PROTECTION OF MEDICAL RECORDS.

All medical records and other records, whether in hard copy or electronic form relating to the admission, care and discharge of a patient are the property of the Hospital. The original documents shall not be removed from control by the Hospital except as required by statue, subpoena, or court order. For purposes of this section, documents are to be considered under the control of the Hospital if in the possession of The Hawaii Permanente Medical Group, Inc. or at the corporate offices of Kaiser Foundation Hospitals, Kaiser Foundation Health Plan, Inc. or their respective attorneys. Medical record information may be released when authorized by the patient, his or her guardian, conservator, the administrator of the patient's estate, or when required by law. Bona fide medical researchers may have access to medical records, providing they assure preservation of confidentiality of patient identify.

SECTION II-C. PATIENT CARE ORDERS.

Ordinarily, orders for patient care are communicated in writing. All written orders shall be dated, timed and signed. A written order may be hardcopy or in electronic form. Verbal orders may be given by a Practitioner with clinical privileges to a registered nurse, pharmacist, licensed vocational practical nurse, physical therapist or a respiratory therapist (within the lawful scope of their activities) and others as determined by the law and as authorized by the Hospital Administrator. The person receiving the verbal order shall document the order and the name of the ordering practitioner in the medical record and date, time and sign the entry his or her own name and title. The ordering practitioner, or another practitioner responsible for the patient’s care, shall review and sign verbal orders within 48 hours, unless earlier review and signature is otherwise required by law or hospital policy and procedure.

Whenever there is a significant change in the level of a patient’s care, after appropriate evaluation, patient care orders shall be reviewed and revised.

SECTION II-D. SUPERVISION OF HOUSE STAFF.

House staff shall be supervised in accordance with the Hospital’s policies and procedures. The attending physician shall document his or her involvement with the supervision of House Staff by complying with supervision documentation requirements, including, but not limited to, countersigning operative reports, consultation, discharge summaries and history and physical examination reports and by reviewing and correcting medical record entries made by House Staff.

SECTION II-E. CONSENT.

The competent patient is entitled to be informed about the nature of the proposed diagnostic and therapeutic procedures, possible benefits, risks, reasonable alternatives to the proposed care or treatment, side effects related to the alternatives, risks of not receiving the proposed care, and potential complications. It is the Professional Staff member's responsibility to convey the necessary information appropriate to the patient and the circumstances, in language which the patient is likely to understand, and to document this discussion in a separate entry in the medical record.

Except in emergencies, no patient shall be subjected to any surgical, diagnostic, or therapeutic procedure that involves a significant risk of bodily harm unless informed consent is obtained from the patient or his or her legally recognized representative and all other persons, if any, from whom consent is required by law. The medical record should indicate the emergent reason for not obtaining consent.

In exceptional cases where the patient asks not to be informed, and/or where discussion of the risks or complications might, in the opinion of the Professional staff member, cause greater harm to the patient than is warranted, the Professional Staff member shall discuss the risks, complications, benefits and alternative treatments, if any, which individuals who would be an appropriate decision maker if the patient lacked capacity to make health care decision. Such a situation should be noted in the patient's medical record.

In cases where a patient is unconscious, or is an unaccompanied, unemancipated minor and requires emergency care, such condition will be documented in the medical record.

Special consents may be required, such as for patient photographs, or for observation of a surgical procedure or delivery, or for educational purposes, and will be identified by the Medical Executive Committee consistent with legal requirements. All such consents shall become part of the medical record.

SECTION II-F. DISCHARGE SUMMARIES/DISCHARGE NOTES.

A concise discharge summary shall be included in the medical records at discharge which contains: the reason for the hospitalization; significant findings; procedures performed and treatment rendered; the patient's condition at discharge; and instruction to the patients hospitalized for less than 48 hours with minor problems, a progress note that includes the above elements may substitute for the discharge summary. For the purpose of this section, a minor problem or intervention is a problem or intervention which does not pose a significant hazard to the patient.

ARTICLE III: OPERATIVE AND HIGH RISK PROCEDURES THAT REQUIRE MODERATE OR DEEP SEDATION OR ANESTHESIA.

SECTION III-A. REQUIREMENTS PRIOR TO SURGERY.

Except in cases of grave emergency, all of the following shall be completed and recorded before any surgery or a high risk procedure, which is defined in this section as those procedures requiring moderate or deep sedation or anesthesia:

1. Verification of the patient’s identity, the side and site of the body to be operated upon;
2. A history and physical examination no more than 30 days prior to or 24 hours after registration or admission but prior to surgery or a procedure requiring anesthesia services or procedural sedation. If the history and physical was completed within 30 days prior to registration or admission, an interval medical history and physical examination update must be performed and recorded within the previous 24 hours prior to surgery or a high risk procedure;
3. Pre-operative diagnosis;

4. All necessary diagnostic work, including appropriate screening tests based upon the needs of the patient accomplished and recorded within 72 hours prior to surgery;
5. Pre-anesthetic, moderate or deep sedation assessment. The pre-anesthesia evaluation is completed within 48 hours prior to surgery or a procedure requiring anesthesia services.
6. Documentation of discussion of informed consent to surgery, including the possible administration of blood or blood components.
7. Consultation if, and to the extent that consultation is required; and
8. Documentation of informed consent for any associated anesthesia or moderate or deep sedation.
9. Before administering sedation or anesthesia, the plan or concurrence with the plan for sedation or anesthesia.
10. Reevaluation of the patient immediately before administering moderate or deep sedation or anesthesia.

If, in any surgical case, these requirements are not met before the time scheduled for surgery, the operation shall be canceled and rescheduled unless the attending practitioner states in writing that such delay would be detrimental to the patient. The medical record should then indicate the nature of the patient's condition before the start of surgery.

SECTION III-B. RECORD OF OPERATIONS AND HIGH RISK PROCEDURES.

A preoperative/pre-procedure diagnosis shall be recorded prior to the performance of surgery or high risk procedures by a Professional Staff member with appropriate privileges.

Monitoring of the patient during operative or other high risk procedures and/or during the administration of moderate or deep sedation or anesthesia is documented.

Immediately following surgery or the procedure and before the patient is transferred to the next level of care, the surgeon must enter a brief postoperative or post-procedure note in the medical record, which shall include those elements required by Hospital policy.

All surgery or high risk procedures performed shall be fully described by the operating surgeon or Professional Staff member. This description shall become a part of the medical record. Such descriptions shall include the name of the primary surgeon and his or her assistants or Professional Staff member(s), the name of the procedure performed, a detailed account of the techniques used, identification of tissues, specimens and foreign material removed, if any, estimated blood loss, if any, a description of findings, and the postoperative or post-procedure diagnosis. Such description shall be written or dictated directly after surgery or a high risk procedure and placed in the medical record. A post procedure note may be written immediately and does not need to include a detailed account of the techniques. A detailed report must be documented in the medical record within 24 hours of the performance of the surgery or procedure.

The medical record contains post-procedure information: patient vital signs and level of consciousness, any medications administered, including IV fluids and administration of blood, blood products and blood components, and any unanticipated events or complications related to the surgery or procedure.

SECTION III-C. PATHOLOGICAL EXAMINATIONS.

Unless exempted by hospital policy, all tissue and foreign material, if any, removed in surgery shall be submitted, together with adequate clinical information, to the hospital pathologist. The pathologist shall make such examination as he or she may deem necessary to arrive at a pathological diagnosis, and shall submit his or her report including recommendations, if any, in writing for the inclusion in the patient's medical record.

SECTION III-D. ANESTHESIA RECORD.

In addition to the operating surgeon's report, the record of every operation involving use of an anesthetic other than local anesthesia shall include a proper anesthetic record with (i) a pre-anesthesia evaluation of the patient and pertinent information relative to the planned choice of anesthesia and the surgical or obstetrical procedure anticipated; (ii) the administration of deep sedation or anesthesia, and (iii) a post-anesthesia follow-up report to be written within 48-hours of surgery or a procedure requiring anesthesia or deep sedation indicating the presence or absence of complications related to anesthesia.

ARTICLE IV: CONSULTATION

SECTION IV-A. CRITERIA FOR CONSULTATION

Except when consultation is precluded by emergency circumstances or is otherwise not indicated, the attending Practitioner shall consult with another qualified Professional Staff member in the following cases:

1. when the diagnosis is obscure after ordinary diagnostic procedures have been completed;
2. when there is doubt as to the choice of therapeutic measures to be used;
3. high risk patients undergoing major operative procedures;
4. in situations where specific skills of other physicians may be needed;
5. when other required by the Professional Staff or Hospital rules.

ARTICLE V: MISCELLANEOUS PROVISIONS

SECTION V-A. DUPLICATION OF LABORATORY PROCEDURES.

The time interval between pre-operative laboratory testing and surgery may vary according to policies formulated by the mutual agreement of the departments of surgery and anesthesia which take into account the nature of the illness and the stability of the condition of the patient, subject to Medical Executive Committee approval.

SECTION V-B. CRITERIA FOR AUTOPSIES.

It shall be the duty of all Professional Staff members to attempt to secure meaningful autopsies in all deaths which meet the following criteria, as identified by the College of American Pathologists, as follows:

1. deaths in which an autopsy would explain unknown or unanticipated medical complications;
2. deaths in which the cause is not known with certainty on clinical grounds;
3. deaths in which an autopsy would allay concerns of or reassure the public or family regarding the death; and
4. cases of unusual academic interest.

Autopsies will be performed only upon the written consent of a legally authorized person in the form consistent with the applicable statutes. In cases within the jurisdiction of the Medical Examiner, his or her authorization shall be obtained first.

A provisional anatomic diagnosis shall be entered into the medical record within three (3) days of the autopsy and a complete protocol shall be entered within sixty (60) days of such autopsy. The appropriate members of the Professional Staff and the attending practitioner of the decedent patient will be notified when an autopsy is performed.

SECTION V-C. EMERGENCY PREPAREDNESS.

In preparation for possible catastrophes and disasters, the Hospital Administrator and Chief of Staff shall jointly be responsible for the establishment of an Emergency Operations Plan. The scope of this plan will relate to situations arising within the Hospital and the community surrounding it. The operational aspects of the plan will be designed to coordinate to the greatest degree possible with area-wide disaster planning.

When the Emergency Operations Plan is activated, members of the Professional Staff are to report to the Hospital, to the extent feasible to do so, and will be required to participate consistent with the Emergency Operations Plan. Practitioners may provide services consistent with the scope of their respective hospital privileges. And will be assigned to appropriate tasks during the emergency situation. The Emergency Operations Plan should be rehearsed at least twice a year, preferably as a part of a coordinated drill in with other community emergency service agencies participate. There shall be a written report and evaluation of all drills, prepared for and reviewed by Hospital Administration and the Medical Executive Committee.

SECTION V-D. EMERGENCY SERVICES.

Only physicians who are members of the Professional Staff shall serve in the Emergency Department.

An appropriate medical record shall be maintained for each patient cared for in the Emergency Department. If the patient is admitted, such records shall be incorporated into the hospital record.

Emergency Department medical records shall include to the extent applicable:

- Patient identification.
- Information concerning time of arrival, means of arrival and how transported.
- History of the emergency, injury or illness and care received prior to arrival at the Hospital.
- Description of significant physical, laboratory and radiologic findings.
- Diagnostic impression.
- Treatment given.
- Condition of patient on discharge, including an indication that the patient left against medical advice, when applicable.
- Final disposition, including instructions given to the patient and family regarding necessary follow-up care.
- Signature of the attending practitioner who is responsible for the clinical accuracy of the record.
- Copy of any information made available to the practitioner or medical organization providing follow up care, treatment, or services.

There shall be periodic review of the Emergency Department medical records in accordance with the Quality Improvement Plan of the Hospital.

All departments shall provide for regularly available consultative services to the Emergency Department.

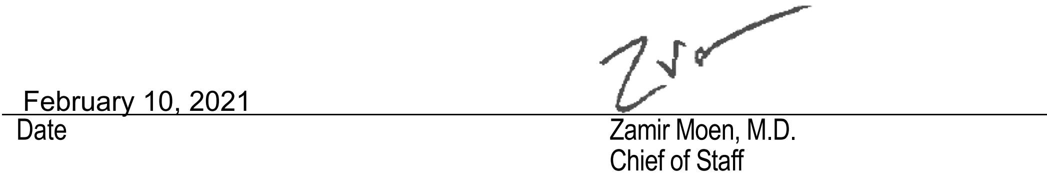
SECTION V-E. REGULATORY COMPLIANCE PROGRAM

All Professional Staff members and practitioners who exercise clinical privileges shall comply with local, state and federal laws and regulations, the Principles of Responsibility, and support and participate in the Regulatory Compliance Program.

SECTION V-F. SIGNIFICANT EVENTS

All Professional Staff members and practitioners who exercise clinical privileges shall support and participate in the identification, reporting and investigation of suspected Significant Events and other patient safety improvement and prevention activities.

The foregoing Rules and Regulations of the Professional Staff of Kaiser Foundation Hospital - Moanalua , were adopted by Active Staff effective:



February 10, 2021
Date

Zamir Moen, M.D.
Chief of Staff

The Rules and Regulations were approved by the Board of Directors effective:

February 10, 2021
Date

Assistant Secretary