STRAUB CLINIC AND HOSPITAL

dba: Straub Medical Center

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MEDICAL STAFF BYLAWS

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HAWAIʻI PACIFIC HEALTH | STRAUB MEDICAL CENTER

MEDICAL STAFF BYLAWS

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PREAMBLE

WHEREAS Straub Clinic & Hospital (also known as Straub Medical Center), a member of Hawai`i Pacific Health, is a nonprofit corporation organized under the laws of the State of Hawai`i;

WHEREAS its primary purpose is to serve as a general hospital providing patient care, education and research; and

WHEREAS the Medical Staff of Straub Medical Center is responsible to the Board of Directors for the quality of medical care provided to patients in Straub Medical Center, and for the ethical conduct of its members, and the Medical Staff must accept and discharge this responsibility—subject to the ultimate authority of the Board of Directors; and

WHEREAS the cooperative efforts of the Medical Staff, Administration, and the Board of Directors are necessary to promote high quality patient care and efficient operation of the Hospital;

NOW, THEREFORE, the Physicians, Dentists, Podiatrists, and Clinical Psychologists practicing in Straub Clinic & Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws.

These Medical Staff Bylaws are adopted to provide a framework for the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of these purposes, and to account to the Board of Directors for the effective performance of the Medical Staff's responsibilities.

These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Directors and with Straub Medical Center Administration, and relations with applicants to and Members of the Medical Staff.

DEFINITIONS

ADVANCED PRACTICE REGISTERED NURSE or **APRN** means a person recognized or licensed by the Hawai`i Board of Nursing as qualified to practice within the scope of practice established by the Board for APRNs. The categories of APRNs recognized by the Hawai`i Board of Nursing include Certified Nurse Midwives, Certified Registered Nurse Anesthetists, Certified Nurse Specialists, and Nurse Practitioners.

ALLIED HEALTH PROFESSIONAL or **AHP** means an individual healthcare provider who is not eligible for Medical Staff membership but who holds a license, certificate, or such other legal credential issued by the State of Hawai`i authorizing the AHP to provide healthcare services within the scope of such authorization. In order to provide such services at the Hospital, an AHP may be independent, as Hawai'i law permits, or may be sponsored and supervised by a Member of the Medical Staff. The Board of Directors has determined to allow the following categories of AHPs to practice in the Hospital: Certified Nurse Midwives (CNMs), Certified Ocularists, Certified Registered Nurse Anesthetists (CRNAs), Certified Nurse Specialists (CNSs), Licensed Clinical Social Workers, Nurse Practitioners (NPs), Optometrists, and Physician Assistants (PAs).

BEHAVIOR THAT UNDERMINES A CULTURE OF SAFETY means aberrant behavior manifested through personal interaction with Physicians, Hospital personnel, AHPs, patients, family members, or others, which interferes with patient care or could reasonably be expected to interfere with the process of delivering quality care. Examples of behavior that undermines a culture of safety include, but are not limited to, refusing to cooperate or work with other caregivers; rude and inappropriate comments, particularly in the presence of patients, family, or peers; improper use of medical records to criticize other caregivers or the Hospital; and insistence on idiosyncratic procedures or services.

BOARD OF DIRECTORS or **BOARD** means the governing body of the Hospital.

CENTRALIZED VERIFICATION SERVICE or **CVS** means the centralized entity designated to carry out all collection and verification of information for purposes of credentialing applicants for appointment and reappointment at any Hawai`i Pacific Health System member.

CHAIR means a Medical Staff Member duly appointed or elected, as specified in these Bylaws, to serve as head of a Medical Staff Department, Division, or committee.

CHIEF EXECUTIVE OFFICER or **CEO** means the individual appointed by the Board to manage the Hospital on its behalf. The CEO may have such other title as is designated by the Board, e.g., Administrator, President, or Executive Director.

CHIEF FINANCIAL OFFICER or **CFO** means the individual appointed by the Board to manage the financial affairs of the Hospital.

CHIEF MEDICAL OFFICER or **CMO** means a Practitioner employed by or contracted with the Hospital on a full-time or part-time basis, whose duties include Hospital-wide administrative responsibilities, and also may include clinical responsibilities.

CHIEF OPERATING OFFICER or **COO** means the individual appointed by the Chief Executive Officer to assist in the management of the Hospital.

CLINICAL PRIVILEGES, PRIVILEGES, PRACTICE PREROGATIVES or PEROGATIVES means the permission granted to Medical Staff Members, or in the case of Practice Prerogatives, to allied health professionals (AHPs), to render specific diagnostic, therapeutic, medical, dental, podiatric, psychological, and/or surgical services.

CLINICAL PSYCHOLOGIST means a practitioner who has successfully completed an approved training program in Clinical Psychology, holds a valid unrestricted state license, and meets all applicable state registration, licensing, and certification requirements.

DATE OF RECEIPT means either (1) the date when any Notice or Special Notice was delivered personally; (2) the date when any Notice was delivered by facsimile or electronic mail (e-mail); (3) if Notice was sent by United States mail, twenty-four (24) hours after the Notice was deposited, postage prepaid, in the United States mail; or (4) if Special Notice was sent by certified or registered United States mail, seventy-two (72) hours after the Special Notice was deposited, postage pre-paid, in the United States mail, unless the Special Notice is refused, in which event the date of refusal shall be the Date of Receipt (*see also* the definitions of "Notice" and "Special Notice" below).

DAYS means calendar days.

DENTIST or **ORAL SURGEON** means a Practitioner with a DDS or DMD degree (as applicable) who is licensed to practice dentistry in Hawai`i.

DISCRIMINATION means conduct directed against any individual (*e.g.*, against another Medical Staff Member, AHP, Hospital employee, or patient) that deprives the individual of full and equal accommodations, advantages, facilities, privileges, or services, based on the individual's race, religion, color, national origin, ancestry, physical disability, behavioral disability, medical disability, marital status, sex, gender, or sexual orientation/preference.

EX-OFFICIO means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means with all the same rights and privileges of regular members of the body, but without voting rights.

FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) means either the process whereby the organization initially evaluates the privilege/prerogative-specific competence of a Provider who does not have documented evidence of competently performing the requested Privileges/Prerogatives at the organization, or the process used when a question arises regarding a current Members or AHP's ability to provide safe, high-quality patient care. FPPE occurs over a time-limited period during which the organization evaluates the Provider's performance to determine whether it meets the organization's standards.

FPPE is not deemed an Investigation as defined in these Bylaws. It is one type of peer review routinely conducted by the Medical Staff in accordance with Joint Commission Standards, and FPPE is not generally a precursor to a professional review action.

GHOST SURGERY means the practice of performing surgery on another physician's patient by arrangement with the physician but unknown to the patient, *i.e*., surgery performed on a patient by a physician other than the one named in the informed consent, without the consent of the patient.

GOOD STANDING means a Medical Staff Member or AHP is not currently (1) subject to suspension, including but not limited to automatic suspension for delinquent medical records or any of the other grounds set forth in Section 9.6 of these Bylaws; or (2) subject to other corrective action or a pending recommendation for corrective action; or (3) under Investigation pursuant to Section 9.4 of these Bylaws.

HARASSMENT means a course of conduct (including but not limited to violence or threat of violence) directed at a specific person that seriously alarms, upsets, or annoys the person, and that serves no legitimate purpose. A single incident may constitute harassment if sufficiently egregious. Concerns about the conduct or performance of other Hospital personnel can and should be raised and addressed in accordance with these Bylaws (see Section 3.4.1) and the applicable Hospital policies and procedures, but such concerns do not constitute a "legitimate purpose" for engaging in harassing behavior.

HE/HIS/HIM, as used herein, shall function as both masculine and feminine pronouns, and shall refer to persons of both sexes.

HOSPITAL means Straub Medical Center.

INVESTIGATION means a formal process initiated as such by the Medical Executive Committee and conducted by the MEC or its designee(s) in compliance with the Hawai`i Health Care Quality Improvement Act of 1989, the federal Health Care Quality Improvement Act of 1986, and Article IX of these Bylaws, to review the competence and/or professional conduct of a Provider, generally as a precursor to a professional review action.

LOCUM TENENS means a physician who is granted temporary privileges for the purpose of temporarily substituting for a Medical Staff Member who is absent from the Hospital due to illness, vacation, leave of absence or other appropriate basis for allowing *locum tenens* coverage as determined in accordance with these Bylaws.

MEDICAL EXECUTIVE COMMITTEE or **EXECUTIVE COMMITTEE** or **MEC** means the Executive Committee of the Medical Staff, consisting of Medical Staff Officers, including the Department Chairs, and other appointees as determined by the Chief of Staff and the Board of Directors in accordance with these Bylaws, to represent and coordinate all activities and policies of the Medical Staff and its Departments and Divisions.

MEDICAL STAFF or **STAFF** means the formal organization of all licensed doctors of medicine and osteopathy (*i.e*., Physicians), Dentists, Clinical Psychologists and Podiatrists who are privileged to attend patients in the Hospital or to provide diagnostic, therapeutic or teaching services and who are Members of the Medical Staff, as designated by the Board of Directors.

MEDICAL STAFF MEMBER or **MEMBER** means a doctor of medicine or osteopathy (Physician), Dentist, Podiatrist, or Clinical Psychologist who has applied for and has obtained current membership in accordance with the policies procedures contained in these Bylaws.

MEDICAL STAFF YEAR means the period from January 1 to December 31.

NOTICE means a written communication delivered to the addressee/recipient personally or by facsimile or electronic mail (e-mail); or by United States mail, postage pre-paid, addressed to the addressee at the last known address as it appears in the official records of the Medical Staff or Hospital (*see also* the definitions of "DATE OF RECEIPT" and "SPECIAL NOTICE").

ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) means the continuous professional evaluation that allows the organization to identify professional practice trends that impact on quality care and patient safety. Such identification may require intervention by the organized Medical Staff.

OPPE is an evaluation of all Providers to aid in the evaluation for granting and monitoring current and ongoing Privileges/Practice Prerogatives. OPPE is not an Investigation as defined in these Bylaws. It is a routine part of peer review.

PEER REVIEW ACTIVITY means any activity of a healthcare entity such as the Hospital with respect to an individual Physician, Dentist, Podiatrist, Clinical Psychologist or AHP to do any of the following: (1) determine whether the Physician, Dentist, Podiatrist, Clinical Psychologist or AHP may be granted Medical Staff membership and/or particular Clinical Privileges or Practice Prerogatives; (2) determine the scope of conditions of such membership and/or Privileges/Practice Prerogatives; and/or (3) change or modify such membership or Privileges/Prerogatives, in accordance with the Hawai`i Health Care Quality Improvement Act.

PHYSICIAN means an individual who has an MD or DO degree and who is fully licensed in Hawai`i to practice medicine.

PODIATRIST means a Practitioner with a DPM degree who is licensed in Hawai`i to practice podiatric medicine.

PRACTICE PREROGATIVES means the permission granted to Allied Health Professionals (AHPs) to render specific patient care services at the Hospital.

PRACTITIONER means a doctor of medicine or osteopathy (*i.e.*, a Physician), Dentist, Podiatrist or Clinical Psychologist applying for or exercising Medical Staff membership and/or Clinical Privileges, or providing other diagnostic, therapeutic or teaching services in the Hospital.

PROVIDER means a Physician, Dentist, Podiatrist, Clinical Psychologist, or AHP, including an APRN.

SEXUAL HARASSMENT means unwelcome verbal or physical conduct of a sexual nature, which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and

visual harassment (such as the display of derogatory cartoons, drawings, or posters). Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct indicating that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

SPECIAL NOTICE means written notification given either by personal delivery or by certified or registered mail, return receipt requested. Refusal or failure to accept Special Notice sent by registered or certified mail shall constitute receipt of such notice as of the date of refusal.

SPECIALTY BOARD CERTIFICATION means a certificate of specialization that documents a review of a Practitioner's training and experience, ethical qualifications, and successful completion of an examination administered by a constituent Board of the American Board of Medical Specialties, the American Osteopathic Association, the American Dental Association or the American Podiatric Association, or the Royal College of Physicians and Surgeons of Canada.

STAFF CATEGORY means (unless the context indicates otherwise) any of the categories of Medical Staff membership described in Article IV of these Bylaws.

SYSTEM means the group of facilities and entities that comprise Hawai`i Pacific Health (HPH), including but not limited to Kapi'olani Medical Center for Women & Children, Pali Momi Medical Center, Straub Medical Center and Wilcox Medical Center.

UNIVERSITY means the John A. Burns School of Medicine, University of Hawai`i.

ARTICLE I:
NAME

The name of this organization is the Medical Staff of Straub Medical Center.

ARTICLE II:
PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

The purposes and responsibilities of this Medical Staff are:

2.1 to be the formal organizational structure through which (a) the obligations of the Medical Staff and its Members may be fulfilled, and (b) the benefits of membership on the Medical Staff may be obtained by individual Practitioners;

2.2 to serve as the body accountable to the Board for the appropriateness of the professional performance and ethical conduct of Members and AHPs, and to strive toward assuring that patient care across all settings in the Hospital is consistently provided at the level of quality and efficiency achievable by the state of the healing arts and the resources locally available;

2.3 to ensure a high level of professional performance on the part of all Providers authorized to provide patient care services in the Hospital through (a) careful screening of applicants for appointment and reappointment; (b) recommending to the Board appropriate Privileges or Practice Prerogatives to be exercised by each Provider practicing in the Hospital; (c) conducting ongoing and focused reviews and evaluations of each Provider's performance in the Hospital; and (d) taking appropriate actions and making appropriate recommendations to the Board based on performance reviews and other quality improvement activities;

2.4 to initiate and maintain Bylaws, Rules & Regulations and policies for self-governance of the Medical Staff and fulfillment of its responsibilities, including by adopting and recommending to the Board such amendments as may be needed from time to time;

2.5 to provide a mechanism through which the Medical Staff, the Board, and the Administration of the Hospital may share information (including Medical Staff input for the Hospital's policy-making and planning processes), discuss issues of mutual concern, and implement programs to address those issues;

2.6 to participate in the Hospital's utilization review program to help ensure that services are provided based upon scientific determinations of individual medical needs;

2.7 to provide an appropriate educational setting and continuing education programs based in part on needs demonstrated though the Hospital's quality improvement activities, which

are designed to promote continuous advancement of professional knowledge and skill among Medical Staff Members and AHPs, including through affiliation with the University and other appropriate educational and healthcare institutions;

2.8 to develop and maintain an organization capable of identifying and meeting the health care needs of the community, including in times of healthcare emergencies; and

2.9 to promote health care research that may benefit the Hospital's patients and community if applicable.

ARTICLE III:
MEDICAL STAFF MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff of the Hospital is a privilege that shall be extended only to professionally competent Practitioners who: (a) continuously meet the qualifications, standards, and requirements set forth in these Bylaws, the Medical Staff Rules & Regulations, and related procedure manuals and polices of the Hospital and its Medical Staff, (b) are professionally qualified to provide services that need to be provided at the Hospital, and (c) propose to provide services in one or more areas of hospital patient care that the Hospital offers to patients and is equipped, staffed and licensed to offer patients.

Medical Staff Members who have been granted admitting Privileges in accordance with these Bylaws may admit patients to the Hospital. Appointment to the Medical Staff confers only those particular Clinical Privileges that have been recommended by the Medical Staff and granted by the Board in accordance with these Bylaws, as listed on the Member's Privileges delineation form. Each Member is responsible for knowing what their Clinical Privileges are, and a Member who provides services outside the scope of their Privileges will be subject to corrective action.

3.2 BASIC QUALIFICATIONS FOR MEMBERSHIP

3.2.1 Threshold Criteria

Each applicant requesting Clinical Privileges and appointment to the Medical Staff must submit a fully completed application that documents all of the following qualifications before an application will be processed:

(a) (i) graduation from an accredited US school of medicine, osteopathy, dentistry, podiatry, or clinical psychology; or (ii) certification for practice in the US by the Education Commission for Foreign Medical Graduates; or (iii) for a Dentist who graduated from a dental school not accredited by the Commission on Dental Education of the ADA, proof he is either a

permanent resident of the United States or an alien authorized to work in the United States;

(b) current, unrestricted license to practice his profession within the state of Hawai`i as a Physician, Dentist, Podiatrist, or Clinical Psychologist;

(c) current, valid unrestricted federal Drug Enforcement Administration (DEA) number and state controlled substances registration, if applicable (*i.e*., if Practitioner's practice ever requires the prescribing of controlled substances);

(d) background, experience, training, health status, and ability, including current clinical competence as shown by active clinical practice within the last twelve (12) months in the area in which Clinical Privileges are sought, with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by the applicant will receive care at the level of quality and efficiency generally accepted in the community;

(e) skills to provide a type of service that the Board has determined to be appropriate for performance within the Hospital and for which a need exists;

(f) adequate written and verbal communications skills;

(g) documented references showing that the applicant adheres strictly to the ethics of his profession; bills in accordance with the Hawaii Pacific Health Standards of Conduct and the requirements of public and private payors; works cooperatively with others (including Medical Staff Members, other health care team members, Hospital management and employees, visitors, patients, volunteers, and the community in general); refrains at all times from behavior that undermines a culture of safety; and is willing to participate in the discharge of Medical Staff responsibilities;

(h) current, continuous professional liability insurance of the type and in the amounts established by the Board, which covers all of the Practitioner's professional activities at the Hospital;

(i) no current exclusion, suspension, debarment or other ineligibility to participate in Medicare, Medicaid, TRICARE or any other federal healthcare program, and/or no conviction of any criminal offense related to the provision of healthcare items or services following which the applicant has not been reinstated to participate in a federal healthcare program after a period of exclusion, suspension, debarment or ineligibility;

(j) no current preclusion from reapplying to any other healthcare organization from which the applicant was excluded for reasons based on competence and/or professional conduct;

(k) proximity of the Practitioner's office and home to the Hospital sufficient to ensure that Practitioner's patients will receive timely, continuous care. The maximum permissible distance may vary based on the type of practice and/or membership in a group practice with nearby members.

(l) Board Certification or active pursuit of Board Certification as follows (except as otherwise provided in these Bylaws):

(1) a Physician applicant, MD or DO, must have successfully completed an allopathic or osteopathic residency program of at least three (3) years, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA), and (except as otherwise provided below) be or have been Board Certified by an approved board of the American Board of Medical Specialties (ABMS), the AOA, or The Canadian Royal College of Physicians and Surgeons in the specialty of application;

(2) a Dentist applicant must have graduated from an American Dental Association (ADA) approved school of dentistry and (except as otherwise provided below) be or have been Board Certified in applicant's specialty;

(3) an Oral and Maxillofacial Surgeon applicant must have graduated from an ADA approved school of dentistry, successfully completed an ADA approved residency program, and (except as otherwise provided below) be or have been Board Certified by the American Board of Oral and Maxillofacial Surgery;

(4) a Podiatrist (DPM) applicant must have successfully completed a residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and (except as otherwise provided below) be or have been Board Certified in Podiatric Orthopedics and Primary Podiatric Medicine or in Foot and Ankle Surgery and Reconstruction Surgery;

(5) a Clinical Psychologist must have successfully completed an approved doctoral training program in psychology, hold a state license in psychology, and (except as otherwise provided below) be or have been certified in one of the psychology specialty areas;

(6) a new applicant who is not or has not been Board Certified at the time of appointment to the Medical Staff must become Board Certified by one of the above-listed specialty or subspecialty boards as soon as the eligibility requirements are met, and no more than seven (7) years following completion of residency training;

(7) the Board Certification requirement shall be waived for Members who were appointed to the Medical Staff prior to December, 2001; and

(m) If an applicant is requesting Privileges to provide services that are furnished on a closed-service or exclusive-contract basis, the applicant must be the contractor, or be a member, contractor, or subcontractor of the Practitioner group that holds the contract. The Board may not grant an exception to this requirement.

3.2.2 Effect of Other Affiliations

No Physician, Dentist, Podiatrist, or Clinical Psychologist is automatically entitled to membership on the Medical Staff or to the exercise of particular Clinical Privileges merely because the applicant is licensed to practice in this or any other state, or because the applicant is a member of any professional organization, or because Practitioner is certified by any clinical board, or because the applicant had, or presently has, staff membership or privileges at another healthcare facility or organization or in another practice setting.

3.2.3 Nondiscrimination

The Medical Staff will not make decisions regarding Medical Staff Members or AHPs based on race, sex, sexual orientation/preference, age, religion, color, national origin, disability (except and to the extent it may affect a Provider's ability to provide safe, high quality patient care), or any other category protected by federal or State law.

3.2.4 Administrative Employees and Medical Directors

A Physician, Dentist, Podiatrist, or Clinical Psychologist employed by the Hospital in a purely administrative capacity, with no clinical duties or Privileges, is subject to the regular personnel policies of the Hospital and to the terms of their contract or other conditions of their engagement, and need not be a Member of the Medical Staff. A Medical Director who performs clinical duties must be a Member, achieving this status by the procedure provided in Article VI. Such Member's Clinical Privileges must be delineated in accordance with Article VII. The Medical Staff membership and Clinical Privileges of any Medical Director shall not be contingent on such person's continued occupation of that administrative position, unless and to the extent otherwise provided in such person's agreement with the Hospital.

3.3 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

As a condition of appointment, reappointment, and continued Medical Staff membership, each Member of the Medical Staff who exercises Clinical Privileges is continuously subject to all of the following responsibilities and obligations, and must at all times:

3.3.1 be capable of performing the Privileges requested;

3.3.2 provide appropriate, timely and continuous care to Member's patients, at the level of quality and efficiency generally recognized as acceptable by professionals in the community;

3.3.3 abide by all applicable laws and regulations of government entities and the standards of The Joint Commission;

3.3.4 reasonably cooperate with the Hospital in its efforts to comply with regulatory (including but not limited to reimbursement) and other legal, accreditation, and payor requirements;

3.3.5 refrain from unlawful harassment or discrimination against any person (including but not limited to any patient, Hospital employee, Hospital independent contractor, Medical Staff Member, or visitor) based upon the person's age, sex, sexual orientation/preference, religion, race, creed, color, national origin, health status, ability to pay, any other category protected by federal or State law, or source of payment;

3.3.6 abide by the ethical principles of their profession, and specifically pledge to:

(a) refrain from fee-splitting or other inducements related to patient referral;

(b) provide continuous care of their patients;

(c) refrain from delegating the responsibility for diagnosis or care of patients to any Provider who is not qualified to undertake this responsibility or who is not adequately supervised;

(d) seek consultation whenever necessary;

(e) refrain from providing "Ghost Surgery Services" or other "ghost" medical services;

(f) participate, as required, in peer evaluation activities; and

(g) obtain appropriate informed consent as required for each intervention or procedure contemplated;

3.3.7 abide by these Bylaws and related procedural manuals, the Medical Staff Rules & Regulations and other policies, standards (including but not limited to the Hawaii Pacific Health Standards of Conduct), procedures and plans of the Medical Staff, the Hospital, and the Board;

3.3.8 maintain cooperative, respectful working relationships with all Hospital personnel and refrain at all times from behavior that undermines a culture of safety;

3.3.9 continuously and promptly inform the Medical Staff (via the Medical Staff Office) of any changes in the information that the Member was required to provide in applying for appointment and/or reappointment;

3.3.10 prepare accurately, legibly, timely, and completely all medical and other required records for all patients the Member admits or in any way provides care to in the Hospital;

3.3.11 provide evidence of continuous professional liability insurance coverage, from the type of carrier and in at least the minimum amounts established in the Medical Staff Rules & Regulations, to cover all of the Member's professional activities at the Hospital without any gaps, except as otherwise expressly permitted by these Bylaws;

3.3.12 discharge in a cooperative manner all Medical Staff, Department, Division, committee, and Hospital functions for which Member is responsible by appointment, election, or otherwise, including but not limited to participating in peer review (including proctoring), quality improvement and utilization review efforts of the Hospital, and/or other activities in support of the Hospital's mission;

3.3.13 participate in the call coverage of the emergency service and other coverage programs as determined by the MEC and/or the Board and when requested by the Department Chair and Chief of Staff, to see that patient needs are met;

3.3.14 provide uncompensated care to indigent patients in accordance with the Code of Medical Ethics of the American Medical Association (Ethics Opinion 9.065) and such other requirements or policies as the MEC and the Board may establish;

3.3.15 cooperate with the Medical Staff and the Hospital to meet any obligations of the Hospital to provide uncompensated or partially compensated care, including compliance with Hospital policies and procedures concerning care of unassigned patients;

3.3.16 complete continuing medical education (CME) that meets all applicable licensure requirements and is sufficient for the Member to maintain current competence in their specialty;

3.3.17 submit to any type of health evaluation, including but not limited to blood, urine, nail and/or hair testing, and neurologic and/or psychiatric evaluation, as requested by the Hospital CEO or designee, Chief Medical Officer, Chief of Staff, Vice Chief of Staff and/or Department Chair, in accordance with the Provider Assistance Committee Policy;

3.3.18 submit documentation of immunity to, and/or testing for infectious diseases as determined to be in the best interests of patient safety by the Board, in consultation with the MEC, from time to time;

3.3.19 provide, or arrange for the requesting party to receive, all requested information and documentation in response to a request from any Medical Staff officer, including any Department Chair, Division Chair, committee Chair, or the Chief Medical Officer in connection with evaluation of the Member's qualifications, conduct and/or practice, which may include (but is not limited to) records from the Member's medical office as well as other health care organizations**;**

3.3.20 participate in patient and family education activities as determined by the Medical Staff;

3.3.21 pay all Medical Staff dues, assessments, and/or application or other fees in the amounts established by the MEC;

3.3.22 use Hospital facilities in a manner and to an extent that enables the Medical Staff to evaluate the Practitioner's competence;

3.3.23 communicate with appropriate Medical Staff leaders whenever the Member has credible information indicating that another Medical Staff Member may have engaged in substandard, unprofessional, or unethical conduct, or may have a mental or physical condition that could pose a threat to safe patient care, and then to cooperate as reasonably necessary to help resolve any such matter;

3.3.24 continuously fulfill all of the qualifications and requirements for membership and Privileges set forth in these Bylaws and the Medical Staff Rules & Regulations, and demonstrate such fulfillment upon reasonable request of the MEC, Credentials Committee, and/or Board of Directors; and

3.3.25 discharge such other Medical Staff obligations as may be established from time to time by the Medical Staff, the MEC, or a Medical Staff Department, Division, or committee in the exercise of its authority under these Bylaws.

3.4 PROHIBITION OF DISCRIMINATION, HARASSMENT, AND BEHAVIOR THAT UNDERMINES A CULTURE OF SAFETY

3.4.1 Standards of Behavior

All Members of the Medical Staff are expected to conduct themselves at all times while on Hospital premises in a courteous, professional, respectful, collegial and cooperative manner. This applies to interactions and communications with or relating to Medical Staff colleagues, AHPs, nursing and technical personnel, other caregivers, other Hospital personnel, patients, patients' family members, visitors, and others. Such conduct is necessary to promote high quality medical care, to maintain a safe working environment, and to avoid disruption of Hospital operations. Discriminatory or harassing behavior, or behavior that undermines a culture of safety, as defined below, will not be tolerated.

If a Medical Staff Member believes that a Hospital employee has behaved inappropriately, the Medical Staff Member may communicate constructive comments politely and discreetly, and may report perceived misconduct to the employee's

supervisor and/or the appropriate representative(s) of Hospital Administration. If the Medical Staff Member believes the employee's conduct warrants reprimand or disciplinary action, the Medical Staff Member should work with Administration to resolve the issue. The types of conduct described below in section 3.4.2 are not acceptable responses to perceived employee deficiencies or misconduct, or disagreements with Physician colleagues, other Providers or the Hospital.

Additionally, medical records should contain only information that is clinically significant. Patient charts are not a proper place to record criticisms of Hospital personnel, equipment, operations, policies, etc.

3.4.2 Definitions

(a) "Behavior that Undermines a Culture of Safety" is aberrant behavior manifested through personal interaction with Physicians, Hospital personnel, AHPs, patients, family members, or others, which interferes with patient care or could reasonably be expected to interfere with the process of delivering quality care. Examples of behavior that undermines a culture of safety include, but are not limited to, refusing to cooperate or work with other caregivers; rude and inappropriate comments, particularly in the presence of patients, family, or peers; improper use of medical records to criticize other caregivers or the Hospital; and insistence on idiosyncratic procedures or services.

(b) "Discrimination" is conduct directed against any individual (*e.g.*, against another Medical Staff Member, AHP, Hospital employee, or patient) that deprives the individual of full and equal accommodations, advantages, facilities, privileges, or services, based on the individual's race, religion, color, national origin, ancestry, physical disability, behavioral disability, medical disability, marital status, sex, gender, or sexual orientation/preference.

(c) "Harassment" is a course of conduct (including but not limited to violence or threat of violence) directed at a specific person that seriously alarms, upsets, or annoys the person, and that serves no legitimate purpose. A single incident may constitute harassment if sufficiently egregious. Concerns about the conduct or performance of other Hospital personnel can and should be raised and addressed in accordance with these Bylaws (see Section 3.4.1 above) and the applicable Hospital policies and procedures, but such concerns do not constitute a "legitimate purpose" for engaging in harassing behavior.

(d) "Sexual harassment" is unwelcome verbal or physical conduct of a sexual nature, which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters). Sexual

harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct indicating that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

3.4.3 Investigation and Remedial/Disciplinary Actions

In the event that a Member of the Medical Staff or an AHP is the subject of a complaint alleging any of the behavior described in Section 3.4.2, the Member or AHP shall be subject to the investigation and remedial/disciplinary action procedures and protections provided herein and in the Disruptive Provider policy. Documentation relating to such investigations, their conclusions, and any resulting corrective action shall be maintained by the Medical Staff Office as peer review documents. As part of the peer review process, the MEC may recommend and the Board may impose a shortened term of reappointment for a Member or AHP who has been the subject of such a complaint. Notwithstanding Section 10.7 of these Bylaws, in any hearing regarding a complaint under this Section, the matter may be heard by an arbitrator who has knowledge of Medical Staff law and employment law, selected by a process mutually agreeable to the parties, in lieu of a Hearing Panel. If the MEC appoints a Hearing Panel, it may, but is not required to, include Hospital personnel other than Physicians. The Provider who is the subject of the hearing may request that the panel include both male and female members, and the request shall be granted if feasible.

3.5 DURATION OF APPOINTMENT

3.5.1 Duration and Renewal of Initial and Modified Appointments

All initial appointments, and modifications of appointments pursuant to Article VI, shall be for a period of not more than two (2) years, with the first year being a provisional period, unless the provisional period is waived by the Board for documented good cause.

3.5.2 Reappointment

Reappointment to the Medical Staff shall be for a period of not more than two (2) years.

3.6 PROVISIONAL STATUS

3.6.1 Initial Appointment and Completion of Provisional Status and of a Focused Professional Practice Evaluation (FPPE)

Except as otherwise determined by the Board, all initial appointments to any Staff Category or as an AHP shall be provisional for a period of at least twelve (12) months when the Provider involved has requested Clinical Privileges or Practice Prerogatives. Each provisional appointee shall be assigned to a Department where the Provider's performance shall be observed by the Chair of the Department or such Chair's designee, and may be observed by an ad hoc committee of Department Members appointed by the Chair, to determine the Provider's eligibility for advancement to non-provisional status and for exercising the Clinical Privileges or Practice Prerogatives provisionally granted to the Provider. FPPE shall be conducted for all Clinical Privileges and Practice Prerogatives, and shall be a part of the basis for these decisions, except when waived by the Board for documented good cause. An initial appointment and renewals thereof shall remain provisional until the appointee has furnished to the Credentials Committee, MEC and to the Board:

(a) a statement, signed by the Chair of the Department to which the Provider is assigned and of each Department in which it is documented that the FPPE has been completed successfully for each named Privilege or Practice Prerogative granted and that the appointee has met all of the qualifications, has discharged all of the responsibilities, and has not exceeded or abused the prerogatives of the category to which the Provider is provisionally appointed; and

(b) a recommendation signed by the Credentials Committee Chair or the Chair of the ad hoc committee, if one has been appointed, that the appointee has demonstrated by the successful completion of the FPPE, the Provider's ability to exercise the Clinical Privileges or Practice Prerogatives provisionally granted.

If the provisional appointee has been determined to meet the qualifications and fulfill the responsibilities of provisional appointment and the FPPE and has demonstrated the ability to exercise the Clinical Privileges or Practice Prerogatives granted, the appointee will be deemed to have completed the term of provisional appointment.

3.6.2 Modification of Staff Category and Clinical Privileges

(a) The MEC may recommend that the Board change the Staff Category of a current Medical Staff Member, or grant additional Privileges or Practice Prerogatives to a current Medical Staff Member or AHP (pursuant to Section 6.6) provisionally, in accordance with the procedures provided in this Section 3.6.

(b) The MEC may recommend that the Board restrict or limit the Privileges or Practice Prerogatives previously granted to a provisional appointee. In that event, the appointee may be entitled to the procedural rights provided by Article X of these Bylaws, depending upon the circumstances.

3.6.3 Renewals

Provisional status may be renewed for a maximum of two (2) six-month periods after the initial provisional year, with or without modification of Privileges or Practice Prerogatives, as recommended by the MEC and approved by the Board. Renewal of provisional status alone does not entitle the affected appointee to any procedural rights.

3.6.4 Mandatory Termination of Provisional Status

(a) No Provider may maintain provisional status for a total period longer than twenty-four (24) months. At the end of the original provisional period or any extension thereof, if the provisional appointee has failed within that period to furnish the certifications required in Section 3.6.1, the Provider will be deemed to have voluntarily resigned. Such Provider shall not be entitled to hearing rights under these Bylaws, unless specifically entitled to such rights under Article X of these Bylaws based upon the circumstances.

(b) Notwithstanding the foregoing, the MEC may, upon written request of a provisional Provider, determine that the Provider has been unable to complete the FPPE or other requirements timely for good cause, and that the Provider may be advanced to non-provisional status with continuation of the FPPE until completion of all such requirements (or until otherwise determined by the MEC). Such determination shall be based upon recommendations of the relevant Department and the Credentials Committee that the Provider has (a) attempted in good faith to meet the deadline for completion of all requirements; and (b) sufficiently demonstrated the requisite professional competence and compliance with other applicable requirements to justify advancement to non-provisional status.

(c) Orientation to the Medical Staff must be completed prior to providing patient care in the Hospital and within ninety (90) days of initial appointment to the Medical Staff. Failure to complete orientation within ninety (90) days of initial appointment shall be deemed an immediate voluntary resignation from the Medical Staff and result in automatic termination of membership and all Clinical Privileges. A Practitioner whose membership is so terminated shall not be entitled to the procedural rights provided in Article X of these Bylaws.

3.7 LEAVE OF ABSENCE

3.7.1 General Leave of Absence

A Medical Staff Member or AHP may obtain a voluntary leave of absence by submitting a written notice to the MEC, the CEO or designee stating the exact period of time of the leave, which may not exceed twelve (12) months unless

extended for good cause by the MEC up to a maximum of 24 months or the end of the appointment term, whichever is earlier. The MEC will acknowledge receipt of the leave request in writing and notify the Provider of the length of the leave that has been granted. During the period of leave, the Provider shall not be entitled to exercise their Clinical Privileges, Practice Prerogatives or other prerogatives in the Hospital (such as meeting attendance), but a Medical Staff Member shall be required to pay dues during the leave.

3.7.2 Medical Leave of Absence

A Provider will be placed on a medical leave of absence to obtain treatment for a physical or mental condition or disability, if the MEC determines such leave is appropriate. The MEC's determination may be based upon either a medical leave request from the Provider with supporting documentation, or reliable information from another source indicating that the Provider voluntarily has entered a rehabilitation program. Such a leave of absence will not be considered reportable if: (a) it is voluntary, and (b) no formal investigation or professional review/corrective action involving the Provider was pending. The effect of the leave and the requirements for reinstatement shall be as otherwise provided in this Section 3.7, except that the Provider's request for reinstatement must include a written statement from the Provider's attending physician that the Provider's condition will not adversely affect their ability to practice safely in the Hospital, and/or such other documentation as the MEC considers necessary under the circumstances.

3.7.3 Military Leave of Absence

A request for a leave of absence to fulfill military service obligations shall be granted upon notice and review by the MEC. Reactivation of appointment and Clinical Privileges or Practice Prerogatives previously held shall be granted notwithstanding the provisions of Section 3.7.4 below, but may be granted subject to FPPE, as determined by the MEC.

3.7.4 Termination of Leave

The Provider may request reinstatement at any time after the leave is granted, but must do so at least sixty (60) days prior to the termination of the leave if the Provider wishes to be reinstated. The reinstatement request should be made by submitting a written notice to that effect to the CEO or designee for transmittal to the MEC, together with a written summary detailing their activities during the leave.

(a) Failure without good cause to request reinstatement as provided above shall constitute a voluntary resignation. The MEC shall, in its sole discretion, and after giving such Provider the opportunity to address the MEC, determine whether or not a good cause existed. A request for appointment subsequently received from a Provider so terminated shall be

submitted and processed in the manner specified for applications for initial appointments.

(b) If the Provider requests reinstatement, the MEC shall make a recommendation to the Board concerning the reinstatement. In its discretion, the MEC may, but is not required to, meet with the Provider prior to making the recommendation. If the recommendation is negative, the Provider may be entitled to the procedural rights provided in Article X, depending upon the circumstances.

(c) At the discretion of the Board, reinstatement may be made subject to FPPE for a period of time during which the Provider's clinical performance is observed by one or more designated clinical Department or service Members to determine the Provider's continued satisfaction of qualifications.

3.7.5 Expiration of Appointment During Leave

Failure of the Provider, without good cause, to submit a timely application for reappointment, if expiration will occur during or at the end of the leave term, shall constitute a voluntary resignation from the Medical Staff or AHP staff and shall result in termination. The MEC shall, in its sole discretion, and after giving such Provider the opportunity to address the MEC, determine whether or not a good cause existed. A Provider who is so terminated shall not be entitled to the procedural rights provided in Article X. A request for appointment subsequently received from a Provider so terminated shall be treated and processed as an application for initial appointment.

3.8 PROVIDER ASSISTANCE

To protect patients as well as Medical Staff Members and others, the Medical Staff provides education and assistance regarding Provider health and the prevention of physical, psychiatric and emotional illness, and facilitates the confidential diagnosis, treatment, and rehabilitation of Providers who suffer from potentially impairing conditions. Medical Staff well-being efforts focus on rehabilitation rather than discipline, by assisting an affected Provider to retain and regain optimal professional functioning consistent with protection of patients. If at any time during the diagnosis, treatment or rehabilitation phase of this process it is determined that a Provider cannot perform their Privileges or Practice Prerogatives safely, the matter is forwarded for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.

3.9 TEMPORARY MEDICAL STAFF MEMBERSHIP

The CEO or designee and the Chief of Staff together may grant temporary Medical Staff membership to appropriately qualified Practitioners for the limited purpose of providing peer review consultation and serving on Hearing Panels. Such temporary Medical Staff Members shall not have Privileges and will not be permitted to admit or treat Hospital patients. Temporary Medical Staff Members may not vote within the Medical Staff organization except on Hearing

Panels. Temporary Medical Staff Members will not be required to pay dues. Temporary Medical Staff membership will expire at the end of the particular peer review matter for which the temporary Medical Staff Member was appointed to provide consultation or serve on the Hearing Panel, unless terminated earlier by the CEO or designee and Chief of Staff. Any such earlier termination shall not actuate any procedural rights.

Temporary Clinical Privileges also may be granted to provide for specific patients' needs, or as otherwise appropriate, in accordance with section 7.5 of these Bylaws.

3.10 RESIGNATION

Whenever a Provider wishes to resign his appointment at the Hospital, the Provider shall submit a written letter of resignation to the Medical Staff Office. The Provider is not required to disclose the reasons for the resignation. However, if a Provider resigns while a Medical Staff investigation or corrective action regarding the Provider's practice is pending, the Hospital may be required to report the resignation in accordance with applicable state and federal law. The resignation will be effective as of the date specified in the notice, or immediately upon receipt of the notice if no effective date is specified.

ARTICLE IV
CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The Medical Staff shall be divided into the Active, Active Refer and Follow, Courtesy, Consulting, Telemedicine, and Emeritus Categories. The qualifications, prerogatives, and responsibilities of Practitioners in each category are set forth below.

4.2 ACTIVE STAFF

4.2.1 Qualifications

The Active Staff shall consist of Practitioners each of whom:

(a) meets the basic qualifications set forth in Section 3.2 of these Bylaws;

(b) resides and practices their profession close enough to the Hospital to provide continuous care for their patients, as applicable;

(c) Assumes overall responsibility for patient care at the Hospital with at least 24 patient encounters per two year credentialing cycle. The term "patient encounters" includes (for the purpose of this Section) inpatient admissions, inpatient and outpatient surgeries, special procedures, consultations, and other hospital outpatient clinical activity; and does not include admissions through covering the Emergency Department unless

the Practitioner requests that these be counted to achieve or maintain Active Staff status.

4.2.2 Prerogatives

The prerogatives of the Active Staff Member shall be to:

(a) admit patients to the Hospital as provided below:

(1) A Physician Member may admit without limitation; and

(2) a Dentist, Podiatrist or Clinical Psychologist may admit provided it is demonstrated at the time of admission that a Physician Member of the Medical Staff has assumed responsibility for the basic medical appraisal of the patient and for the care of any medical problems that may be present or may arise during the hospitalization, and provided that such Physician Member ensures that a medical history and physical examination (H&P) of the patient are performed in accordance with the requirements of Section 18.11 of these Bylaws and the Rules & Regulations;

(b) exercise such Clinical Privileges as are granted to Practitioner pursuant to Article VII;

(c) vote on all matters presented at general and special meetings of the Medical Staff and of each Department, Division and committee of which he is a member; and

(d) hold office in the Medical Staff organization, including in any Department, Division or committee of which he is a member.

4.2.3 Responsibilities

Each Member of the Active Staff shall do the following:

(a) meet the basic responsibilities set forth in Section 3.3;

(b) retain responsibility within Practitioner's area of professional competence for the daily care and supervision of each patient in the Hospital to whom Practitioner is providing services, or arrange for a suitable alternative Medical Staff Member to provide such care and supervision;

(c) actively participate in patient care audit and other quality management activities, including but not limited to peer review activities, and discharge such other Medical Staff functions as may be required from time to time;

(d) maintain paid-up status of current membership dues;

(e) participate in Department and Emergency Room specialty coverage when required by the Department Chair and Chief of Staff. The Department Chair shall determine the amount of call required of each provider based on the need to provide adequate coverage for patient care, the number of other physicians available for call, and the amount of coverage, if any, provided by the Member at other HPH facilities.

Any conflicts regarding the nature or amount of call will be resolved by the Chief of Staff after discussion with the MEC, taking into consideration both patient care needs and physician wellbeing.

(f) serve as an observer and participate in FPPE and OPPE of Providers with comparable Privileges who require observation.

4.3 REFER AND FOLLOW STAFF

4.3.1 Qualifications

The Refer and Follow Staff shall consist of Practitioners each of whom:

(a) meets the basic qualifications set forth in Section 3.2 of these Bylaws as appropriate for this Category where no Clinical Privileges are granted;

(b) shall require credentialing at initial appointment which shall include but not be limited to: current Hawai'i licensure; Board Certification status; current professional liability insurance certificate; AMA/AOA Profile; National Practitioner Data Bank query; State of Hawaii Regulated Industries Complaint Office query; OIG Sanctions queries and Systems Award Management (SAM).

(c) regularly refers patients for admission to the Hospital or is otherwise regularly involved in medical staff activities at the Hospital.

4.3.2 Prerogatives

The prerogatives of the Refer and Follow Staff Member shall be to:

(a) refer patients to the Hospital for admission as provided below:

A Practitioner Member may refer for admission and follow patients without limitation provided it is demonstrated at the time of admission that a Physician Member with admitting privileges has assumed responsibility for the basic medical appraisal of the patient and for the care of any medical problems that may be present or may arise during the hospitalization, and provided that such Physician Member ensures that a medical H&P of the patient is performed in accordance with the requirements of Section 18.11 of these Bylaws and the Rules & Regulations;

(b) exercise no Clinical Privileges, and write no orders;

(c) vote at general and special meetings of the Medical Staff, and at each meeting of any Department, Division and/or committee of which Practitioner is a member; and

(d) Refer and Follow Staff Members may hold office in the Medical Staff organization, including in any Department, Division or committee.

4.3.3 Responsibilities

Each Member of the Refer and Follow Staff shall do the following:

(a) meet the basic responsibilities set forth in Section 3.3, as appropriate for this Category where no Clinical Privileges are granted;

(b) refer and follow patients admitted to the Hospital. Practitioner may visit Practitioner's patients and review the medical record; and

(c) maintain paid-up status of current membership dues.

4.4 COURTESY STAFF

4.4.1 Qualifications

The Courtesy Staff shall consist of Practitioners each of whom:

(a) meets the basic qualifications set forth in Section 3.2;

(b) assumes overall responsibility for patient care at the Hospital with at least one and no more than 24 patient encounters per two year credentialing cycle. The term "patient encounters" includes (for the purpose of this Section) inpatient admissions, inpatient and outpatient surgeries, special procedures, consultations, and other hospital outpatient clinical activity; and

(c) is a Member of the Active Staff (or its equivalent) of another hospital in the State of Hawai`i or, in the MEC's discretion, a licensed and accredited surgical center where Practitioner actively participates in performance improvement and quality management activities.

4.4.2 Prerogatives and Limitations

The prerogatives of the Courtesy Staff Member shall be to:

(a) admit patients to the Hospital within the limits established by Section 4.4.1(b) and under the same conditions as specified in Section 4.2.2(a) for Active Staff Members.

(b) exercise such Clinical Privileges as have been granted to Practitioner pursuant to Article VII;

(c) attend meetings of the Medical Staff, including the Department, Division and/or committee(s) of which Practitioner is a member, as well as Medical Staff educational programs; and

(d) serve on Medical Staff committees, without vote.

Courtesy Staff Members are not eligible to vote or hold office or other leadership positions such as Department Chair, Division Chair, or committee Chair in the Medical Staff organization.

4.4.3 Responsibilities

Each Member of the Courtesy Staff shall do the following:

(a) meet the basic responsibilities set forth in Section 3.3;

(b) retain responsibility within their area of professional competence for the daily care and supervision of each patient in the Hospital to whom Practitioner is providing services, or arrange for a suitable alternative Medical Staff Member to provide such care and supervision; and

(c) maintain paid-up status of current membership dues.

(d) serve as an observer and participate in FPPE and OPPE of Practitioners with comparable Privileges or related Practice Prerogatives who require observation.

(e) assist the Hospital in the fulfillment of its mission.

4.5 CONSULTANT STAFF

4.5.1 Qualifications

The Consultant Staff shall consist of Practitioners each of whom:

(a) meets the basic qualifications set forth in Section 3.2 of these Bylaws;

(b) resides and practices Practitioner's profession close enough to the Hospital to provide consultative services to Hospital patients in a timely manner; and

(c) has an established and respected office-based practice but provides consultations within Practitioner's specialty to patients at the Hospital.

4.5.2 Prerogatives and Limitations

The prerogatives of a Consultant Staff Member shall be to:

(a) provide consultation on patients at the Hospital when requested by a Medical Staff Member or AHP;

(b) exercise such Clinical Privileges as are granted to Practitioner in accordance with Article VII;

(c) attend meetings of the Medical Staff and the Department, Division and committee(s) of which Practitioner is a member, and attend Medical Staff educational programs;

(d) serve on Medical Staff committees; and

(e) may vote and hold office in the Medical Staff organization.

Consulting Staff Members' participation is limited as follows:

(f) may not admit patients.

4.5.3 Responsibilities

Each Member of the Consultant Staff shall do the following:

(a) meet the basic responsibilities set forth in Section 3.3;

(b) retain responsibility within the Practitioner's area of professional competence for providing consultative services for each patient in the Hospital for whom Practitioner is providing such services; and

(c) maintain paid-up status of current Medical Staff membership dues.

4.6 TELEMEDICINE STAFF

4.6.1 Qualifications

Each Member of the Telemedicine Staff shall do the following:

(a) meet the basic qualifications for membership set forth in Section 3.2 of these Bylaws, except the geographic proximity requirement; and except as otherwise provided in Section 7.8, which sets forth the requirements for telemedicine privileges;

(b) be willing and able to respond when requested to render clinical consultation within their areas of expertise;

(c) be recommended for appointment to this category by the applicable Department.

4.6.2 Prerogatives and Limitations

Telemedicine Staff Members may do the following:

(a) provide diagnostic, consultation and treatment services to patients at the Hospital when requested by a Medical Staff Member or AHP; and

(b) exercise such Clinical Privileges as are granted to Practitioner in accordance with Article VII.

Telemedicine Staff Members' participation is limited as follows:

(c) Telemedicine Staff Members may not admit patients; and

(d) Telemedicine Staff Members may not vote or hold Medical Staff office.

4.6.3 Responsibilities

(a) Each Member of the Telemedicine Staff shall comply with all applicable provisions of these Bylaws and the Medical Staff Rules & Regulations and policies, including the Medical Staff's Peer Review Activities.

(b) Telemedicine Staff Members are not required to (but may, if feasible) attend Medical Staff meetings or serve on Medical Staff committees.

4.7 EMERITUS STAFF

4.7.1 Qualifications

(a) The Emeritus Staff shall consist of Practitioners who are retired or otherwise have no Hospital activity, but who are appointed to this category in recognition of their past Medical Staff participation and their contributions to the Medical Staff's patient care, education, and/or research activities.

(b) Although Emeritus Staff Members have no Clinical Privileges, the MEC in its discretion may decline to recommend reappointment of such a Member, *e.g.*, based upon lack of contact with the Hospital during the prior term. An Emeritus Staff Member who is not recommended for reappointment will not have the right to a hearing under Article X of these Bylaws unless the reason relates to the Member's competence or professional conduct.

4.7.2 Prerogatives and Limitations

The prerogatives of the Emeritus Staff shall be to:

(a) attend Medical Staff meetings and educational programs; and

(b) serve on Medical Staff committees, without vote.

Emeritus Staff Members have no Clinical Privileges, and they may not admit or treat patients, hold Medical Staff leadership positions (*e.g*., Medical Staff office or Department or committee Chair positions), or vote on Medical Staff matters.

4.7.3 Responsibilities

Emeritus Staff Members shall have no assigned duties and shall not be required to pay dues.

4.8 AUTOMATIC CATEGORY TRANSFER UPON RETIREMENT

Retiring Members will automatically be transferred to the Emeritus Staff.

4.9 WAIVER OF PARTICULAR QUALIFICATIONS FOR GOOD CAUSE

Any qualification for assignment to a particular Medical Staff category may be waived in the discretion of the Board upon determination and documentation that such waiver will serve the best interests of the patients and the Hospital, except that the requirement for a valid license to practice in this state may not be waived for any Practitioner who provides professional services to Hospital patients.

ARTICLE V
ALLIED HEALTH PROFESSIONALS (AHPs)

5.1 QUALIFICATIONS

Allied Health Professionals (AHPs) are not eligible for Medical Staff membership. An AHP may be appointed and granted Practice Prerogatives if the AHP (a) holds a license, certification, boards and/or other credential(s) required by law in order to engage in the AHP's particular profession; (b) is professionally qualified to provide patient care services that need to be provided at the Hospital, as such need is determined to exist from time to time by the Board; (c) proposes to provide services in one or more of the areas of Hospital patient care that the Hospital offers to patients and is equipped, staffed and licensed to offer to patients; (d) resides and practices their profession close enough to the Hospital to provide continuous care to their patients; and (e) continuously complies with all applicable provisions of these Bylaws, the Medical Staff Rules & Regulations and the policies of the Medical Staff and the Hospital. The MEC, in its discretion, may establish particular qualifications for each specific AHP category.

5.1.1 Independent AHPs

(a) This category is limited to Certified Nurse Midwives, Certified Nurse Specialists, Certified Registered Nurse Anesthetists, Licensed Clinical Social Workers, and Nurse Practitioners.

(b) Independent AHPs may provide patient care services only in their areas of professional competence, and only to the extent approved by the relevant Department.

5.1.2 Sponsored/Dependent AHPs

(a) This category includes Certified Ocularists, Optometrists, Physician Assistants, and Surgical Assistants/Technicians as well as those listed above that practice dependently.

(b) A sponsored/dependent AHP shall provide patient care services only within their scope of licensure/certification and area of professional competence, and to the extent authorized by the appropriate Department and approved by the sponsoring Member of that Department who shall provide supervision and direction and assume ultimate responsibility for patient care.

(c) Written notice to the CEO or designee by the sponsoring Medical Staff Member indicating withdrawal of sponsorship, or termination of a sponsor's Medical Staff membership or relevant Privileges, will automatically terminate the Hospital's approval of the sponsored AHP, unless another qualified sponsor continues to provide sponsorship. The Hospital reserves the right to terminate approval of a sponsored AHP at any time, subject to any applicable procedural rights.

5.1.3 Relationship to Sponsoring Member of the Medical Staff

The sponsoring Medical Staff Member utilizing the services of and supervising an AHP shall:

(a) clearly delineate and define the proposed services of the AHP;

(b) provide supervision and assume responsibility and liability for any actions taken and services performed by the AHP;

(c) document that Member has ordered the services of the AHP; and

(d) document approval of the services provided in accordance with specific requirements as outlined in Medical Staff Rules & Regulations and/or policies relating to AHPs.

5.2 PROCEDURES FOR APPOINTING AND GRANTING PRACTICE PREROGATIVES TO AHPs; CORRECTIVE ACTION; AND PROCEDURAL RIGHTS OF AHPs

Procedures Applicable to AHPs

Applications for appointment, reappointment and Practice Prerogatives for AHPs shall be submitted and processed in the same manner as provided in Articles VI and VII for Medical Staff membership and Clinical Privileges. Each AHP shall be individually assigned to the clinical Department appropriate to their professional training and shall be subject in general to the same terms and conditions of appointment as specified in Sections 3.2 through 3.9 of these Bylaws for Medical Staff appointments, as applicable to AHPs. Corrective action with regard to AHPs, including termination or suspension of Practice Prerogatives, shall be in accordance with the provisions of Article IX. For the purposes hereof, the provisions of Article X shall apply and be the same for all AHPs, who also shall be subject to the provisions of Article XV.

5.3 PREROGATIVES

The prerogatives of an AHP shall be to:

(a) exercise the Practice Prerogatives granted to Provider if independent—which for Certified Nurse Midwives (CNM), Clinical Nurse Specialists (CNS), Certified Registered Nurse Anesthetists (CRNA) and Nurse Practitioners (NP) may include admitting Prerogatives—or do so under the supervision or direction of a Medical Staff Member in the appropriate Department consistent with the limitations stated in Article VII, and in accordance with Hospital policies and Medical Staff Rules & Regulations and policies relating to AHPs;

(b) write orders to the extent permitted by the Rules & Regulations and policies of the Medical Staff and of the Department to which the AHP is assigned, and within the scope of their license, certificate or other legal credential;

(c) serve on Medical Staff, Department, Division and Hospital committees as and to the extent assigned to do so; and

(d) exercise such other prerogatives as may be deemed appropriate to the education, training and experience of the AHP, and approved (in the form of Rules & Regulations or policies) by the Medical Staff or by any of its Departments or committees and by the Board, for AHPs as a group or for any specific category of AHP, such as the right to vote on specified matters, or to hold defined leadership positions.

(e) may request and be granted status similar to Refer and Follow, in which case 5.1. (c), and 5.1.(d) would not be applicable.

5.4 RESPONSIBILITIES

Each AHP shall:

(a) meet the same basic responsibilities as Medical Staff Members, as applicable to the more limited practice of AHPs, in accordance with Section 3.3 of these Bylaws;

(b) retain appropriate responsibility within their area of professional competence for the care and supervision of each patient in the Hospital for whom the AHP is providing services, or arrange a suitable alternative for such care and supervision;

(c) participate as appropriate in patient care audits and other quality maintenance activities, in supervising provisional appointees of their same profession, and in discharging such other functions as may from time to time be required;

(d) demonstrate that the AHP is not currently excluded, suspended, debarred or otherwise ineligible to participate in any federal or state healthcare program (*e.g.*, if the AHP ever was excluded, suspended or debarred in the past, the AHP must demonstrate that the AHP has been reinstated and is currently eligible to participate), and that the AHP has never been convicted of a criminal offense related to the provision of healthcare items or services; and

(e) acknowledge receipt of the Hawaii Pacific Health Standards of Conduct and agree to comply with those standards for the duration of the appointment.

ARTICLE VI
APPOINTMENT AND REAPPOINTMENT

6.1 GENERAL PROCEDURE

6.1.1 Application Process

(a) The application packet will include at a minimum the System-wide application form, and copies of the Medical Staff Bylaws and Rules & Regulations. Each applicant must review the Medical Staff Bylaws and Rules & Regulations prior to submitting the application, and must complete the application fully as described below.

(b) Once a completed application has been submitted and verified, the Medical Staff, through its appropriate Departments, Divisions, committees and officers, shall investigate and consider each application for appointment or reappointment, each application for Clinical Privileges/Practice Prerogatives or modification of same, and each request

for modification of Staff Category, and shall adopt and transmit recommendations to the Board, which shall be ultimately responsible for granting membership and Privileges/Practice Prerogatives. The Medical Staff shall also investigate, evaluate and make recommendations regarding appointment, reappointment and Practice Prerogatives of AHPs, who shall not, however, be granted Medical Staff membership. The report of each individual or body required to review and/or act on an application, including the Board, must state in writing the reasons for each recommendation made and/or action taken, with specific reference to the completed application and any other documentation that was considered.

6.1.2 Requirement for Cooperation and Compliance

By applying for or accepting appointment or reappointment, each applicant agrees that regardless of whether applicant is appointed or granted requested Privileges or Practice Prerogatives, applicant will cooperate fully with the Medical Staff, the Hospital, and their representatives, and comply with these Medical Staff Bylaws and the Medical Staff Rules & Regulations as they exist and as they may be modified from time to time, in all matters pertaining to the Hospital and the Medical Staff. Each applicant also agrees that information about the Provider obtained by any Hawai`i Pacific Health facility, hospital and/or its Medical Staff Departments, Divisions or committees may be shared with the other Hawai`i Pacific Health facilities, hospitals and their medical staffs.

6.2 APPLICANT'S BURDEN

6.2.1 Burden of Producing Information

An applicant for appointment, Temporary Privileges, reappointment, advancement, or transfer to a different Medical staff category, and/or for Privileges or Practice Prerogatives, shall have the burden of producing complete and accurate information sufficient for a thorough evaluation of applicant's qualifications and suitability for the requested Staff Category, Privileges, Practice Prerogatives and/or other requested status including but not limited to applicant's experience, background, training, ability, professional ethics, judgment and health status; resolving any doubts about these or any of the other basic qualifications specified in these Bylaws; and satisfying requests for information. The applicant shall interpret each application question broadly and provide all information that may reasonably be considered responsive. The applicant's burden of producing information may include a requirement to undergo a medical or psychological examination as provided in these Bylaws or the Rules & Regulations. The applicant is responsible for ensuring that all of the information listed in Section 6.3.3 below and/or on the application form is included in the application and attachments submitted.

6.2.2 Obligation to Appear for Interviews and/or Submit Additional Information

At any time during the application process for appointment, reappointment, or additional Privileges or Practice Prerogatives, the Medical Staff Coordinator, Credentials Committee, MEC, Department and/or Division to which the applicant seeks appointment, and/or the Board, may require the applicant to appear for interviews and/or to submit additional information and/or documentation, and may require that such additional information be submitted under oath. If an applicant is notified of the requirement to appear for an interview, the applicant is responsible for scheduling the interview promptly and appearing as scheduled. An applicant who fails to fulfill any such responsibility within thirty (30) days of receiving such notice will be deemed to have withdrawn their application.

6.2.3 Consequences of Failure to Meet the Applicant's Burden

(a) Neither the Board nor any Medical Staff committee, Department or Division shall have any obligation to review any application until the applicant completes the application in all respects and submits all required information and supporting material. The applicant shall provide complete, accurate, up-to-date information on the application itself and in all supporting materials.

(b) Any significant misstatement, misrepresentation or omission, and/or failure to meet the burden of producing information constitutes a sufficient basis for ceasing to process an application or request (*see* Section 6.5.2), for denial of an application or request, or—if the applicant already has been (i) appointed, (ii) granted the requested Privileges or Practice Prerogatives, or (iii) reappointed when such misstatement, misrepresentation or omission is discovered—for termination of membership and Privileges or Practice Prerogatives. An applicant whose application is not processed on this basis will be notified in writing of that final disposition and the reason(s) thereof within thirty (30) days after processing terminates. However, the applicant generally will not be entitled to any of the procedural rights set forth in Article X. Procedural rights may apply to denials based on significant misstatements, misrepresentations or omissions, but only in those circumstances where expressly required by applicable law.

6.3 APPLICATION FOR INITIAL APPOINTMENT

6.3.1 Submission of Application

Each application for appointment shall be in writing, submitted on the System-wide application form used by all System members, without any alterations, and signed by the applicant. The application shall be accompanied by full payment of any required application fees.

6.3.2 System-Wide Cooperation

Each applicant desiring to exercise Privileges or Practice Prerogatives at one or more System member(s) is subject to the following provisions:

(a) System-wide Application Form: the applicant shall indicate on the System-wide application form which System members applicant is applying to, and the specific Privileges or Practice Prerogatives sought;

(b) Available Privileges/Practice Prerogatives in an Exclusive Department or Service: an applicant requesting Privileges/Practice Prerogatives in a Department or service subject to an exclusive contracting arrangement must first demonstrate a contractual or employment relationship with the party holding the exclusive contract, and Privileges/Practice Prerogatives at any System member shall be limited by the scope of Privileges/Practice Prerogatives normally available at that System member;

(c) System Verification of Information: a coordinated process of verifying the information submitted on the application shall be followed by the CVS in accordance with the System's information sharing and joint credentialing program rules established pursuant to the written agreement(s) developed between or among the System members.

6.3.3 Content

The application form shall include all of the following elements:

(a) Acknowledgment and Agreement: a statement that the applicant has received and read the Bylaws and Rules & Regulations of the Medical Staff and that applicant agrees to be bound by the terms thereof throughout the application process and thereafter with respect to all dealings with the Hospital and/or its Medical Staff, regardless of whether applicant is granted membership and/or Clinical Privileges or Practice Prerogatives;

(b) Qualifications: detailed information concerning the applicant's qualifications, including but not limited to information documenting the basic qualifications specified in Sections 3.1 and 3.2.1 as applicable, and of any additional qualifications specified in these Bylaws for the particular status to which the applicant requests appointment. Such information shall include at least the following:

(1) identifying information, including a current form of official photographic identification such as a driver's license or passport;

(2) postgraduate education;

(3) internship(s);

(4) residency/fellowship training;

(5) the name of every healthcare facility with which the applicant is or ever has been affiliated as intern, resident, medical staff Member, contractor, employee, or otherwise, including the nature and dates of each affiliation, along with a detailed explanation for any gap in training/practice history;

(6) membership in professional associations, societies, academies, colleges, and faculty or training appointments;

(7) complete details of specialty Board certification status, including disclosure of any failure of a Board certification examination, upcoming scheduled examination dates, etc.

(8) state licensure(s), with expiration date(s);

(9) Federal DEA registration indicating coverage for schedules II, IIN, III, IIIN, IV and V, with expiration date, if applicable;

(10) continuing medical education for the past two (2) years; and,

(11) state narcotics license indicating coverage for schedules II, IIN, III, IIIN, IV and V, with expiration date, if applicable.

(c) Requests: specific requests stating the staff status and Clinical Privileges or Practice Prerogatives for which the applicant wishes to be considered;

(d) References: the names of at least three (3) persons, who preferably are not related by birth or marriage and are not current partners or associates. It is preferred that references be persons in a supervisory position who have worked with the applicant and observed applicant's professional performance in the past year, and who can provide reliable information based on significant personal experience as to the applicant's clinical ability, ethical character, judgment and ability to work with others, and other qualifications for eligibility under these Bylaws, including but not limited to the following specific requirements:

(1) if residency training was completed within the past five (5) years, one letter from the current director of the residency program and another from the institution with which the applicant was most recently affiliated; and

(2) if residency training was completed more than five (5) years ago, one letter from the chief of the relevant department at the institution with which the applicant was most recently affiliated;

(e) Professional Investigations, Sanctions, Etc.:

(1) disclosure of any voluntary or involuntary relinquishment (including by expiration), revocation, restriction, or limitation of any professional license, certification, or registration (including Federal DEA and/or state narcotics registration) in any jurisdiction, whether past or current, and any past, current, or pending investigation by a licensing or regulatory body, or disciplinary action or challenge to licensure, certification, registration, or participation by any regulatory body in any jurisdiction, including (but not limited to) a request to surrender a license or certification, imposition of a fine or conditions of probation, or issuance of a letter of reprimand;

(2) disclosure of any exclusion, debarment or suspension from or limitation on the applicant's eligibility to participate in any of the federal healthcare programs, whether past or current, or any investigation, past or pending, relating to such eligibility;

(3) disclosure of any voluntary or involuntary termination, revocation, suspension, restriction, reduction, limitation, or loss of medical staff membership, clinical privileges, practice prerogatives or employment at any healthcare organization or facility, and any past or pending focused monitoring, investigations or proceedings related to competence or conduct in any healthcare organization or facility; and

(4) disclosure of any felony convictions (excluding parking tickets and minor traffic violations; DUI or driving with an alcohol level above the legal limit is not a minor traffic violation) under the laws of any state, the United States or a foreign jurisdiction, the effects of which will be evaluated on a case-by-case basis in the application process; (Also see sections 9.6.4 and 9.6.11, (a) (2)).

(f) Continuing Responsibility to Notify of Federal or State Program Sanctions: a statement acknowledging the applicant's continuing responsibility to give immediate written notification of any suspension, exclusion, debarment, or ineligibility to participate in any federal or state healthcare program; and any criminal conviction related to the provision of healthcare items or services with no reinstatement in any federal or state healthcare program after a period of exclusion, suspension, debarment, or investigation, or ineligibility related to any federal or state healthcare program;

(g) Standards of Conduct: a statement that the applicant acknowledges receipt of, understands contents of, and agrees to abide by the Hawai`i Pacific Health Standards of Conduct;

(h) Professional Liability Insurance:

(1) a certificate documenting that the applicant carries the type (*e.g.*, Hawaii-admitted carrier, minimum A.M. Best rating) and at least the minimum amount of professional liability insurance covering the scope of the applicant's requested Clinical Privileges or Practice Prerogatives and all professional activities in the Hospital, as delineated from time to time by resolutions of the MEC and the Board;

(2) complete, detailed information and documentation describing the applicant's malpractice claims history and experience, including a consent to the release of information by applicant's present and any past malpractice insurance carriers, as follows: all instances where a final judgment in a malpractice action was rendered against the applicant, and all instances where the applicant has settled an action based on an allegation of malpractice by payment to the plaintiff; and

(3) disclosure of any previous denial, cancellation, limitation, refusal to renew or lapse of the applicant's professional liability insurance coverage, or notification of any insurer's intent to deny, cancel, not review or limit such coverage;

(i) Continuing Responsibility to Notify of Settlements or Judgments: a statement acknowledging the applicant's continuing responsibility to give immediate written notification of any settlement, judgment order, or formal legal resolution determining allegations of medical malpractice, including but not limited to the description of the allegations, and the terms of the settlement, judgment or order for formal legal resolution;

(j) Health Status: information regarding the applicant's current physical and mental capacity to provide patient care at a level that meets the standard of care in areas of requested Clinical Privileges or Practice Prerogatives:

(1) any specific information relating to an applicant's physical or mental health status (other than the "yes" or "no" answer on the application form to the question whether the applicant is able to perform the requested Privileges or Practice Prerogatives safely) shall be maintained separately from the remainder of the application materials; any such specific information will be forwarded to the Provider Assistance Committee (PAC) upon receipt from the applicant or from persons or entities providing information to the Medical Staff in connection with processing of the application, and will be maintained by the PAC as confidential except as expressly provided below;

(2) the PAC will be responsible for evaluating any Provider who has or may have a physical or mental condition that might affect

Provider's ability to perform requested Privileges or Practice Prerogatives; this evaluation may include requiring the applicant to undergo a medical examination by a health professional selected by the PAC, and/or an interview of the applicant by the PAC;

(3) an application from an applicant who has or may have a physical or mental condition that might affect Provider's ability to perform requested Privileges or Practice Prerogatives will be processed in the usual manner without regard to that physical or mental condition, until such time as the MEC determines that the applicant is otherwise qualified to perform the requested Privileges or Practice Prerogatives. If the MEC determines that the applicant is *not* qualified, then the MEC will recommend denial of the application without regard to the physical or mental condition;

(4) once the MEC determines that the applicant is otherwise qualified, then the PAC will disclose to the MEC any information it has obtained regarding the applicant's physical or mental condition that might affect applicant's ability to perform requested Privileges or Practice Prerogatives. Representatives of the PAC and the MEC, Credentials Committee and/or Department will meet with the applicant to discuss the possibility of reasonable accommodations that might enable the applicant to perform the requested Privileges/Practice Prerogatives in accordance with the Hospital's standards; and

(5) the Hospital will attempt to provide reasonable accommodations to an applicant with physical or mental disabilities, as required by applicable law, if the applicant is otherwise qualified and can perform requested Privileges or Practice Prerogatives in a manner that meets the Hospital's standards with such reasonable accommodations; if the MEC determines that reasonable accommodations are not possible, and recommends denial or limitation of requested Privileges or Practice Prerogatives, then the applicant will have the hearing and appeal rights set forth in Article X of these Bylaws;

The provisions noted above (6.6.3.j) will also apply at reappointment and at any time throughout the term of appointment if the Provider has any health status changes.

(k) Notification of Release and Immunity Provisions: a statement acknowledging that the applicant has read, understands, and agrees to be bound by the scope and extent of the authorization, confidentiality, immunity and release provisions of Section 6.4 and Article XV, including but not limited to information sharing between the System's member

hospitals for purposes of collection and verification of all information required in the credentialing process; and

(l) Administrative Remedies: A statement that the applicant agrees to exhaust the administrative remedies afforded by these Bylaws before resorting to legal action, when an adverse recommendation is made or action is taken with respect to applicant's application, staff status, Clinical Privileges or Practice Prerogatives.

6.4 EFFECT OF APPLICATION

By applying for appointment or reappointment, the applicant does all of the following:

(a) signifies applicant's willingness to appear for interviews in regard to applicant's application;

(b) authorizes Hospital and/or HPH representatives to consult with others who have been associated with applicant or who may have information bearing on applicant's competence and qualifications or otherwise relevant to the pending review, whether or not such other persons are listed as references by the applicant; and authorizes entities and individuals consulted with to provide all such information requested, both orally and in writing;

(c) consents to the inspection and copying by Hospital and/or HPH representatives of all records and documents, including otherwise confidential or privileged information that may reasonably be material to an evaluation of applicant's professional qualifications, ability and/or health status to carry out the Clinical Privileges or Practice Prerogatives applicant requests, and/or applicant's professional qualifications for appointment, reappointment continued membership and/or or a particular Staff Category, regardless of who possesses such records, and directs individuals who have custody of such records and documents (including but not limited to an applicant's medical office personnel as well as representatives of hospitals, health plans and other health care organizations) to permit inspection and/or copying, and consents to the sharing of such information among the Hawai`i Pacific Health hospitals and their medical staffs;

(d) releases from any and all liability, to the fullest extent permitted by law, the Hospital, HPH, and all Hospital and HPH representatives for their acts performed in connection with evaluating the applicant and applicant's credentials, and recommending or determining appointment, reappointment, Clinical Privileges or Practice Prerogatives;

(e) releases from any and all liability, to the fullest extent permitted by law, all individuals, corporations, organizations and governmental agencies who provide information, including otherwise privileged or confidential information to the Hospital and HPH representatives concerning the applicant's ability, training, experience, background, professional ethics, character, health status, malpractice

claims history and other qualifications relevant to requested Medical Staff status and Clinical Privileges or Practice Prerogatives;

(f) authorizes and consents to Hospital and HPH representatives providing other hospitals, professional associations and other organizations concerned with provider performance and the quality and efficiency of patient care with any relevant information the Hospital and HPH may have concerning applicant, and releases the Hospital, HPH, and all Hospital and HPH representatives from liability for so doing to the fullest extent permitted by law;

(g) agrees to be bound by all conditions of application and membership, as stated in the appointment or reappointment application form, the Temporary Privileges application form, the Clinical Privileges/Practice Prerogatives delineation form, these Bylaws, the Rules & Regulations, and all other Medical Staff-related policies and procedures;

(h) represents and warrants that all information provided by applicant is true, correct and complete in all material respects;

(i) acknowledges that if the applicant has been excluded from any federal or state healthcare program, the Board will deny Medical Staff membership or AHP appointment, as applicable;

(j) acknowledges that if the applicant becomes a Medical Staff Member or AHP appointee and is subsequently excluded from any federal or state healthcare program, the Board will remove applicant from responsibility for, or involvement with Hawai`i Pacific Health's business operations related to any federal or state healthcare program and any position for which the person's compensation or the items or services rendered, ordered, or prescribed by the person are paid in whole or in part, directly or indirectly, by any federal or state healthcare program or federal or state funds;

(k) acknowledges that applicant has received, understands and agrees to abide by the Hawai`i Pacific Health Standards of Conduct;

(l) agrees that the Hospital and Medical Staff may conduct joint credentialing with other System hospitals and share relevant information with representatives or agents from any System hospital, including relevant information obtained from other sources, and releases each person and each entity who receives the information and each person and each entity who discloses the information from any and all liability;

(m) agrees that any misrepresentations or omissions, or failure to meet the burden set forth in Section 6.2 may result in non-processing of the application or denial of appointment or reappointment as set forth in Section 6.2.3 and 6.5.2;

(n) agrees to update promptly all information requested in the application, as set forth in the application form and these Bylaws;

(o) consents to undergo and to release the results of a medical, psychiatric or psychological evaluation by a Practitioner acceptable to the PAC or MEC, at the applicant's expense, if deemed necessary by the PAC or MEC; and

(p) pledges to maintain an ethical practice, including but not limited to providing for the continuous care of applicant's patients, seeking consultation whenever necessary, refraining from illegal inducements for patient referrals, refraining from illegal billing practices, refraining from providing Ghost Surgical services or other "ghost" medical services, and refraining from delegating patient care responsibility to unqualified or inadequately supervised personnel.

For purposes of this Section, the term "Hospital representative" includes the Board, its directors and committees, the CEO or designee, all Medical Staff Members, Departments, Divisions and committees that have responsibility for collecting or evaluating the applicant's credentials or acting upon applicant's application; and Hospital employees and other authorized representatives.

6.5 PROCESSING THE APPLICATION

6.5.1 Verification of Information

(a) The applicant shall deliver a completed application to the CVS, which shall, in a timely fashion, seek to collect and/or verify the references, licensure and other documents and information submitted. The CVS shall submit a query to the National Practitioner Data Bank (NPDB or Data Bank) and/or other centralized governmental informational data bank and applicable state licensing Board(s), if required, in compliance with existing laws and Hospital policy, regarding each applicant.

(b) The CVS shall promptly notify the applicant of any failure of others to respond within thirty (30) days to such collection or verification efforts. After such notice, the applicant shall have the obligation of obtaining responses to requests for such information.

(c) If and when collection and verification have been accomplished by receipt of responses from all persons or entities so contacted, the CVS shall transmit copies of the application and all related materials to the CEO or CEO's designee, the Chair of each Department in which the applicant seeks Privileges or Practice Prerogatives, and the Credentials Committee of each Hospital at which the applicant has requested membership, Clinical Privileges or Practice Prerogatives.

(d) The CEO or CEO's designee shall also solicit and receive relevant information concerning the applicant from Medical Staff Members and, if appropriate, from other persons providing patient care at the Hospital who have information concerning the applicant's qualifications.

6.5.2 Incomplete Application/Further Information/Application Withdrawn from Processing

The CVS and any committee or individual(s) responsible under these Bylaws for reviewing an application for appointment, reappointment, or new Clinical Privileges or Practice Prerogatives may request further documentation or clarification from the applicant. The applicant has thirty (30) days from receipt of the request to provide the requested information, documentation or clarification. Failure to do so will be deemed a voluntary withdrawal of the application and will cause the processing of the application to be discontinued. If this occurs, the CVS, committee or individual that made the request shall so notify the applicant in writing. Any further application submitted by an applicant whose application has been removed from processing as incomplete shall be processed as an initial application under these Bylaws. The applicant shall not be entitled to hearing and appeal rights under these Bylaws. An applicant who fails to submit a complete application more than once will not be permitted to apply again for a minimum period of five (5) years from the most recent application.

6.5.3 Department Action

(a) Upon receipt, the Chair of the Department shall review the application and related documentation and, at the Chair's discretion, conduct a personal interview with the applicant. The Chief Nurse Executive or designee will review applications for appointment from APRNs and provide input to the Chair of the Department. The Chair shall transmit to the Credentials Committee a written report and recommendation as to approval, denial or deferral of the application and Privileges/Practice Prerogatives request and any special conditions to be imposed on the appointment. The report shall state concisely the reason(s) for recommending deferral, special conditions or denial.

6.5.4 Credentials Committee Action

(a) The Credentials Committee shall review the application, the related documentation, each Department Chair's report and recommendations, and other available information that may be relevant to consideration of the applicant's qualifications for the Staff Category and/or Clinical Privileges/Practice Prerogatives requested. The Credentials Committee may interview the applicant, and/or defer action until additional information has been obtained. Once the Credentials Committee determines it has all necessary information, the Credentials Committee shall transmit to the MEC a written report and recommendations as to approval or denial of the application and, if appointment is recommended, as to Staff Category, Department/Division assignment, Clinical Privileges/Practice Prerogatives to be granted and any special conditions to be imposed on the appointment. The reason(s) for each special condition shall be concisely stated. Any minority views shall also be

reduced to writing, supported by concise statements of reasons and transmitted with the majority report.

6.5.5 Medical Executive Committee Action

(a) At its next regular meeting after receipt of the Credentials Committee reports and recommendations, the MEC shall consider the reports, the application, the related documentation compiled and other relevant information available to it.

(b) If the MEC finds the applicant is qualified for appointment and Clinical Privileges or Practice Prerogatives, then the MEC shall consider any information and recommendation from the PAC regarding the applicant's health status and need for reasonable accommodation, if any. After considering all relevant information, the MEC shall then forward to the CEO or designee for transmittal to the Board, or to a committee of the Board designated for this purpose, the application, related documentation and relevant information, and a written report and recommendation. The MEC may recommend that the application be granted, limited, deferred, or denied. If appointment is recommended, the MEC also will recommend Staff Category, Department/Division assignment, Clinical Privileges or Practice Prerogatives to be granted, and any special conditions to be imposed on the appointment. FPPE will be required for all new Privileges and Practice Prerogatives. The report shall state concisely the reasons for each recommendation. Any minority views shall also be reduced to writing, supported by concise statements of reasons, and transmitted with the majority report.

6.5.6 Effect of Medical Executive Committee Action

(a) Deferral: action by the MEC to defer the application for further consideration must be followed within thirty (30) days by a subsequent favorable or adverse recommendation.

(b) Favorable Recommendation: when the recommendation of the MEC is favorable to the applicant, the CEO or designee shall promptly forward it, together with the application and all related documentation, to the Board.

(c) Adverse Recommendation: when the recommendation of the MEC is adverse to the applicant, the MEC also shall determine whether the adverse recommendation entitles the applicant to a hearing pursuant to Article X. For the purposes of this Section 6.5.6(c), an "adverse recommendation" by the MEC is as defined in Section 10.2. If the adverse recommendation entitles the applicant to a hearing and appellate review in accordance with Section 10.2 of these Bylaws, Notice shall be given in accordance with Section 10.3. If the applicant is not entitled to

such hearing and appellate review, the adverse recommendation shall be forwarded to the Board for final action.

6.5.7 Board Action

(a) On MEC Recommendation: the Board shall, in whole or in part, adopt or reject a recommendation of the MEC, or refer the recommendation back to the MEC for further consideration, stating the reasons for such referral back and setting a reasonable time limit within which a subsequent recommendation shall be made. If the Board proposes to reject an MEC recommendation without referring the matter back, the Board shall so notify the MEC, and the MEC may invoke the conflict management process set forth in Section 18.13 of these Bylaws before the Board notifies the applicant. If the Board's proposed action (following any referral back or conflict management process) is adverse to the applicant as defined in Section 10.2, the CEO or designee shall promptly so inform the applicant by special notice, and applicant shall be entitled to the procedural rights provided in Article X.

(b) After Procedure Rights: in the case of an adverse MEC recommendation pursuant to Section 6.5.6(c) or an adverse Board decision pursuant to Section 6.5.7(a), which entitles the applicant to a hearing pursuant to Section 10.2 of Article X, the Board shall take final action in the matter only after the applicant has exhausted or waived applicant's procedural rights as provided in Article X, if applicable. Action thus taken shall be the exclusive decision of the Board, except that the Board may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the Board's reasons and shall set a reasonable time limit within which a subsequent recommendation to the Board shall be made. After receipt of the subsequent recommendation, the Board shall make a final decision.

6.5.8 Notice of Final Decision

(a) Notice of the Board's decision shall be given to the Chair of the MEC, to the Chair of the Credentials Committee, to the Chair of each Department concerned and to the applicant by means of special notice.

(b) A decision and notice to appoint shall include: (l) the Staff Category to which the applicant is appointed, if applicable; (2) the Department, and Division, if applicable, to which applicant is assigned; (3) the Clinical Privileges or Practice Prerogatives applicant may exercise; (4) FPPE; and (5) any special conditions attached to the appointment.

6.5.9 Time Periods for Processing

Applications for appointment should be considered in a timely manner by all individuals and groups required by these Bylaws to act thereon, shall be processed

within any time limits specified in applicable state law, and, except for documented good cause, ordinarily shall be processed within 180 days. This provision is intended as a guideline for processing and does not create any right to have an application processed within any specific time period.

6.6 REAPPOINTMENT

6.6.1 System-Wide Application for Reappointment

The CVS shall, at least six (6) months prior to the date when a Provider's appointment is due to expire, provide such Provider with a System-wide application for reappointment. Each Provider who seeks reappointment shall, within thirty (30) days of receipt of the application, return the completed application for reappointment to the CVS.

6.6.2 Effect of Failure to Submit a Reappointment Application

Failure without good cause to return a fully completed reappointment application form timely shall be deemed a voluntary resignation and shall result in automatic termination of Medical Staff or AHP staff appointment together with all Clinical Privileges or Practice Prerogatives, at the expiration of the Provider's current appointment. A Provider who is so terminated shall not be entitled to the procedural rights provided in Article X.

6.6.3 Content of System-Wide Reappointment Application Form

The System-wide reappointment application form shall require the applicant to provide all information necessary to assemble and maintain a current Hospital/ HPH file including, without limitation, information about:

(a) status of current licensure verified with primary source(s);

(b) any challenges (past or pending, regardless of outcome) to any licensure, certification, or registration, and any voluntary or involuntary relinquishment (including expiration), limitation, or restriction of such licensure, certification, or registration in any jurisdiction;

(c) any past or current exclusion, suspension, or sanction in connection with any of the federal healthcare programs, or any pending investigation that might affect the Provider's eligibility to participate in those programs;

(d) voluntary or involuntary termination, limitation, or reduction of Medical Staff membership or Privileges/Practice Prerogatives, and any past or pending investigation, remediation, and/or disciplinary action, at any healthcare organization or facility;

(e) sanctions of any kind imposed by any other healthcare institution, organization, licensing or certifying authority, or other government or law

enforcement agency (other than parking tickets or minor traffic violations; DUI or driving with a blood alcohol level above the legal limit is not a minor traffic violation);

(f) the circumstances of any professional liability action involving the Provider, including at a minimum a detailed description of any claims that resulted in judgments or settlements;

(g) notification of any new or anticipated claims, settlements, or judgments during the current term of appointment;

(h) documentation of continuing professional education related to Privileges or Practice Prerogatives and sufficient to meet the requirements of state law and the Medical Staff;

(i) ability to perform the Privileges or Practice Prerogatives requested with respect to renewal of existing Privileges or Practice Prerogatives, and in the absence of adverse information from other sources;

(j) documentation of professional liability coverage that meets the Hospital's requirements;

(k) relevant specific information from Hospital performance-improvement activity which is reviewed and compared to aggregate data where appropriate for comparison and evaluation of professional performance, judgment, and skills; such information may be obtained from (among other sources) the following processes:

(1) medical assessment and treatment of patients;

(2) use of medications;

(3) use of blood and blood components;

(4) use of operative and other procedures;

(5) efficiency of clinical practice patterns;

(6) significant departures from established patterns or standards of clinical practice;

(7) education of patients and families;

(8) coordination of care with other Providers and Hospital personnel, as relevant to the care of individual patients;

(9) accurate, timely, and legible completion of patients' medical records;

(10) FPPE, if any; and

(11) OPPE;

(l) ability to work harmoniously with Medical Staff Members, AHPs and Hospital personnel so as not to adversely affect patient care or Hospital operations;

(m) ethics and conduct;

(n) compliance with the Medical Staff Bylaws and Rules & Regulations, and Medical Staff and Hospital policies and procedures, including but not limited to the Hawaii Pacific Health Standards of Conduct, and submission of a new statement acknowledging receipt and understanding of the Bylaws, Rules & Regulations and the Hawaii Pacific Health Standards of Conduct, and confirming the applicant's commitment to continued compliance;

(o) attendance at Medical Staff meetings and participation in Medical Staff functions and affairs as required and

(p) any requested modification of the applicant's Staff Category or Privileges/Practice Prerogatives;

(q) a statement acknowledging continuing responsibility to give immediate notification of any change in any of the information provided in the application; and

(r) any other matter considered pertinent to the credentialing decision.

6.6.4 Low- and No-Volume Practitioners

(a) A Practitioner in the Active, Courtesy, or Consulting Staff Category who, during the preceding term, has not had sufficient Hospital volume necessary for evaluating Practitioner's clinical competency at the time of re-credentialing, shall submit H&Ps from Practitioner's office and/or other facilities as determined by Practitioner's Department Chair and/or the Credentials Committee, in accordance with the requirements of Practitioner's Staff Category as defined by these Bylaws. A minimum of five (5) H&Ps, preferably from initial office visits or significant office visits, is required, but the Department Chair and/or Credentials Committee may request that the Practitioner provide additional H&Ps and/or other specified documentation sufficient to assess competency.

(b) A Provider who refers a patient to the Hospitalist Service will be required to submit a complete list of the patient's medications and an H&P or most recent office note, or otherwise assist the admitting physician as needed to

ensure preparation of a complete H&P, within twenty-four (24) hours of admission.

6.6.5 Processing of Reappointment Applications; Action Options

Following timely receipt of a complete reappointment application, processing of the application, recommendations, and action will proceed in the same manner as for initial applications, as set forth in Section 6.5 above. However, in addition to the recommendation/action options described above for initial appointments, the MEC also may recommend, and the Board may decide based on the MEC recommendation or its own review, to grant limited reappointment for a period of less than two (2) years. Such an action does not constitute a restriction on Privileges/Practice Prerogatives, and does not give rise to procedural rights.

6.7 REQUESTS FOR MODIFICATION OF APPOINTMENT

A Provider may, either in connection with reappointment or at any other time, request modification of Provider's Staff Category, Department or Division assignment, Clinical Privileges or Practice Prerogatives by submitting a written request to the Medical Staff Office on the prescribed form (if any). Such request which either materially changes a Provider's Staff Category or Department or Division assignment and/or increases or expands the scope of a Provider's Clinical Privileges or Practice Prerogatives shall be processed in the same manner as an application.

6.8 REAPPLICATION AFTER ADVERSE RESULT

6.8.1 Hiatus Period Following an Adverse Result; Requirements for Reapplication

A Provider who has been subject to an adverse result, as defined in Section 6.8.2, shall not be eligible to reapply until at least two (2) years after the date on which the adverse result becomes final, as defined in Section 6.8.3. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as the Medical Staff and/or the Board may require to demonstrate that the basis for the earlier adverse result no longer exists.

6.8.2 What Constitutes an Adverse Result

Each of the following events constitutes an adverse result, if it is based on conduct that would constitute grounds for corrective action as set forth in Article IX:

(a) denial of an application for appointment, reappointment, Clinical Privileges or Practice Prerogatives;

(b) withdrawal or abandonment of an application for appointment, reappointment, Clinical Privileges or Practice Prerogatives; (provided that such Privileges and Prerogatives may be withdrawn for appropriate reasons such as being infrequently performed, no longer performing such

procedures, lack of current competency due to inactivity, etc. without being considered an adverse result as defined above.)

(c) termination of Medical Staff membership, AHP status, Clinical Privileges, or Practice Prerogatives; and/or

(d) resignation or voluntary relinquishment of Clinical Privileges or Practice Prerogatives following notice (whether formal or not) of an Investigation or impending adverse professional review action.

6.8.3 When a Result Becomes Final

An adverse result becomes final for purposes of this Section upon the date on which an application is abandoned, withdrawn or deemed withdrawn, or the date on which the Provider submits notice of Provider's resignation or relinquishment of Privileges/Practice Prerogatives or is deemed to have resigned, or upon waiver or exhaustion of all administrative and judicial remedies relating to a formal adverse action.

ARTICLE VII

CLINICAL PRIVILEGES AND PRACTICE PREROGATIVES

7.1 EXERCISE OF CLINICAL PRIVILEGES/PRACTICE PREROGATIVES

Every Provider furnishing direct patient services at this Hospital shall be entitled to exercise only those Clinical Privileges or Practice Prerogatives specifically granted to Provider by the Board, except as otherwise provided in Sections 7.4, 7.5, 7.6 and 7.7. Regardless of the Clinical Privileges or Practice Prerogatives granted to a Provider, each Provider shall obtain consultation when necessary or appropriate for patient care or when required by Medical Staff or Department/Division Rules & Regulations and/or policies.

7.2 DELINEATION OF PRIVILEGES/PRACTICE PREROGATIVES IN GENERAL

7.2.1 Requests

Each application for Medical Staff or AHP appointment and reappointment must contain a request for the specific Clinical Privileges or Practice Prerogatives sought by the applicant. A request pursuant to Section 6.7 for a modification of Privileges or Practice Prerogatives must be accompanied by documentation of training and/or experience supportive of the request.

7.2.2 Basis for Privileges/Practice Prerogatives Determinations

(a) Requests for Clinical Privileges or Practice Prerogatives shall be evaluated on the basis of the Provider's education, training, experience and

demonstrated current competence and judgment. The basis for Privileges/Practice Prerogatives determinations to be made in connection with periodic reappointment or otherwise shall include observed clinical performance and the documented results of the patient care audit and other quality assurance activities conducted at the Hospital. Clinical Privileges/ Practice Prerogatives shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and healthcare settings where a Provider exercises or has exercised Clinical Privileges/Practice Prerogatives. This information shall be added to and maintained in the Hospital Credentials file established for a Provider. Such information may be shared among the Hawai`i Pacific Health hospitals and their Medical Staffs.

(b) If a Provider requests Privileges/Practice Prerogatives to perform a procedure that would be new to the Hospital, such that no criteria for granting the Privileges/Practice Prerogatives have been established, the request will be tabled for a reasonable period of time, usually not to exceed sixty (60) days, during which the Credentials Committee and MEC will gather and review information from appropriate subject matter specialists as well as input from any Department that would be involved in performance of the new procedure. The MEC will then make recommendations to the Board about whether the new procedure should be added, and if so, what the criteria for Privileges/Practice Prerogatives and the processes for provisional evaluation should be. If the Board approves MEC recommendations for such criteria and processes, then the Privileges/Practice Prerogatives request will be processed. All new Clinical Privileges/Practice Prerogatives require FPPE.

7.2.3 Procedure

All requests for Clinical Privileges/Practice Prerogatives shall be evaluated and granted (with or without modification) or denied pursuant to, and as part of, the procedures outlined in Articles VI and VII. All new Clinical Privileges/Practice Prerogatives will require FPPE.

7.3 SPECIAL CONDITIONS FOR DENTAL AND PODIATRIC PRIVILEGES

Requests for Clinical Privileges from Dentists and Podiatrists shall be processed, evaluated and granted or denied in the manner specified in Section 7.2. Surgical procedures performed by Dentists and Podiatrists shall be under the overall supervision of the Chair of Surgery and shall be subject to the supervision policies adopted from time to time by the Department of Surgical Services, which policies need not be identical as they relate to Dentists, Podiatrists and other Medical Staff Members and need not be the same for all procedures. All dental patients shall receive the same basic medical appraisal, including an H&P, as other patients admitted by Physicians or AHPs, which will be documented in the medical record, except that an Oral/Maxillofacial Surgeon may be granted the Privilege to perform H&Ps on their own patients upon submission of documentation of completion of an accredited postgraduate residency in

oral/maxillofacial surgery and demonstrated current competence. An admitting Physician of the Medical Staff or AHP shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of any proposed surgical or other procedure on the total health status of the patient.

7.4 SPECIAL CONDITIONS FOR AHP PRACTICE PREROGATIVES

Requests for Practice Prerogatives from AHPs shall be processed, evaluated, granted or denied in the manner specified in Section 7.2. An AHP may, subject to applicable licensure requirements or other legal limitations, exercise independent judgment within the areas of their professional competence, and may participate directly in the medical management of patients independently as permitted by state law or under the supervision of a Physician or AHP who has been accorded Privileges or Practice Prerogatives to provide such supervision and who shall have ultimate responsibility for the those patients' care.

7.5 TEMPORARY PRIVILEGES

7.5.1 Circumstances

Upon the concurrence of the Chair of the Department in which the Privileges or Practice Prerogatives will be exercised and the Chair of the MEC, on a case-by-case basis the CEO or designee, (or the Administrator-On-Call) may grant temporary Privileges to fulfill an important patient care need that supports granting immediate authorization to practice, as set forth below. There is no right to temporary Privileges or Practice Prerogatives, regardless of the status of any application, and temporary Privileges do not entitle a Provider to hold any Medical Staff leadership position or to vote in the Medical Staff organization.

(a) Specific Patients: upon receipt of a request and verification of a Provider's current licensure, evidence of professional liability insurance, current Federal DEA and state narcotics registration if applicable, and current competence, an appropriately licensed Provider who is not at present an applicant for Medical Staff membership or AHP status may be granted temporary Privileges or Practice Prerogatives for a period of up to thirty (30) days for the care of one or more specific patients or types of patients, if such patients' needs could not otherwise be met adequately. Such Privileges or Practice Prerogatives may be requested no more than four (4) times in any one (1) year by any Provider, after which such Provider shall be required to apply for the appropriate status before being allowed to attend additional patients at the Hospital. Such Provider shall consent to be bound by the Medical Staff Bylaws, Rules & Regulations and any Division or Department rules or policies as well as the Hawaii Pacific Health Standards of Conduct in all matters relating to such Provider's temporary Privileges or Practice Prerogatives.

(b) New Applicants: upon receipt of a request for temporary Privileges or Practice Prerogatives from an applicant, temporary Privileges or Practice Prerogatives may be granted based on patient care need while the application is awaiting review and approval by the MEC and the Board. The application must have been otherwise fully processed, including verification of current licensure; education, training and experience; current competence; current Federal DEA and state narcotics registration (if applicable); current professional liability insurance as required by the Hospital; malpractice history; peer references specific to the applicant's competence and ability to perform the Privileges or Practice Prerogatives requested; and results of the Hospital's query to the NPDB or other national data bank.

Temporary Privileges or Practice Prerogatives may be granted to such a qualified applicant for an initial period of no more than thirty (30) days, and may be renewed for no more than three (3) successive periods of 30 days, for a maximum of 120 days total. The applicant shall consent to be bound by the Medical Staff Bylaws, Rules & Regulations and any Division or Department rules or policies in all matters relating to their temporary Privileges or Practice Prerogatives.

(c) *Locum Tenens*: upon receipt of a written request, an appropriately licensed and qualified Provider with professional liability insurance coverage, who is serving as a *locum tenens* for a Medical Staff Member or AHP may, without applying for similar status, be granted temporary Privileges or Practice Prerogatives for an initial period of thirty (30) days. Such Privileges may be renewed for no more than three (3) successive periods of 30 days (120 days total), but not to exceed Provider's term of service as *locum tenens*. Such Privileges/Practice Prerogatives shall be limited to the treatment of patients of the Provider for whom Provider is serving in *locum tenens*, and shall not entitle such Provider to admit or attend his own patients. Such Provider shall sign a consent to be bound by the Medical Staff Bylaws, Rules & Regulations and any Division or Department rules or policies in all matters relating to their *locum tenens* temporary Privileges or Practice Prerogatives.

7.5.2 Conditions

(a) Temporary Privileges/Practice Prerogatives shall be granted only when the information available reasonably supports a favorable determination regarding the requesting Provider's or applicant's qualifications, ability and judgment to exercise the Privileges or Practice Prerogatives requested. The request must be limited to only those Privileges or Practice Prerogatives that the requesting Provider reasonably anticipates he will need to exercise during the term of the temporary Privileges or Practice Prerogatives. If the available information on the requesting Provider is inconsistent or casts any reasonable doubts on Provider's qualifications,

action on the request for Temporary Privileges or Practice Prerogatives may be deferred until the doubts have been satisfactorily resolved.

(b) During the period of temporary Privileges or Practice Prerogatives, the Provider will be observed as required by Medical Staff policy. Special requirements of consultation, observation and reporting may be imposed by the Chair of the Department responsible for supervision of a Provider granted temporary Privileges or Practice Prerogatives, at the Chair's discretion. Before temporary Privileges or Practice Prerogatives are granted, the Provider must agree to be bound by the Medical Staff Bylaws and Rules & Regulations, and the Hawai`i Pacific Health Standards of Conduct (and the Provider shall be so bound regardless of whether he signs a written acknowledgement or agreement to that effect), in all matters relating to such Provider's temporary Privileges or Practice Prerogatives.

(c) The granting or renewal of temporary Privileges or Practice Prerogatives pursuant to these Bylaws shall not be deemed to confer upon any Provider any form of or right to Medical Staff membership or AHP appointment, or to any procedural rights except as expressly required by law.

7.5.3 Termination

(a) Temporary Privileges shall automatically terminate at the end of the designated period and any extensions, unless earlier terminated.

(b) The CEO or designee acting on behalf of the Board may at any time upon reasonable notice under the circumstances and for any reason, after consultation with the Department Chair responsible for supervision and/or the Chair of the MEC, terminate any or all temporary Privileges/Practice Prerogatives granted. If it is determined that a Provider with temporary Privileges or Practice Prerogatives poses a danger to patients, any person authorized to impose a summary suspension under these Bylaws may terminate the temporary Privileges or Practice Prerogatives.

(c) In the event of any such termination, the Provider's patients then in the Hospital shall be assigned to another Provider by the Department Chair responsible for supervision or, in the absence of the Chair, by the Chair of the MEC. The wishes of the patient shall be considered, where feasible, in choosing a substitute.

7.5.4 Procedural Rights

No Provider shall be entitled to the procedural rights set forth in Article X because of such Provider's inability to obtain temporary Privileges or Practice Prerogatives or because of any termination or suspension of temporary Privileges or Practice Prerogatives, unless such rights are specifically afforded by Article X based upon the circumstances.

7.6 EMERGENCY PRIVILEGES

For the purposes of this section, an "emergency" is defined as a condition in which serious or permanent harm could result to a patient or in which the life of a patient is in imminent danger and any delay in administering treatment would add to that danger. In the case of an emergency, any Medical Staff Member with Clinical Privileges or AHP with Practice Prerogatives, to the degree permitted by their license and regardless of Division, Department, Staff Category or status, or Clinical Privileges or Practice Prerogatives, shall be permitted to do, and be assisted by Hospital personnel in doing everything possible to save the life of a patient or to save the patient from serious harm. Such Provider exercising emergency Privileges or Practice Prerogatives is obligated to summon all consultative assistance deemed necessary and to arrange for appropriate follow-up care. Timely documentation of the emergency nature of the situation must be accomplished by both medical and Hospital personnel.

7.7 DISASTER PRIVILEGES

7.7.1 Who May Grant Disaster Privileges

In circumstances of disaster in which the Hospital's Emergency Management Plan has been activated, the CEO or designee and/or Chief of Staff and/or their designee(s) may grant disaster Privileges, on a case-by-case basis, at their discretion, to Licensed Independent Practitioners (LIPs) who volunteer their services, but are not Members of the Hospital's Medical Staff.

7.7.2 Responsibilities and Mechanisms

The responsibilities of the grantor of said Privileges/Practice Prerogatives are defined in the Hospital's Emergency Management Plan. The mechanisms for managing individuals who have been granted disaster Privileges/Practice Prerogatives, as well as identification of these individuals, are described in the Hospital's Disaster Privileging for Licensed Independent Practitioners policy and the Emergency Management Plan.

7.7.3 Verification of Requirements

(a) The CEO or Chief of Staff or their designee may, but is not required to, grant disaster Privileges/Practice Prerogatives upon presentation of any of the following:

(1) a current hospital picture ID card that clearly identifies professional designation;

(2) a current license to practice and a valid picture ID issued by a federal, state or local government agency;

(3) primary source verification of the license;

(4) identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organization or group;

(5) identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity; or

(6) confirmation by a current Medical Staff Member(s) or other current Hospital personnel with personal knowledge regarding the volunteer's identity and ability to act as a volunteer LIP during a disaster.

(b) Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer LIP presents to the organization. In circumstances where primary source verification cannot be completed within the 72-hour timeframe, it is expected to be done as soon as possible. In this situation, there must be documentation of:

(1) the reason(s) why verification could not be performed timely;

(2) evidence that the LIP has demonstrated ability to provide care and treatment; and

(3) an attempt to rectify the situation as soon as possible.

7.7.4 Oversight

The Medical Staff will oversee the provision of professional services by volunteer LIPs who have been granted disaster Privileges.

7.7.5 Termination of Disaster Privileges

Disaster Privileges granted under this Section 7.6 may be terminated at any time without cause by the CEO, the Chief of Staff, or their designee(s). Once the Emergency Management Plan has been deactivated, all disaster Privileges shall terminate automatically. Such termination shall not entitle the LIP to the procedural rights set forth in Article X.

7.8 TELEMEDICINE SERVICES PRIVILEGES

7.8.1 Definition

(a) Telemedicine is defined as the use of medical information exchanged from one site to another via telephonic (excluding peer to peer consultations) or electronic communications for the health and education of the patient or healthcare provider and for the purpose of improving patient care, treatment, and services. Telemedicine services include, but are not limited to:

(1) obtaining the patient's relevant medical history from the patient and/or the patient's significant others;

(2) performing a physical examination relevant to the patient's presenting complaints, symptoms and/or diagnoses insofar as is possible via remote interaction;

(3) viewing of and interpretation of relevant X-rays, scans, slides and other medical images;

(4) interpreting and discussing relevant laboratory or other diagnostic procedures;

(5) engaging in clinical consultations; and

(6) monitoring (*e.g.*, cardiac, pulmonary monitoring) of the patient with data transmitted to another location for assistance in interpretation of the data and planning appropriate treatment responses to observed findings.

7.8.2 Granting of Telemedicine Services Privileges/Practice Prerogatives

Telemedicine services may be provided only by a duly qualified Provider who has obtained such Privileges/Practice Prerogatives through the Medical Staff credentialing and privileging mechanisms set forth in Article VI and Article VII of these Bylaws.

Telemedicine Privileges/Practice Prerogatives may be granted using the following guidelines:

(a) If the service to be provided will be a one-time occurrence, such as clinical consultation by a sub-specialist on a difficult diagnostic or therapeutic problem for which expertise is not locally available, a Provider may be granted temporary Privileges/Practice Prerogatives pursuant to Article VII, Section 7.5.

(b) Credentialing and privileging information provided by the distant site where the Provider is located may be used to make telemedicine credentialing and privileging decisions at the Hospital under the following circumstances:

(1) the distant site is a Joint Commission-accredited hospital or telemedicine entity;

(2) the Hospital ensures through a written agreement that the distant hospital or telemedicine entity will provide all necessary documentation and comply with all applicable Medicare regulations and accreditation standards, as well as any other applicable legal requirements;

(3) the distant site provides documentation that the Provider is privileged at the distant site for the services to be provided at the Hospital;

(4) the distant site provides documentation of an internal review of the Provider's performance of these Privileges/Practice Prerogatives at the distant site that enables the Hospital to assess the quality of care and services, including any adverse events and/or complaints, consisting of the following documents a minimum:

(i) documentation that the Provider is licensed both in the state where the distant site is located and in Hawai`i;

(ii) a copy of the Provider's current malpractice policy;

(iii) a copy of the Provider's Privileges/Practice Prerogatives delineation form from the distant site;

(iv) a peer reference attesting that the Provider has actively exercised the relevant clinical Privileges/Practice Prerogatives at the distant site during the previous 12 months and has done so competently;

(v) a hospital affiliation letter documenting that the Provider is in good standing at the distant site, and satisfies all of the distant site's qualifications for the clinical Privileges/ Practice Prerogatives granted;

(vi) a signed attestation that all information provided by the distant site is complete, accurate, and up-to-date; and

(vii) any other attestations or documentation required by the Hospital's written agreement with the distant site or requested by the Hospital; and

(5) information furnished by the distant site will be provided to the MEC for review and recommendation to the Board for final action. Notwithstanding the process set forth in this subsection 7.8.2(b), the MEC and/or the Board may determine that an applicant is ineligible for appointment or Clinical Privileges/Practice Prerogatives if the applicant fails to satisfy the threshold criteria set forth in these Bylaws, or that there is insufficient information to determine eligibility, so the application will be removed from processing as incomplete.

(c) Alternatively, a Provider also may be fully credentialed and privileged to provide telemedicine services at the Hospital in accordance with the processes set forth in Article VI and Article VII of these Bylaws.

7.8.3 Term of Telemedicine Privileges

Telemedicine Privileges/Practice Prerogatives, if granted, shall be for a period of not more than two (2) years.

7.8.4 Obligations and Peer Review of Telemedicine Providers

Individuals granted telemedicine Privileges/Practice Prerogatives shall be subject to all applicable provisions of the Medical Staff Bylaws and the Medical Staff Rules & Regulations, including the Medical Staff's peer review activities. The results of the peer review activities, including (but not limited to) any adverse events and complaints from patients, families, other Providers, and/or Hospital staff about a Provider providing telemedicine services, will be shared with the distant hospital or telemedicine entity from which the Provider is providing telemedicine services.

7.8.5 Effect of Contractual Agreement

Telemedicine Privileges/Practice Prerogatives granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement. Termination of a contract will not give rise to any procedural rights under these Medical Staff Bylaws.

7.8.6 Quality Monitoring

The Hospital shall retain responsibility for overseeing the safety and quality of services offered to patients via remote electronic communication (telemedicine) or by out-of-state consultants.

ARTICLE VIII
PERFORMANCE EVALUATION AND MONITORING

8.1 OVERVIEW OF PERFORMANCE EVALUATION AND MONITORING

To conduct the credentialing and privileging processes described in Articles VI and VII effectively, the Medical Staff must develop FPPE and OPPE and monitoring activities to ensure that decisions regarding appointment and reappointment, as well as the granting and renewing of Clinical Privileges and Practice Prerogatives, are based upon detailed, current, accurate and objective evidence. These evaluations are an essential mechanism to maintain and improve quality care delivery. Additionally, performance evaluation and monitoring activities help to ensure timely identification of practice trends that could adversely affect the quality of care and patient safety. Problems identified through performance evaluation and monitoring are addressed through performance improvement and/or remedial action as described in Article IX.

8.2 PERFORMANCE MONITORING GENERALLY

8.2.1 The Medical Staff shall regularly monitor all Providers' performance in accordance with these Bylaws and such Rules & Regulations and policies as may be developed by the Medical Staff and approved by the MEC and the Board.

8.2.2 Performance monitoring is an information-gathering activity and not a disciplinary measure. Performance monitoring does not give rise to procedural rights, except as may be required under Article X in any instance where focused monitoring constitutes a restriction on a specific Provider's practice.

8.2.3 The Medical Staff shall ensure that information gathered during performance monitoring is shared appropriately (and in accordance with the confidentiality requirements of Article XV) to improve performance and implement corrective action as necessary. Performance monitoring activities and reports shall be integrated regularly into other Hospital and Medical Staff performance improvement activities.

8.2.4 The results of Provider-specific performance monitoring shall be considered when granting, renewing, modifying or revoking a Provider's Clinical Privileges or Practice Prerogatives.

8.3 ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

(a) Each Department shall develop for MEC and Board approval the criteria and processes for OPPE of the Providers overseen by the Division or Department, and OPPE data shall be factored into decisions to grant, maintain, modify or revoke Clinical Privileges and Practice Prerogatives. The criteria used in OPPE may include, but is not limited to, the following:

(1) performance in operative and other procedures and their outcomes;

(2) pattern of blood and pharmaceuticals usage;

(3) requests for tests and procedures;

(4) length of stay patterns;

(5) morbidity and mortality data;

(6) use of consultants; and

(7) other relevant criteria as determined by the Medical Staff.

(b) The information used in OPPE may be acquired through, but is not limited to, the following methods:

(1) periodic chart review;

(2) direct observation;

(3) monitoring of diagnostic and treatment techniques; and

(4) discussion with other individuals involved in a patient's care including consulting physicians, assistants at surgery, and nursing or administrative personnel.

8.4 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

(a) The Medical Staff is responsible for developing criteria and processes for evaluating the competence and conduct of any Provider for whom the Hospital lacks sufficient documented evidence that the Provider can competently perform particular Privileges or Practice Prerogatives or otherwise meet the Hospital's standards. FPPE is conducted with respect to all newly appointed Providers, those with newly granted Privileges/Practice Prerogatives and any Provider about whom concerns have developed regarding the Provider's ability to practice safely and/or conduct themselves appropriately in the Hospital. Such FPPE is time-limited rather than ongoing. FPPE does not constitute an Investigation.

(b) Information for FPPE may include, but is not limited to, the following:

(1) chart review (retrospective and/or concurrent);

(2) monitoring of clinical practice patterns;

(3) simulation;

(4) proctoring (for which the proctored Provider may be required to pay);

(5) discussion with other individuals involved in the care of a patient, *e.g.*, consulting physicians, assistants at surgery, and nursing or administrative personnel; and

(6) external peer review, which may be obtained by the Credentials Committee or the MEC on its own motion or upon the request of a Division or Department in the following circumstances:

(i) when a Division or Department or committee review that could affect a Provider's Privileges or Practice Prerogatives has not established a sufficiently clear basis for deciding how to proceed;

(ii) when no current Medical Staff Member can provide the necessary expertise in the clinical procedure or area under review;

(iii) when outside review is sought to ensure impartial peer review; and/or

(iv) upon the reasonable request of the affected Provider, at the discretion of the MEC.

(c) FPPE should occur in at least the following situations:

(1) when a Provider is initially appointed as a provisional Medical Staff Member or AHP, or granted new Clinical Privileges or Practice Prerogatives (such Providers will be evaluated per Section 3.6);

(2) when a Provider seeks renewal of specific Privileges or Practice Prerogatives in an instance where additional evaluation of competence is necessary, *e.g.*, a Provider has exercised a particular Privilege or Practice Prerogative so infrequently during the prior term that current competence cannot be assessed based on the existing data;

(3) when concerns have arisen about a Provider's competence to perform a specific Privilege or Practice Prerogative, supported by a preliminary evaluation of the Provider's current clinical competence, practice behavior, and ability to perform the requested Privilege or Practice Prerogative; and

(4) in other circumstances as defined in Medical Staff and/or Division or Department Rules & Regulations and/or policies, *e.g.*, sentinel events or other specified adverse outcomes, patient complaints, etc.

(d) An FPPE monitoring plan includes a panel of observers for this monitoring. Any Provider with the same or similar Privileges or Practice Prerogatives can act as an observer. The method(s) and duration of FPPE shall be formulated in each case.

(e) Relevant information resulting from the FPPE process is integrated into the Hospital's performance improvement activities, consistent with the confidentiality provisions of Article XVI.

(f) FPPE and any resulting remedial measures shall be implemented consistently in accordance with the criteria and requirements defined by the Medical Staff.

(g) FPPE information may be shared among the Hawai`i Pacific Health hospitals and their medical staffs.

ARTICLE IX

PERFORMANCE IMPROVEMENT AND CORRECTIVE ACTION

9.1 MEDICAL STAFF ROLE IN PERFORMANCE IMPROVEMENT

The Medical Staff is responsible for overseeing the quality of medical care, treatment and services rendered by Medical Staff Members and AHPs in the Hospital. The Medical Staff works to achieve quality improvement through collegial peer review and educational measures whenever possible, recognizing that when circumstances warrant, the Medical Staff is responsible for implementing remedial and/or corrective action as necessary to ensure that all Providers practicing in the Hospital consistently meet the Hospital's professional standards. Information regarding performance improvement activities and remedial and/or corrective action may be shared among the Hawai`i Pacific Health hospitals and their medical staffs.

9.1.1 All Members of the Medical Staff and all AHPs are expected to participate actively and cooperatively in a variety of peer review and performance improvement activities to measure, assess and improve their own performance and that of their peers in the Hospital.

9.1.2 The initial goals of the peer review process are to prevent, detect and resolve problems and potential problems through routine, collegial monitoring, evaluation, education, and counseling. When necessary, however, corrective measures including formal Investigation and discipline must be implemented and monitored for effectiveness.

9.1.3 Peers (which generally means other Providers with the same licensure) are responsible for timely, effectively, and fairly conducting the review and performance improvement functions delegated to them by their Divisions, Departments, and committees.

9.1.4 The Divisions, Departments, and committees may be assisted by the CMO.

9.2 INFORMAL REMEDIAL/CORRECTIVE ACTIVITIES

The Medical Staff officers and the leaders of Medical Staff Divisions, Departments, and committees may counsel, educate (or refer for outside education), issue letters of warning, reprimand or censure, and/or initiate FPPE in the course of performing their duties, without initiating formal Investigation or corrective action. Comments, suggestions and warnings may be communicated verbally or in writing. The affected Provider shall be given an opportunity to respond in writing and may be given an opportunity to meet with the officer, Division, Department, or committee. Any informal actions, monitoring or counseling shall be documented in the Provider's file. MEC approval is not required for such activities, but such activities shall be reported to the MEC. Such informal activities shall not give rise to any hearing or appeal rights under Article X.

9.3 CRITERIA FOR INITIATION OF CORRECTIVE ACTION

9.3.1 A formal corrective action Investigation may be initiated whenever any officer of the Medical Staff, the Chair of a Department, Chair of a Division, the Chair or a majority of any Medical Staff committee, the Chair of the Board, the CEO or designee has reason to believe that:

(a) a Provider lacks the requisite clinical competence;

(b) the conduct of a Provider may be detrimental to patient safety or the delivery of quality patient care within the Hospital;

(c) a Provider has violated an applicable legal or ethical standard, or the Bylaws, Rules & Regulations or policies of the Medical Staff or the Hospital;

(d) the behavior or conduct of a Provider is below recognized acceptable standards and/or undermines a culture of safety by intervening with or threatening the orderly or efficient operation of the Hospital, or to its component parts, including but not limited to, its Administration, Medical Staff, Nursing Staff, Support Services, or Volunteer Staff, which behavior or conduct includes, but is not limited to, the inability of the Provider to work harmoniously with others; or

(e) a Provider makes improper use of Hospital resources.

9.3.2 Any person who believes that a formal Investigation should be initiated and it appears likely that the formal Investigation will be a precursor to corrective action shall provide information to any individual identified in Section 9.3.1, and request a formal Investigation of the matter, making specific reference to the activity or conduct that gave rise to the request. FPPE is not an Investigation. A formal Investigation request may be submitted either verbally or in writing, but a request that is submitted verbally shall be documented by the recipient as soon as reasonably practicable and confirmed promptly by the Medical Staff Office.

9.4 INVESTIGATION

9.4.1 The MEC shall meet as soon as practicable under the circumstances after receiving a request for a formal Investigation, to consider the request. The MEC may then consider one of the following four (4) options with respect to a request for an Investigation:

(a) determine that the request for a formal Investigation contains sufficient information to form the basis of a recommendation for corrective action against the Provider to the Board, pursuant to Section 9.4.2;

(b) determine that the MEC, itself, shall investigate the matter pursuant to Section 9.4.3(a);

(c) determine that a formal Investigation shall be conducted by an Ad Hoc Investigating Committee, pursuant to Section 9.4.3(b);

(d) determine that the request for an investigation warrants no action by the MEC or that other action is appropriate, including, but not limited to:

(1) an informal meeting with the person who requested the Investigation;

(2) a letter to the person who requested the Investigation;

(3) a discussion with and/or letter to the Provider who is the subject of the Investigation request, or the Chief of the Provider's Division or Department; or

(4) other action deemed appropriate under the circumstances.

9.4.2 If the MEC concludes that a request for a formal Investigation contains sufficient information to warrant a corrective action recommendation to the Board, the MEC shall then proceed in accordance with Article X of these Bylaws.

9.4.3 If the MEC concludes that a request for a formal Investigation does not contain sufficient information to warrant a corrective action recommendation to the Board, but concludes the matter should be investigated, a quorum of the MEC shall, as soon as practicable, take one of the following actions to assemble a group to conduct the investigation (the "Investigating Committee"):

(a) appoint a subcommittee of its members consisting of no fewer than three (3) and no more than five (5) to conduct a formal Investigation; or

(b) appoint an ad hoc Investigating Committee to investigate the matter, pursuant to either subsection 9.4.3(b)(i) or subsection 9.4.3(b)(ii) below:

(1) the MEC may, in its discretion, appoint the Chair of the Division in which the affected Provider has Privileges/Practice Prerogatives to the ad hoc Investigating Committee, and if it does, the Chair shall serve as Chair of the Investigating Committee. The MEC shall appoint an even number of other individuals (not fewer than two (2)) as members of the Investigating Committee, who may be temporary Medical Staff Members appointed for this purpose; or

(2) the MEC may appoint an ad hoc Investigating Committee that does not include the Chair of the Division in which the affected Provider has Privileges/Practice Prerogatives. This ad hoc Investigating Committee shall consist of at least three (3) persons, any of whom may be temporary Medical Staff Members, and one (1) of whom shall be appointed as Chair.

9.4.4 Whenever the MEC decides that a formal Investigation shall be conducted, the CEO or CEO's designee shall give notice to the affected Provider in writing, by certified mail, return receipt requested. This notice shall contain a brief description of the matter under investigation and shall inform the affected Provider that Provider has a right to meet with the Investigating Committee and should make a request for such a meeting to the Chief of Staff. If requested, the meeting shall occur within a reasonable period of time and shall not unduly delay the investigation. The Investigating Committee may also require the affected Provider attend a meeting whether or not the affected Provider requests such a meeting. The failure to attend a meeting required by the Investigating Committee shall constitute failure to appear and the provisions of Section 9.6.8 shall apply. The Investigating Committee may, but is not obligated to, interview any other persons involved.

9.4.5 If the affected Provider is present at an investigative meeting or interview, the affected Provider shall be informed, at the meeting, of the general nature of the evidence supporting the requested formal Investigation and may be invited to discuss, explain or refute the evidence. The affected Provider may not bring medical or legal representation to any Investigating Committee meeting or interview. The Investigating Committee shall have the authority to determine the appropriate manner in which the meeting will be conducted, including the time and manner in which information is presented. No Investigating Committee meeting or interview shall constitute a "hearing," as this term is used in Article X of these Bylaws, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply to such a meeting or interview.

9.4.6 Notwithstanding the existence, non-existence or status of any formal Investigation, the MEC shall at all times retain the authority and discretion to take whatever action may be warranted by the circumstances, including but not limited to summary restriction or suspension of membership and/or Clinical Privileges/Practice Prerogatives.

9.4.7 The Investigating Committee shall complete the Investigation in a timely manner and prepare a written report including a summary of the interview or meeting with the affected Provider (if one took place), any other interviews, and its recommendation(s), and submit its report to the MEC.

9.4.8 As soon as practicable after the conclusion of the investigative process, if any, but in any event within ninety (90) days after receipt of the request to the initiate the corrective action process, unless good cause exists to extend the time, the MEC shall act thereon. If summary suspension has been imposed, the MEC shall make its recommendation to the Board within twenty-one (21) days from the date of the initiation of suspension, and the Board shall act on the MEC's recommendation within thirty (30) days from the date of initiation of the suspension. The MEC may, without limitation:

(a) determine that no corrective action be taken and, if the MEC determines there was no credible evidence for the complaint in the first instance, clearly document those findings in the Provider's file;

(b) defer taking action, pending further Investigation or observation of the affected Provider's conduct;

(c) issue letters of admonition, censure, reprimand or warning, although nothing herein shall be deemed to preclude the Department or Division Chair from issuing informal written or oral warnings outside of the mechanism for corrective action, and in the event such letters are issued, the affected Provider may make a written response that shall be placed in Provider's file;

(d) recommend the imposition of terms of probation or special limitation upon Clinical Privileges or Practice Prerogatives, including, without limitation, requirements for co-admissions, mandatory consultation, proctoring, or retrospective and/or concurrent monitoring;

(e) recommend reduction, modification or revocation, or impose suspension, of Clinical Privileges or Practice Prerogatives, and if suspension is imposed, state the terms and duration of the suspension and the conditions that the Provider must meet before the suspension will be lifted;

(f) recommend a change in Staff Category;

(g) recommend probation or revocation, or impose suspension, of Medical Staff membership or AHP appointment, and if probation is recommended or suspension is imposed, state the terms and duration of the probation or suspension and the conditions that the Provider must meet before the probation or suspension will be lifted; and/or

(h) take other actions deemed appropriate under the circumstances.

9.4.9 If the MEC recommends to the Board action against an affected Provider that is a ground for a hearing under Article X, Section 10.2, the MEC shall, as soon as practicable thereafter, give the affected Provider notice as provided in Article X, Section 10.3 of the proposed action or recommendation and of the right to a hearing in accordance with Article X of these Bylaws.

9.4.10 If the MEC determines that no corrective action is required or takes or recommends an action that is not a ground for a hearing under Article X, Section 10.1.2, the decision shall be transmitted to the Board. The Board may affirm, reject, or modify the proposed action or recommendation. The decision shall become final if the Board affirms it or takes no action on it within seventy (70) days after receiving the notice, unless good cause exists for extending the time for final action, *e.g*., to allow for a conflict management process if the Board rejects the MEC's action or recommendation.

9.5 SUMMARY RESTRICTION OR SUSPENSION OF CLINICAL PRIVILEGES/ PRACTICE PREROGATIVES AND/OR MEDICAL STAFF MEMBERSHIP OR AHP APPOINTMENT

9.5.1 Grounds for Summary Restriction or Suspension

The Chief of Staff, the Chair of a Clinical Department or Division, the CEO, or designee the Chief Operations Officer, or, in their absence, their designee, or the Chair of the Board, shall each have the authority to suspend or restrict all or any portion of the Clinical Privileges/Practice Prerogatives and/or Medical Staff membership or AHP appointment of a Provider ("summary action"), whenever such summary action is required to protect patient care or safety, or the continued effective or efficient operation of the Hospital.

As an alternative to summary action, the Provider may be offered the opportunity to refrain voluntarily from exercising the Privileges or Practice Prerogatives at issue, pending a determination of appropriate next steps, *e.g*., remediation or corrective action. If the Provider agrees, no action will be taken summarily.

9.5.2 Notice

Unless otherwise stated, such summary action shall become effective immediately upon imposition. The person or body responsible for the summary action shall immediately give written notice of the summary action to the CEO or CEO's designee, the Chief of Staff, the Chair of the Board, and the affected Provider. Other Hospital personnel who will be involved in implementing the summary suspension, (*e.g*., OR scheduling personnel), will be notified as necessary and appropriate. The summary action shall remain in effect for the period stated, or if none, until resolved as set forth herein.

9.5.3 Medical Executive Committee Action

(a) As soon as practicable, but no more than ten (10) days after such summary action has been imposed, a meeting of the MEC shall be convened to review and consider the action. The Provider has a right to attend the meeting and make a statement on such terms and conditions as the MEC may specify. In no event shall any such meeting of the MEC constitute a "hearing" within the meaning of Article X, nor shall any procedural rights apply.

(b) The MEC may modify, continue, or terminate the summary action, but in any event it shall furnish the affected Provider with notice of its decision within fourteen (14) days of the meeting. The MEC may commence a corrective action Investigation pursuant to Article IX, Section 9.4, if the summary action is modified or terminated. If the summary action is continued for more than fourteen (14) days, the affected Provider shall have the hearing and appeal rights provided by Article X.

9.5.4 Effect of Summary Suspension or Restriction at Another HPH Hospital

Information concerning summary suspensions and restrictions may be shared among the Hawai`i Pacific Health hospitals and their medical staffs. Whenever the Chief of Staff or the MEC receives information that a Provider who has Privileges or Practice Prerogatives at the Hospital and another HPH hospital has been summarily suspended or restricted at that other HPH hospital, any person authorized to implement a summary suspension or restriction under this section is, authorized to, but is not required to, impose a comparable suspension or restriction at this Hospital, subject to review and further action in accordance with these Bylaws.

9.5.5 Care of Suspended Provider's Patients

Unless otherwise indicated by the terms of the summary action, upon imposition of the summary action, the appropriate Department or Division Chair or the Chief of Staff, in their discretion, may confer with the affected Provider, whenever practicable, and shall arrange for the transfer of the care of any of the suspended Provider's patients to another Medical Staff Member or AHP. The wishes of the patient shall be considered, whenever feasible, in the selection of a substitute Provider.

9.6 AUTOMATIC REVOCATION, SUSPENSION, LIMITATION AND/OR DEEMED RESIGNATION

In the following instances, a Provider's Privileges/Prerogatives and/or appointment or participation at the Hospital may be subject to revocation, suspension or limitation as described, which shall be final without a right to a hearing or further review, except where a bona fide dispute exists as to whether the triggering circumstances have occurred:

9.6.1 Licensure

(a) Revocation, Suspension or Expiration: Whenever a Provider's license or other legal credential authorizing practice in Hawai`i is revoked, suspended or expires without an application pending for renewal, the Provider's Medical Staff or AHP appointment and Clinical Privileges or Practice Prerogatives at the Hospital shall be automatically revoked as of the date such action becomes effective.

(b) Restriction: Whenever a Provider's license or other legal credential authorizing practice in Hawai`i is limited or restricted by the applicable licensing or certifying authority, any Clinical Privileges or Practice Prerogatives that the Provider has been granted at the Hospital that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner as of the date such action becomes effective and throughout its term.

(c) Probation: Whenever a Provider is placed on probation by the applicable licensing or certifying authority, Provider's appointment and Clinical Privileges or Practice Prerogatives shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

9.6.2 Controlled Substances

(a) Revocation, Suspension or Expiration: Whenever a Provider's Federal DEA certificate or State Narcotics Certificate is revoked, limited, suspended, or expired, the Provider shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

(b) Probation: Whenever a Provider's Federal DEA certificate and state controlled substances registration is subject to probation, the Provider's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

9.6.3 Federal or State Healthcare Program Sanctions

Whenever a Provider is excluded, suspended, debarred or otherwise ineligible for participation in any federal healthcare program or has been convicted of a criminal offense related to the provision of healthcare items or services and has not been reinstated in any federal or state healthcare programs after the period of exclusion, suspension, debarment or ineligibility, the Provider will automatically be removed from responsibility for, or involvement in business operations related to, the federal or state healthcare programs and any position for which the Provider's compensation for the items or services rendered, ordered or prescribed

by the Provider are paid in whole or in part, directly or indirectly, by any federal or state healthcare program, or from federal or state funds.

9.6.4 Felony Conviction

A Provider who has been convicted of, or pleaded "guilty" or "no contest" or its equivalent to any felony in any jurisdiction shall be required to notify the Hospital immediately through the Medical Staff Office. If the MEC deems the conviction related to the provision of healthcare services, the Provider shall be automatically suspended as of the date of the conviction or plea, regardless of whether an appeal is filed. Such suspension shall remain in effect until the matter is resolved by subsequent action of the MEC, except that if the Provider remains suspended pursuant to this Section at the end of Provider's term of appointment, the Provider will be deemed to have resigned. (Also see sections 6.3.3 (e) (4) and 9.6.11 (a) (2)).

9.6.5 Medical Records

All Providers must complete their patients' medical records within fourteen (14) days of each patient's discharge. Medical records not completed within that period will be considered delinquent. Failure to complete medical records timely may result in automatic suspension and such other consequences as the Medical Staff and the Board may establish from time to time (*e.g.*, assessment of fines). The specific notification and suspension procedures pertaining to incomplete medical records are set forth in the Medical Records section of the Medical Staff Rules & Regulations. A medical records suspension shall continue until the medical records are completed. Persistent failure to complete medical records timely will be referred to the MEC for action.

9.6.6 Failure to Pay Dues/Assessments

Failure without good cause, as determined by the MEC, to pay dues or assessments as required by these Bylaws shall be grounds for automatic suspension of a Member's Clinical Privileges, and if within three (3) months after written warnings of the delinquency, the Member does not pay the required dues or assessments, the Member's membership shall be automatically suspended until the dues or assessments are paid. If the dues or assessments are not paid by the end of the Member's term of appointment, the Member will be deemed to have resigned.

9.6.7 Professional Liability Insurance

Failure to maintain continuous professional liability insurance to cover the scope of all Clinical Privileges, Practice Prerogatives and activities at the Hospital with no gaps, of the type and in the amounts required by the Board, shall be grounds for automatic suspension of a Member's Clinical Privileges or an AHP's Practice Prerogatives. Written warning of such delinquency shall be provided to the Member or AHP. If within ninety (90) days after receipt of the written warning of

the delinquency, the Member or AHP does not provide evidence of the required professional liability insurance, including prior acts ("nose") and/or extended reporting endorsement ("tail") coverage, as applicable under the circumstances to ensure there are no gaps in coverage, the Member or AHP shall be automatically terminated at the end of the ninety (90) days.

9.6.8 Failure to Meet the Special Appearance Requirement

Failure of a Member or AHP to appear at any meeting that he is requested to attend after reasonable notice that the Member's or AHP's practice or conduct is scheduled for discussion, unless excused by the body calling the meeting upon a showing of good cause, shall be grounds for automatic suspension of a Member's or AHP's Clinical Privileges or Practice Prerogatives pending action by the body that called the meeting and/or the MEC.

9.6.9 Failure to Complete Health History and/or TB Questionnaire, or to Provide Documentation of Immunity Following Exposure to Infectious Disease

Failure to submit a complete Health History Questionnaire at the time of initial appointment, and periodically thereafter, an annual TB Questionnaire as required by the Medical Staff Rules & Regulations and Hospital policy, and/or adequate documentation of immunity following exposure to an infectious disease, or otherwise as determined to be in the best interests of patient safety by the Board in consultation with the MEC, shall result in an automatic suspension of Medical Staff Privileges or AHP Practice Prerogatives, and in the case of infectious disease exposure, the Member or AHP may not enter the Hospital premises until adequate documentation of immunity has been provided to the Medical Staff and the Hospital.

9.6.10 Notice of Automatic Revocation, Suspension or Limitation

Special notice of an automatic revocation, suspension, limitation or deemed resignation shall be given immediately to the affected Provider, and regular notice shall be given to the MEC, CEO, or designee, and Board, but such notice shall not be required for the automatic revocation, suspension, limitation or deemed resignation to become effective. Patients affected by an automatic revocation, suspension, limitation or deemed resignation shall be assigned to another Provider by the Chief of Staff. The wishes of the patient and affected Provider shall be considered, where feasible, in choosing a substitute Provider.

9.6.11 Automatic Revocation

(a) Circumstances: The occurrence of any of the following events shall result in automatic revocation of appointment and Clinical Privileges or Practice Prerogatives, without any right to a hearing or appeal, except where a bona fide dispute exists as to whether the triggering circumstances have occurred:

(1) Federal Health Care Program Sanctions/Program Exclusion: Whenever a Provider is excluded, suspended, debarred or otherwise ineligible for participation in any federal healthcare program or has been convicted of a criminal offense related to the provision of healthcare items or services and has not been reinstated in any federal healthcare program(s) after the period of exclusion, suspension, debarment or ineligibility, the Provider's appointment and Clinical Privilege or Practice Prerogatives at the Hospital will be automatically revoked;

(2) Felony Conviction: The appointment and Clinical Privileges or Practice Prerogatives of a Provider who has been convicted of, or pleaded "guilty" or "no contest" or its equivalent to any felony involving or relating to the Provider's ability to provide health care services safely and ethically in any jurisdiction shall be automatically revoked, and such revocation shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed; and (Also see sections 6.3.3(e)(4) and 9.6.4)

(3) Professional Liability Insurance: Failure to maintain professional liability insurance to cover the scope of all Clinical Privileges, Practice Prerogatives and activities at the Hospital with no gaps, of the type and in the amounts required by the Board, shall result in automatic revocation of a Provider's appointment and Clinical Privileges or Practice Prerogatives.

(b) Effective Date and Notice: Unless otherwise stated, such revocation shall become effective immediately upon the occurrence of the triggering circumstances. Special notice of the revocation shall be given to the affected Provider, and regular notice shall be given to the MEC, CEO, or designee and the Chair of the Board, but such notice shall not be required for the automatic revocation to become effective.

(c) Care of Provider's Patients Following Revocation: Unless otherwise indicated, upon occurrence of the revocation, the appropriate Clinical Department or Division Chair or the Chief of Staff, in their discretion, may confer with the affected Provider whenever practicable, and shall arrange for the transfer of the care of any of the Provider's patients to another Medical Staff Member or AHP. The wishes of the patient shall be considered, whenever feasible, in the selection of a substitute Provider.

9.6.12 MEC Review and Procedural Rights

As soon as practicable after any automatic suspension or limitation described in Section 9.6 becomes effective, the MEC shall convene to review and consider the facts, and may recommend such further corrective action according to these Bylaws as it may deem appropriate. A Provider who is subject to automatic

revocation, suspension, limitation and/or resulting deemed resignation shall not be entitled to the procedural rights set forth in Article X. A Provider may request an opportunity to be heard by the MEC if the Provider can present reasonable evidence that the event that triggered an automatic revocation, suspension, limitation or deemed resignation did not actually occur.

ARTICLE X
HEARING AND APPELLATE REVIEW PROCEDURES

10.1 GENERAL HEARING AND APPELLATE REVIEW PROVISIONS

10.1.1 Policy of Promoting Fair, Efficient and Effective Peer Review Processes

(a) The hearing and appellate review procedures set forth in these Bylaws are intended to provide for fair review of decisions that adversely affect Providers, while simultaneously protecting peer review participants. These procedures are meant to be flexible and to minimize burdens that might discourage participation, and should be interpreted in that light.

(b) The Medical Staff, the Board, and their respective officers, directors, committees and agents hereby constitute themselves as peer review bodies under the federal Health Care Quality Improvement Act of 1986 and state peer review laws, and claim all Privileges, immunities and other protections afforded by federal and state law.

10.1.2 Exhaustion of Remedies

If a professional review action described in this Article X is taken or recommended, the affected Provider (as defined in Section 10.1.5) must exhaust the remedies afforded by these Bylaws before taking any other action. Hearing and appellate review procedures shall be the same for all Providers entitled to such rights.

10.1.3 Availability of Intra-Organizational Remedies

The hearing and appeal rights established in these Bylaws are strictly "quasi-judicial" rather than "quasi-legislative" in structure and function. The hearing committees have no authority to adopt, modify, or resolve questions regarding the merits or substantive validity of Bylaws, Rules & Regulations, policies or standards. Challenges to the substantive validity of any bylaw, rule/regulation or policy shall be handled according to Section 10.14 below.

10.1.4 Joint Hearings and Appeals

The Medical Staff and the Board are authorized to participate in a joint hearing and appeal process with one or more other HPH hospitals in accordance with Section 10.15 of these Bylaws, as appropriate to promote efficiency and an expeditious conclusion where more than one hospital has taken or recommended action with respect to the same Provider for related reasons.

10.1.5 Definitions

Except as otherwise provided in these Bylaws, the following definitions shall apply under this Article X:

(a) "body whose decision prompted the hearing" means (i) the MEC in any case where the MEC or authorized Medical Staff officers, Members or committees took the action or rendered the decision that resulted in the hearing request; and (ii) the Board in any case where the Board or its authorized officers, directors or committees took the action or rendered the decision that resulted in the hearing request; and

(b) "Provider" means a Provider as defined in the Definitions Section of these Bylaws who has requested a hearing pursuant to Section 10.4 of this Article.

10.1.6 Substantial Compliance

Technical, insignificant and/or non-prejudicial departures from the procedures set forth in these Bylaws shall not constitute grounds for invalidating any action.

10.2 GROUNDS FOR HEARING

Except as otherwise specified in these Bylaws, the right to a hearing shall be triggered when any one or more of the following actions or recommended actions shall be deemed an actual or potential adverse professional review action based upon competence or professional conduct, and shall constitute grounds for a hearing, in accordance with Hawai`i Revised Statutes Section 671D-4:

10.2.1 denial of initial appointment and/or requested initial Clinical Privileges or Practice Prerogatives, unless the denial of appointment is based upon the applicant's failure to meet any of the threshold criteria for appointment set forth in these Bylaws;

10.2.2 denial of requested advancement in a Medical Staff Category or increase in Clinical Privileges or Practice Prerogatives;

10.2.3 denial of reappointment, unless the denial is based upon the applicant's failure to meet any of the threshold criteria for appointment;

10.2.4 revocation of Medical Staff membership or AHP appointment and/or Clinical Privileges or Practice Prerogatives (except automatic revocation in accordance with Section 9.6);

10.2.5 involuntary decrease of Clinical Privileges or Practice Prerogatives except for removal from responsibility for or involvement with Hospital's business operations related to any federal or state healthcare program, or from any position for which the Provider's compensation or the items or services rendered, ordered, or prescribed by the Provider are paid in whole or in part, directly or indirectly, by any federal or state healthcare program, or from federal or state funds, if such removal is due to an exclusion, suspension, debarment, or ineligibility from any federal or state healthcare program or a criminal conviction related to any federal or state healthcare program;

10.2.6 imposition of a co-admission, mandatory consultation, or restrictive proctoring requirement (routine proctoring does <u>not</u> constitute an adverse professional review action);

10.2.7 suspension or restriction of any Clinical Privileges or Practice Prerogatives (except automatic suspension in accordance with Section 9.6);

10.2.8 termination of all Clinical Privileges or Practice Prerogatives;

10.2.9 summary suspension or restriction of Medical Staff membership, AHP appointment, Clinical Privileges or Practice Prerogatives for more than fourteen (14) days; and

10.2.10 any other disciplinary action or recommendation that must be reported by the Hospital to the Hawai`i Board of Medical Examiners and/or the National Practitioner Data Bank.

10.3 NOTICE OF PROPOSED ADVERSE PROFESSIONAL REVIEW ACTION

10.3.1 <u>Requirement for Prompt Notice</u>

In all cases in which an action or proposed action constitutes a ground for a hearing as set forth in Section 10.2, the affected Provider shall promptly be given Special Notice, in writing, by certified mail, return receipt requested by the Chief of Staff, CEO designee with a copy to the CEO or designee, and Chief of Staff.

10.3.2 <u>Content of Notice</u>

Such notice shall contain, at a minimum:

(a) a statement of the proposed action or recommendation(s) and a brief explanation of the reasons for it;

(b) a statement that the Provider has the right to request a hearing within thirty (30) days of receipt of this notice pursuant to Section 10.4; and

(c) a summary of the affected Provider's rights in the hearing as provided by these Bylaws; and

(d) a statement that the Provider may request mediation of the dispute pursuant to Section 10.5, and that mediation must be requested in writing within ten (10) days from the Provider's receipt of the notice.

10.4 PROVIDER'S REQUEST FOR HEARING OR ACCEPTANCE OF THE ACTION

10.4.1 Deadline for Requesting a Hearing

An affected Provider shall have thirty (30) days following the date of the receipt of such notice of professional review action or recommendation within which to submit a written request for a hearing to the CEO designee with a copy to the Chief of Staff. Such written hearing request shall state whether the Provider intends to be represented by legal counsel in the hearing itself.

10.4.2 Effect of Failure to Request a Hearing Timely

In the event the affected Provider does not request a hearing, in writing, within the time and in the manner set forth herein, such Provider shall be deemed to have waived their right to such hearing and to have accepted the action or recommendation.

10.4.3 Board Action Following the Provider's Waiver of Hearing Rights

If the Provider has failed to request a hearing timely, the action taken or recommended by the MEC shall thereafter become effective upon approval by the Board. If the Board does not approve the action, the MEC may request initiation of the conflict management process.

10.5 MEDIATION

If the Provider requests mediation in writing, in accordance with Section 10.3.2(d), and the body whose decision prompted the hearing agrees to engage in mediation in an effort to resolve the pending peer review matter, the parties shall cooperate in the selection of a mutually agreeable mediator with experience in such matters. The parties and the mediator shall work together to determine the procedures to be followed during the mediation and how the costs of the mediation will be allocated between the parties. The hearing process will await completion of the mediation, which shall be accomplished as expeditiously as possible. If the parties cannot agree on selection of a mediator or any essential procedural matter, or if the mediation is unsuccessful, the mediation process will terminate and the hearing process will resume. The mediation will be confidential, and no substantive matters discussed in the mediation may be used in any subsequent hearing.

10.6 NOTICE OF HEARING

10.6.1 Notice of Date, Time and Place of Hearing

(a) If a timely request for a hearing is made, the Chief of Staff, CEO, COO or designee shall within thirty (30) days schedule a commencement date for the hearing and shall give Special Notice, in writing, by certified mail, return receipt requested, to the affected Provider of the following:

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

(2) a list of the witnesses, if any, expected to testify at the hearing on behalf or in support of the body whose decision prompted the hearing. The affected Provider shall provide a list of witnesses pursuant to Section 10.10.1. Amendment of the witness list shall be governed by Section 10.10.1.

(b) The hearing shall be convened not less than thirty (30) days nor more than sixty (60) days from the date of receipt of the affected Provider's request for a hearing, unless the affected Provider is then under summary suspension, in which event the hearing shall commence as soon as the arrangements may reasonably be made, but not to exceed forty-five (45) days from the date of receipt of the request for a hearing, except as otherwise agreed by the parties or ordered by the Hearing Officer on a showing of good cause.

10.6.2 Statement of Reasons

Together with the notice stating the time, date and place of the hearing provided pursuant to Section 10.6.1, the notice of hearing shall contain a statement of the reasons for the action or recommendation, including the acts or omissions with which the Provider is charged, and a list of patient records that will be considered at the hearing, if applicable. This statement of reasons and the list of patient records may be amended or supplemented at any time, even during the hearing, so long as the additional material is relevant to the continued appointment or Clinical Privileges/Practice Prerogatives of the affected Provider, and the affected Provider has sufficient time to review this additional information and the opportunity to rebut it.

10.7 HEARING PANEL

When a hearing is requested, the Chief of Staff shall appoint a Hearing Panel which shall be composed of not fewer than three (3) Members. The hearing Panel may include Providers and/or specified professional personnel who may, but need not, be Medical Staff Members, or persons who are not connected with the Hospital, or a combination of such persons. The Hearing Panel shall include at least one (1) Member who has the same healing arts licensure as the Provider and, when feasible, who practices the same specialty (but not necessarily the same sub-specialty) as the Provider. Members of the Hearing Panel may not include any individual who is in direct economic competition with the affected Provider, or any individual who is professionally

associated with or related to the affected Provider, and may not include any Medical Staff Member who has acted as an accuser, investigator, fact finder or initial decision-maker, or who has actively participated in consideration of the matter at any previous level. One (1) person so appointed shall be designated as the Chair. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel.

10.8 HEARING OFFICER

10.8.1 Selection and Role of the Hearing Officer

The CEO designee, in consultation with the Chief of Staff, shall appoint an individual who may be, but is not required to be, an attorney-at-law, and is qualified to preside over a quasi-judicial hearing as a Hearing Officer. However, an attorney regularly utilized by the Hospital for legal advice regarding its affairs and activities shall not be eligible to serve as a Hearing Officer. Such Hearing Officer shall not be biased for or against any party, must not act as a prosecuting officer, or as an advocate for either side at the hearing. The Hearing Officer may not be in direct economic competition with the affected Provider. The Hearing Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but, the Hearing Officer shall not be entitled to vote.

10.8.2 Duties of the Hearing Officer

The Hearing Officer shall do all of the following:

(a) strive to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross-examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

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

(c) maintain decorum throughout the hearing;

(d) resolve questions of procedure throughout the hearing, including, but not limited to the order of, and/or procedure for presenting evidence and argument during the hearing;

(e) exercise the authority and discretion to make rulings on all questions that pertain to matters of law, procedure, or the admissibility of evidence that are raised prior to, during, or after the hearing, including deciding when evidence may not be introduced, granting continuances, ruling on disputed discovery requests, and ruling on challenges to Hearing Panel members or oneself serving as the Hearing Officer;

(f) act in such a way that all appropriate information relevant to the appointment, continued appointment or Clinical Privileges or Practice Prerogatives of the Provider is considered by the Hearing Panel in formulating its findings and recommendations;

(g) endeavor to avoid excessive formality and to promote the swiftest possible resolution of the matter consistent with the standards of fairness set forth in these Bylaws;

(h) take such discretionary action as may be deemed warranted by the circumstances if the Hearing Officer determines that either side is not proceeding in an efficient and expeditious manner; and

(i) at the request of both parties, engage in effort to resolve the matter informally.

10.9 RIGHTS OF THE PARTIES

10.9.1 At a hearing, each party shall have the following rights, subject to reasonable limits determined by the Hearing Officer:

(a) to inspect and copy as soon as practicable, at the party's own expense, any relevant documents or other evidence in the possession or control of the other party, except for confidential information referring solely to individually identifiable Medical Staff Members or AHPs other than the Provider under review (original documents may not be removed); failure by either party to provide access to this information at least thirty (30) days before the hearing, or as soon as practicable if the request is made less than thirty (30) days prior to the hearing, constitutes good cause for a continuance;

(b) to ask the Hearing Panel members and Hearing Officer questions directly related to evaluating their qualifications to serve and for challenging such members and/or the Hearing Officer;

(c) to call and examine witnesses, to the extent available, for relevant testimony;

(d) to present evidence determined to be relevant by the Hearing Officer, and present the type of evidence on which responsible persons customarily rely in the conduct of serious affairs, regardless of its admissibility in a court of law;

(e) to introduce relevant exhibits or other documents;

(f) to cross-examine and/or impeach any witness who shall have testified orally on any matter relevant to the issues and to rebut any evidence; and

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

10.9.2 Any Provider requesting a hearing who does not testify in their own behalf may be called and examined as if under cross-examination.

10.9.3 The Hearing Panel may question the witnesses, call additional witnesses or request additional documentary evidence, but may not conduct research on any matter relevant to the hearing.

10.9.4 These rights shall be exercised in an efficient and expeditious manner.

10.9.5 The privacy rights of patients shall be protected in accordance with applicable law. Each participant in the hearing process may be required to sign a statement to that effect.

10.10 PRE-HEARING AND HEARING PROCEDURE

10.10.1 List of Witnesses

The affected Provider shall provide a written list of the names and contact information for the individuals expected to offer testimony or evidence on Provider's behalf within ten (10) days after receiving the notice of hearing. The witness list of either party may, at the discretion of the Hearing Officer, be supplemented or amended at any time prior to or during the course of the hearing, provided that sufficient notice of the change is given to the other party to allow such party to prepare adequately.

10.10.2 Failure to Appear or Proceed

Except upon a showing of good cause, the Provider's failure to attend personally and proceed at such a hearing in an efficient and orderly manner, as determined by the Hearing Officer in consultation with the Hearing Panel, shall be deemed to constitute voluntary acceptance of the recommendation or action involved and it shall thereupon become the final action or recommendation of the body whose decision prompted the hearing. Such final action or recommendation shall be considered by the Board within forty-five (45) days (or such longer period as required for documented good cause), but shall not be binding on the Board.

10.10.3 Postponements and Extensions

Once a request for a hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted within the discretion of the Hearing Officer, on a showing of good cause, or upon agreement of the parties.

10.10.4 Procedural Disputes

(a) Duty to Raise Issues: It shall be the duty of the affected Provider and the body whose decision prompted the hearing to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

(b) Motions: The parties may file motions to seek resolution of such procedural matters as the Hearing Officer determines may be resolved outside the presence of the Hearing Panel. Any such motion shall be in writing and shall state the ruling requested, all relevant factual information, and any supporting authority for the motion. The moving party shall deliver a copy of the motion to the opposing party, who shall have five (5) working days, which excludes weekends and holidays to submit a written response to the Hearing Officer, with a copy to the moving party (unless the time is extended by the Hearing Officer for good cause). The Hearing Officer shall determine whether to allow oral argument on such motions. The Hearing Officer's ruling shall be in writing and shall be provided to the parties promptly. All motions, responses and rulings shall be entered into the hearing record by the Hearing Officer.

10.10.5 Representation

(a) Representation by Counsel: The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency, or character. The affected Provider shall have a right to be represented by legal counsel at the hearing. The affected Provider shall state, in writing, the Provider's intentions with respect to representation by legal counsel at the time the Provider submits the written request for a hearing. If the affected Provider is represented by legal counsel in the hearing, the body whose action prompted the hearing shall also be represented by legal counsel.

(b) Representation When the Provider Chooses Not to Be Represented by Counsel: In the absence of legal counsel in the hearing, the affected Provider shall be entitled to be accompanied by and represented at the hearing by a Provider licensed to practice in the state of Hawai`i who is not also an attorney at law, and the body whose action prompted the hearing shall appoint a representative who is not an attorney at law. Each side shall notify the other of the name of the individual who will act as its representative in the hearing at least ten (10) days prior to the date of the hearing.

(c) Regardless of whether the parties are represented by legal counsel in the hearing itself, both parties shall have the right to consult with legal counsel to help them prepare for and participate in the hearing.

10.10.6 Pre-Hearing Conference

If the Provider is represented, the Hearing Officer may require the Provider's representative and the representative of the body whose decision prompted the hearing to participate in a pre-hearing conference for purposes of resolving procedural questions and/or defining the scope of the issues prior to the hearing.

10.11 THE HEARING

10.11.1 Burdens of Presenting Evidence and Proof

(a) At the hearing, the body whose decision prompted the hearing shall have the initial burden to present evidence for each case or issue in support of its action or recommendation. The affected Provider shall be obligated to present evidence in response.

(b) An applicant for appointment and/or Privileges or Practice Prerogatives shall bear the burden of persuading the Hearing Panel, by a preponderance of the evidence, of applicant's qualifications by producing information that allows for adequate evaluation and resolution of reasonable doubts concerning their current qualifications for appointment and/or Privileges or Practice Prerogatives. An applicant shall not be permitted to introduce information not produced during the application process unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(c) Except as provided above for applicants, throughout the hearing, the body whose decision prompted the hearing shall bear the burden of persuading the Hearing Panel, by a preponderance of the evidence, that its action or recommendation was reasonable and warranted at the time it was taken/ made. If evidence introduced at the hearing indicates a substantial change in the circumstances that resulted in the action or recommendation, the Hearing Panel may remand to the body whose decision prompted the hearing for reconsideration of the action or recommendation.

(d) The term "preponderance of the evidence" means evidence that has more convincing force than that opposed to it. If the evidence on a particular issue is so evenly balanced that the Hearing Panel is unable to say that the evidence on either side preponderates, then the Hearing Panel must find on that issue against the party who had the burden of proving it. In evaluating the evidence, the Hearing Panel should consider all of the evidence bearing upon every issue regardless of which party produced it or had the burden of proof on the issue.

10.11.2 Record of the Hearing

An audio recording or a shorthand reporter shall be present to make a verbatim record of the hearing proceedings, and the pre-hearing proceedings if deemed appropriate by the Hearing Officer. The cost of attendance of the shorthand reporter shall be borne by the Hospital. The cost of a transcript, if any, shall be borne by the party requesting it. The Hearing Panel may, but shall not be required to, order that oral evidence be taken only on oath administered by any person lawfully authorized to administer such oath or by affirmation under penalty of perjury to the Hearing Officer.

10.11.3 Basis for Decision

(a) The Hearing Panel's decision shall be based on the evidence produced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. However, the decision may not be based upon evidence that is inherently improbable or irrelevant to the issues, or upon the testimony of any expert who relied on assumptions or conclusions that were not supported by the evidence in the record.

(b) The hearing record may consist of the following:

(1) oral testimony of witnesses;

(2) memoranda of law and/or other legal and/or medical authorities or literature presented in connection with the hearing;

(3) any other pertinent information regarding the affected Provider so long as that information has been admitted into evidence at the hearing and the affected Provider had the opportunity to comment and/or refute it;

(4) any and all applications, references, and accompanying documents;

(5) other documentary evidence, including but not limited to medical records; and

(6) any other evidence that has been admitted.

10.11.4 Admissibility of Evidence

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted by the Hearing Officer if it is the type of evidence on which responsible persons customarily rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

10.11.5 Adjournment and Conclusion

After consultation with the Chair of the Hearing Panel, the Hearing Officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed. The Hearing Panel shall thereupon conduct its deliberations outside the presence of any other person, except the presence of the Hearing Officer upon the Hearing Panel's request.

10.11.6 Presence of Hearing Panel Members and Vote

All Hearing Panel members shall be present throughout the hearing and deliberations, except that in unusual circumstances, the Hearing Officer may determine that a Hearing Panel member who unavoidably was absent from some part of the proceedings may participate in the deliberations and the decision if the member has read the entire transcript of the portion(s) of the hearing from which the member was absent. The final decision of the Hearing Panel must be sustained by a majority vote of the members.

10.11.7 Decision of the Hearing Panel

Within thirty (30) days after final adjournment of the hearing, the Hearing Panel shall render a decision to uphold, modify or reverse the recommendation or action of the body whose decision prompted the hearing, and submit a written report and recommendation to the Board, CEO or designee (which shall be drafted by the Hearing Officer). If the affected Provider is currently under suspension, however, the time for the decision and report shall be fifteen (15) days. These time limits may be extended upon agreement of the parties, or by the Hearing Officer upon a showing of good cause. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. The CEO or designee shall forward the report and recommendation to the affected Provider and to the body whose decision prompted the hearing as soon as practicable.

10.12 APPEAL

10.12.1 Time for Appeal

(a) Within ten (10) days after receipt of the Hearing Panel's decision, either the affected Provider or the body whose decision prompted the hearing may request an appellate review by the Board. Such request shall be in writing, and shall be delivered to the Board Chair, CEO or designee, as applicable, either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific

facts or circumstances warranting an appeal. The request for appellate review shall be forwarded to the Board.

(b) If such appellate review is not requested within ten (10) days as provided herein, both parties shall be deemed to have waived any right to an appeal, and the Hearing Panel decision shall become the final action or recommendation of body whose decision prompted the hearing. Such final action or recommendation shall be forwarded to the Board for final action within thirty (30) days of the date it was issued, except that this time period may be extended by the Hearing Officer for good cause. The Board shall exercise its independent judgment in reviewing the Hearing Panel's decision, and shall affirm the Hearing Panel's decision as the final action if the decision is supported by the weight of the evidence.

10.12.2 Grounds for Appeal

The grounds for appeal shall be limited to the following:

(a) there was substantial non-compliance with the Medical Staff Bylaws so as to deny a fair Hearing;

(b) the Hearing Panel's decision was made arbitrarily or capriciously; and/or

(c) the Hearing Panel's decision is not supported by substantial evidence.

10.12.3 Notice of Date, Time and Place of Appellate Review

Whenever an appeal is requested in accordance with Section 10.12.1(a), the Chair of the Board or the Chair's designee shall, within thirty (30) days after receipt of such request, schedule and arrange for an appellate review. The affected Provider shall be given notice of the date, time and place of the appellate review. The Appellate Review Panel shall be convened not less than thirty (30) days nor more than sixty (60) days from the date of receipt of the request for appellate review, unless the Provider is then under suspension, in which event the Appellate Review Panel shall be convened as soon as the arrangements may reasonably be made but not more than fourteen (14) days from the date of receipt of the request for an appeal. The time for appellate review may be extended by the Chair of the Board, or by the Appellate Review Hearing Officer, if one has been appointed, for good cause or by agreement of the parties.

10.12.4 Composition of the Appellate Review Panel

The Chair of the Board shall appoint an Appellate Review Panel composed of not less than three (3) persons, either members of the Board or others, including but not limited to reputable persons from outside the Hospital, to consider the record of the hearing. Alternatively, the Board as a whole may sit as the Appellate Review Panel. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appellate Review Panel, so long as that person

did not take part in a prior hearing on the same matter. If the Appellate Review Panel is not the Board as a whole but consists entirely of Board members, the Board may delegate to the Appellate Review Panel the authority to make a final decision in the matter without review of the full Board.

10.12.5 Appellate Review Panel Hearing Officer

The Appellate Review Panel shall select an attorney to assist it in the proceeding, who shall act as the Appellate Review Hearing Officer. If requested by the Appellate Review Panel, the Appellate Review Hearing Officer shall participate in the Appellate Review Panel's deliberations and may serve as its legal advisor; however, the Appellate Review Hearing Officer shall not be entitled to vote. The Appellate Review Hearing Officer selected by the Appellate Review Panel shall not be the attorney who represented either party at the hearing or the Hearing Officer at the hearing.

10.12.6 Evidence

(a) The Appellate Review Panel proceeding shall be in the nature of an appellate hearing based upon the record of the hearing before the Hearing Panel. Additional evidence will be accepted only if the Appellate Review Panel determines, on the basis of a written foundational showing, that:

(1) there is additional relevant evidence that could not have been produced in the exercise of reasonable diligence during the hearing; and/or

(2) an opportunity to admit relevant evidence was improperly denied by the Hearing Officer during the hearing.

(b) Any oral or written additional evidence that is accepted by the Appellate Review Panel shall be subject to the same rights of cross-examination or confrontation that would have been available at the Hearing Panel proceedings. Alternatively, the Appellate Review Panel may remand the matter to the Hearing Panel for it to hear such additional evidence, in which event the Hearing Panel shall render a remand report and recommendation to the Board.

10.12.7 Parties' Rights

Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, and to present a written statement in support of its position on appeal. The Appellate Review Panel may allow each party or a representative to appear personally and present oral argument.

10.12.8 Record of the Proceedings

An audio recording or a shorthand reporter shall be present to maintain a record of any appellate review proceedings during which oral argument shall be present. The cost of attendance of the shorthand reporter shall be borne by the Hospital. The cost of a transcript, if any, shall be borne by the party requesting it.

10.12.9 Deliberations

The Appellate Review Panel may conduct, at a time convenient to itself, deliberations outside the presence of the appellant, respondent and their representatives.

10.12.10 Recommendation of the Appellate Review Panel

(a) The Appellate Review Panel shall recommend final action to the Board, unless the Board has delegated authority to render the final decision to the Appellate Review Panel under Section 10.12.4. The Appellate Review Panel may decide that the Hearing Panel's decision should be affirmed, modified or reversed, or that the matter be remanded to the Hearing Panel for further review and consideration. If the Appellate Review Panel determines that the Provider was denied fair procedure in some material respect, the matter shall be remanded for further Hearing Panel proceedings in accordance with the Appellate Review Panel's decision.

(b) The Appellate Review Panel shall give great weight to the Hearing Panel's decision, and shall not act arbitrarily or capriciously. The Appellate Review Panel shall, however, exercise its independent judgment in determining whether the Provider was afforded a fair hearing, and whether the Hearing Committee decision was reasonable, warranted, and supported by the weight of the evidence. The Appellate Review Hearing Officer shall assist the Appellate Review Panel in preparing its report, which shall specify the reasons for the decision and provide findings of fact and conclusions articulating the connection between the evidence produced and the Appellate Review Panel's decision, if such findings and conclusions differ from those of the Hearing Panel. The Appellate Review Committee shall forward copies of its report to the parties and the Board within thirty (30) days after conclusion of the Appellate Review hearing, unless this time period is extended by the Appellate Review Hearing Officer for good cause.

(c) If the matter is remanded, the further review shall include a remand report from the Hearing Panel to the Appellate Review Panel, and shall be completed within thirty (30) days from the date of the remand, unless the parties agree otherwise or for good cause as determined by the Appellate Review Hearing Officer. Following receipt of the Hearing Panel's remand report, the Appellate Review Panel shall prepare and submit its final report to the parties and the Board.

10.12.11 Final Board Decision

(a) Unless the Board delegated final decision-making authority to the Appellate Review Panel per Section 10.12.4, the Board shall exercise its independent judgment in determining whether the Provider was afforded a fair hearing, and whether the Hearing Panel decision was reasonable, warranted, and supported by the weight of the evidence. The Board may affirm, modify or reverse the recommendation of the Appellate Review Panel or remand the matter to the Appellate Review Panel or the Hearing Panel for further review and consideration. If the Board determines that the Provider was denied fair procedure in some material respect, the matter shall be remanded to the Hearing Panel or Appellate Review Panel for further proceedings per the Board's decision.

(b) If the matter is remanded, the further review shall be completed within thirty (30) days from the date of the remand, unless the parties agree otherwise or for good cause as determined by the Board, and the review shall include a remand report from the Hearing Panel or the Appellate Review Panel (as applicable). Following receipt of the remand report, the Board shall prepare its final report.

(c) The Appellate Review Hearing Officer shall assist the Board in the preparation of its report, which shall specify the reasons for the decision and provide findings of fact and conclusions articulating the connection between the evidence produced and the Board's decision, if such findings and conclusions differ from those of the Appellate Review Panel. The Board shall issue its report within thirty (30) days of the receipt of the Appellate Review Panel's recommendation, or any remand report, unless this time period is extended by the Appellate Review Hearing Officer for good cause. The Board shall deliver copies of its report to the affected Provider and to the Chairs of the Credentials Committee and MECs, in person or by certified mail, return receipt requested.

10.12.12 Right to One Hearing and One Appeal Only

No Provider shall be entitled to more than one (1) hearing and one (1) appeal on any matter which has been the subject of adverse action or recommendation. If the Board denies initial appointment or reappointment, or revokes or terminates the appointment and/or Clinical Privileges or Practice Prerogatives of a current Medical Staff Member or AHP, that Provider may not reapply for appointment, Clinical Privileges or Practice Prerogatives at this Hospital except in accordance with Section 6.8 of these Bylaws, unless the Board expressly provides otherwise in its final decision.

10.13 EXCEPTIONS TO HEARING RIGHTS

10.13.1 Closed Staff or Exclusive-Use Departments

The hearing and appeal rights under these Bylaws do not apply to a Provider whose application for appointment, reappointment, Clinical Privileges or Practice Prerogatives was denied on the basis that the Clinical Privileges or Practice Prerogatives Provider seeks are granted pursuant only to a closed-staff or exclusive-use policy.

10.13.2 Medical-Administrative Practitioner

The hearing and appeal rights under these Bylaws do not apply to Provider serving the Hospital in a Medical-Administrative capacity. Termination of such Providers' rights to practice in the Hospital shall instead be governed by the terms of their individual contracts with the Hospital. However, the hearing and appeal rights of these Bylaws shall apply to the extent that Staff Category or Clinical Privileges or Practice Prerogatives that are independent of the Provider's contract also are reduced, removed or suspended, unless the contract includes a specific provision establishing alternative procedural rights applicable to such decisions, or as otherwise specifically required by law.

10.13.3 Removal from Emergency Room Call Panel

The hearing and appeal rights under these Bylaws do not apply to any actions or recommendations affecting a Provider's emergency room call panel service.

10.13.4 Failure to Meet Minimum Qualifications or Submit a Complete Application

The hearing and appeal rights under these Bylaws do not apply to any denial of appointment, reappointment, Clinical Privileges and/or Practice Prerogatives, or to any decision not to furnish or process an application, based upon the Provider's failure to meet the minimum objective criteria set forth in these Bylaws, including but not limited to any minimum activity requirement for reappointment, or failure to submit a complete application.

10.13.5 Automatic Revocation, Suspension, Limitation or Deemed Resignation

(a) The hearing and appeal rights under these Bylaws do not apply to any situation involving automatic revocation, suspension, limitation or deemed resignation as set forth in Section 9.6.

(b) A Provider may request an opportunity to be heard by the MEC, which shall not actuate any other procedural rights, if the Provider can present evidence that the event that triggered an automatic revocation, suspension, limitation or deemed resignation did not actually occur.

10.14 VALIDITY OF BYLAWS, RULES & REGULATIONS AND/OR POLICIES

No hearing provided for in this article shall be utilized to make determinations as to the merits of substantive validity of any Medical Staff bylaw, rule, regulation or policy. Where a Provider is adversely affected by the application of a Medical Staff bylaw, rule/regulation, or policy, the affected Provider's sole remedy is to seek review of such bylaw, rule/regulation, or policy initially by the MEC. The MEC may in its discretion consider the request according to procedures it deems appropriate. If the Provider is dissatisfied with the action of the MEC, the Provider may request review by the Board, which shall have discretion whether to conduct a review according to such procedures as it deems appropriate. The Board shall consult with the MEC before taking final action regarding the bylaw, rule, regulation or policy involved. This procedure must be utilized prior to any legal action.

10.15 JOINT HEARINGS AND APPEALS

10.15.1 Joint Hearings

(a) Whenever a Provider is entitled to a hearing at this Hospital pursuant to Article X because corrective action that constitutes grounds for a hearing has been taken or recommended, and the Provider also is entitled concurrently to a hearing or hearings on similar grounds at one or more other HPH hospitals, a single joint hearing may be conducted upon agreement of the MECs and Boards of the involved hospitals. Such a joint hearing shall be conducted in accordance with hearing procedures that have been jointly adopted by the involved hospitals, provided such procedures are substantially comparable to those set forth in Article X, and further provided at least one (1) member of the Hearing Panel is a Member of this Hospital's Medical Staff.

(b) In the event there is such a joint hearing, the recommendation of the Hearing Panel shall be reported to this Hospital's Board for final action.

10.15.2 Joint Appeals

The joint hearing procedures also may provide for joint appeal rights, so long as such procedures are substantially comparable to those set forth in Section 10.12 of these Bylaws, and further provided that at least one (1) member of the Appeal Board is a representative of this Hospital's Board.

10.15.3 Provider's Right to Request a Separate Hearing

A Provider for whom the involved hospitals have agreed to conduct a joint hearing may request, at least thirty (30) days prior to commencement of the joint hearing, that a separate hearing be held at this Hospital. Such a request shall be submitted in writing to the Chief of Staff and the CEO or designee and must include a showing that any potential benefits of a joint hearing are outweighed by particular burdens or unfairness unique to the individual Provider's

circumstances. The body whose decision prompted the hearing may, in its sole discretion, order that a separate hearing and/or appeal be conducted solely with respect to Privileges or Practice Prerogatives at this Hospital, in accordance with this Hospital's Hearing and Appellate Review provisions.

ARTICLE XI
OFFICERS

11.1 OFFICERS OF THE MEDICAL STAFF

The Officers of the Medical Staff shall be:

(a) Chief of Staff

(b) Vice Chief of Staff

(c) Secretary-Treasurer

(d) Immediate Past Chief of Staff

(e) Department Chairs

11.2 QUALIFICATIONS OF OFFICERS

11.2.1 Each officer must be a Member in Good Standing (as defined in these Bylaws) of the Medical Staff at the time of nomination and election and must remain an active Member in Good Standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

11.2.2 Each officer shall be or have been Board Certified.

11.2.3 All officers shall be members of the MEC who attend meetings regularly.

11.2.4 No person may hold the office of Chief of Staff while serving as the Chair of a Department or other position carrying with it a seat on the MEC.

11.2.5 The Chief of Staff must have been a member of the MEC within the past seven (7) years.

11.2.6 To serve as an officer, a Medical Staff Member must:

(a) understand the purposes and functions of the Medical Staff;

(b) demonstrate willingness to ensure that patient welfare always takes precedence over other concerns;

(c) understand and be willing to work toward maintaining the Hospital's compliance with applicable legal and other requirements as set forth in the Bylaws, Rules and Regulations and policies of the Hospital and the Medical Staff;

(d) demonstrate administrative capability, including the ability to work cooperatively with others to achieve the objectives of the Medical Staff and the Hospital; and

(e) demonstrate (by submitting a completed Medical Staff conflict-of-interest disclosure form and providing additional information as requested) that the Member has no conflicts of interest that would impede their participation as an officer.

11.3 ELECTION OF OFFICERS

11.3.1 Except for the Department Chairs, Officers shall be elected by majority vote in a secret ballot election at the annual meeting of the Medical Staff every third year. The Chief of Staff will become the Immediate Past Chief of Staff. Only Members of the Medical Staff with voting Privileges shall be eligible to vote. Voting by proxy shall not be allowed. If no candidate for an office receives a majority of the votes on the first ballot, a run-off election will be held between the two candidates who received the highest number of votes. If there is a tie, the winner will be selected by drawing lots.

11.3.2 The MEC shall appoint a Nominating Committee at least ninety (90) days prior to the annual meeting in an election year. The Nominating Committee will identify suitable candidates for open officer positions, including by soliciting the names of potential candidates from the Members of the Medical Staff, and will verify the potential candidates' qualifications and willingness to serve. The Medical Staff Secretary shall distribute a list of nominees presented by the Nominating Committee, and a list of potential candidates whose names were submitted and who meet the qualifications and are willing to serve, to the Members of the Active Medical Staff at least thirty (30) days prior to the election, along with a list of the qualifications for office set forth in Section 11.2.

11.3.3 Nominations also may be made from the floor with the consent of the nominee at the annual meeting, or may be made by petition signed by at least twenty-five (25) percent of the voting Members of the Medical Staff who are eligible to vote and filed with the Secretary of the Medical Staff at least five (5) days prior to the annual meeting, provided that any such additional nomination must be from the list of candidates who meet the qualifications for office established by these Bylaws. Members will be informed at the annual meeting of any candidates who have been nominated by petition. The ballot will include spaces for write-in candidates who have been nominated by petition or from the floor.

11.4 TERM OF OFFICE

Each officer shall serve a three (3) year term or until a successor is elected. Officers shall take office on the first day of the Medical Staff year following election at the annual meeting. For the purpose of these Bylaws, the Medical Staff year commences on the first day of January and ends on the last day of December of each year. An officer may be reelected, but no officer may serve more than three (3) consecutive terms.

11.5 VACANCIES IN OFFICE

Vacancies in office may occur upon the death or disability, resignation or removal of an officer, or such officer's loss of active Medical Staff membership or Good Standing status. A vacancy in the office of Chief of Staff shall be filled by the Vice Chief of Staff for the remainder of the term, and a new Vice Chief of Staff will be selected by the MEC. Any other vacancy in office during the Medical Staff year shall be filled by the MEC from among its eligible Medical Staff Members, and the interim appointee shall serve pro tem for the remainder of the term.

11.6 REMOVAL FROM OFFICE

11.6.1. Removal of any officer during their term may be initiated by:

(a) the MEC;

(b) the Board; or

(c) a written petition signed by twenty five percent (25%) of the voting Active Staff, stating the reasons for the proposed recall.

11.6.2 A proposal to remove an officer shall be submitted to the MEC, which shall convene a special meeting as soon as reasonably possible and determine whether the basis for the recall proposal constitutes one of the reasons for removal established by these Bylaws. If so, a Medical Staff vote will be arranged.

11.6.3 Removal shall be effected by a majority vote of all voting Active Staff Members in a vote held either at a special meeting, or by mail ballot.

11.6.4 Removal may be based only upon failure or inability to perform the duties of the position, or failure to meet the threshold qualifications for office established by these Bylaws.

11.6.5 Removal of an officer shall become effective only upon ratification by the Board.

11.7 RESIGNATION

Any elected Medical Staff officer may resign at any time by giving written notice to the MEC. Such resignation shall become effective on the date of receipt, or at such other time as specified in the notice, and the resulting vacancy shall be filled in accordance with Section 11.5.

11.8 DUTIES OF OFFICERS

11.8.1 Chief of Staff

The Chief of Staff shall serve as the chief administrative officer of the Medical Staff responsible for the organization and conduct of the Medical Staff, to do the following:

(a) act in coordination and cooperation with the CEO or designee and other Hospital leaders in all matters of mutual concern within the Hospital;

(b) call and preside at each general and special Medical Staff meeting, and assume responsibility for the agenda of such meetings;

(c) appoint committee members and Chairs to all standing, special, and multidisciplinary Medical Staff committees except as otherwise provided in these Bylaws;

(d) serve as Chair of the MEC, and in the interim between MEC meetings, perform such functions of the MEC as in Chief of Staff's reasonable judgment must be accomplished prior to the next regular or special MEC meeting;

(e) serve as an ex officio member of all Medical Staff committees and participate as may be invited on Board and/or Hospital committees, but the Chief of Staff shall not serve as Chair of any committee other than the MEC;

(f) report to the Board the Medical Staff's recommendations concerning appointment, reappointment, delineation of Clinical Privileges and Practice Prerogatives, and corrective action with respect to Provider applicants and appointees, and concerning the effectiveness of the Medical Staff's credentialing, privileging, and professional performance evaluation processes;

(g) review, implement and enforce the Medical Staff Bylaws, Rules & Regulations, Medical Staff and Hospital policies, and the ethical and behavioral standards of the Medical Staff, to promote the provision of high-quality care and efficient operation of the Hospital;

(h) oversee the implementation of sanctions where indicated, and the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been initiated against a Provider;

(i) represent the views, policies, needs and grievances of the Medical Staff to the Board and to the CEO, the COO or designee, of the Hospital, and promote communication between the Board and the Medical Staff;

(j) serve as a member of the Board of Directors if so specified by the Bylaws of the Hospital;

(k) receive and interpret the policies of the Board to the Medical Staff, and report regularly to the Board on the Medical Staff's performance of its delegated responsibility for providing medical care and overseeing the professional work performed in the Hospital;

(l) encourage and support Medical Staff participation and leadership in the Hospital's interdisciplinary performance improvement activities;

(m) serve as the spokesman for the Medical Staff in external professional and public relations, including as a liaison with outside licensing and accreditation agencies as appropriate; and

(n) perform such other duties and exercise such other authority as may be assigned to the Chief of Staff by these Bylaws, the MEC or the Board.

11.8.2 Vice Chief of Staff

The Vice Chief of Staff shall:

(a) assume all the duties and have the authority of the Chief of Staff during the Chief of Staff's absence, and succeed the Chief of Staff if he is no longer able to serve;

(b) serve as the Vice Chair of the MEC;

(c) consider and grant or deny requests from Members for excused absences from Medical Staff meetings;

(d) serve as a member of the Quality Council;

(e) serve as ex officio member of all Medical Staff committees; and

(f) perform such other duties as may be assigned to the Vice Chief of Staff by the Chief of Staff or the MEC.

11.8.3 Secretary-Treasurer

The Secretary-Treasurer shall:

(a) keep accurate and complete minutes of all Medical Staff meetings;

(b) oversee maintenance of an up-to-date roster of Medical Staff Members;

(c) call and give notice of Medical Staff meetings at the request of the Chief of Staff;

(d) attend to all Medical Staff correspondence;

(e) conduct elections for officers;

(f) serve as Chair of the Bylaws Committee;

(g) serve as Treasurer, supervise the collection and keep accurate records of all Medical Staff dues, assessments and application fees, and keep an accounting of all Medical Staff expenditures; and

(h) perform such other duties as may be assigned to the Secretary-Treasurer by the Chief of Staff or the MEC.

11.8.4 Immediate Past Chief of Staff

The duties of the Immediate Past Chief of Staff are advisory in nature. The Immediate Past Chief of Staff is a member of the MEC and Chair of the Nominating Committee.

11.8.5 Department Chairs

The Department Chairs shall be considered officers of the Medical Staff. Their duties are listed in Article XII.

ARTICLE XII
CLINICAL DEPARTMENTS AND DIVISIONS

12.1 MEDICAL STAFF ORGANIZATION CONSISTING OF DEPARTMENTS

12.1.1 Departments

The Medical Staff shall be divided into clinical Departments, each organized as a separate component of the Medical Staff and headed by a Department Chair whose qualifications and responsibilities are outlined in Section 12.5.

12.1.2 Divisions

Departments may be further divided into Divisions, each of which is directly responsible to the Department and headed by a Division Chair whose qualifications and responsibilities are outlined in Section 12.6.

12.2 SPECIFIC DEPARTMENTS

The Medical Staff of the Hospital includes the following six (6) Departments:

Acute Care Services;

Adult Primary Care Services;

Diagnostic Support Services;

Medical Subspecialty Services;

Surgical Services; and

Women's and Children's Services.

12.3 FORMATION AND ELIMINATION OF DEPARTMENTS AND DIVISIONS

12.3.1 Subdivision of Departments into Divisions

Each Department may propose to subdivide itself into Divisions, create a new Division to perform functions assigned to it by the Department Chair, or eliminate any existing Division. The decision to propose formation or elimination of a Division should be approved by majority vote of the Members of the Department present and eligible to vote for general officers of the Medical Staff.

12.3.2 MEC Recommendation

Based on a proposal from a Department or on the MEC's own initiative (following consultation with the relevant Department), the MEC shall recommend to the Medical Staff for approval at any quarterly, semiannual or special meeting of the Medical Staff, in accordance with provisions for Bylaws amendment, the creation, elimination or combination of Medical Staff Departments or Divisions.

12.3.3 Initial Probationary Period

Any newly created Department or Division shall serve a probationary period of twelve (12) months, during which time its activity shall be evaluated by an ad hoc committee appointed by the Chief of Staff and chaired by the Vice Chief of Staff. That ad hoc committee will report to the MEC its findings and recommendations concerning approval of Department or Division status, continued probation or elimination.

12.3.4 Later Probationary Period

When the MEC has been presented with evidence that any Department or Division is unable to perform its functions effectively, the Department or Division shall be placed on a period of twelve (12) months' probation by majority vote of the MEC. Performance will be evaluated by an ad hoc subcommittee appointed by the Chief of Staff and chaired by the Vice Chief of Staff. That ad hoc committee will report to the MEC with recommendations of termination of probation status, continuation of probation status or elimination of Department or Division status.

12.3.5 Vote to Eliminate a Department or Division

If the MEC approves elimination of a Department or Division by majority vote, that recommendation must be presented to the next quarterly or semi-annual Medical Staff meeting for ratification, along with a summary of the reasons for eliminating the Department or Division. Any proposed Department or Division elimination must be approved by a two-thirds vote of the Medical Staff Members present and voting.

12.4 DEPARTMENT FUNCTIONS

Each Department will be responsible for the following functions:

12.4.1 conducting patient care reviews and other monitoring and evaluation functions mandated by The Joint Commission and other agencies for the purpose of assessing and improving the quality and appropriateness of care, treatment and services provided to patients within the Department;

12.4.2 recommending to the MEC guidelines for the granting of Clinical Privileges/Practice Prerogatives and performance of specific services within the Department;

12.4.3 evaluating and making appropriate recommendations regarding qualifications of applicants seeking appointment or reappointment and Clinical Privileges/Practice Prerogatives within the Department.

12.4.4 providing and/or making recommendations regarding continuing education programs pertinent to Department clinical practice.

12.4.5 reviewing and evaluating Department adherence to:

(a) Medical Staff policies and procedures; and

(b) sound principles of clinical practice;

12.4.6 coordinating patient care provided by the Department's Members with nursing and ancillary patient care services;

12.4.7 establishing and appointing committees or other mechanisms as necessary and desirable for performing the functions of the Department, including Provider observation (proctoring), meeting at least quarterly for the purpose of considering patient care review and the results of other Department reviews and evaluation activities (including FPPE and OPPE reports), as well as reports from other Department, Division, committee and Hospital personnel;

12.4.8 taking appropriate actions to improve patient care and clinical performance when important problems are identified; and

12.4.9 reporting to the MEC concerning:

(a) Department review and evaluation activities, actions taken thereon and the results of those actions;

(b) recommendations for maintaining and improving the quality of care provided within the Department and the Hospital;

(c) other professional and Medical Staff administrative activities within the Department; and

(d) recommendations for Department rules and regulations reasonably necessary for proper discharge of its responsibilities subject to the approval of the Department Members and the MEC.

12.5 DEPARTMENT CHAIRS

12.5.1 Qualifications

Each Department shall have a Chair who shall be a Member of the Medical Staff qualified by training, experience and demonstrated administrative and clinical ability for the position. In addition, each Chair shall be or have been Board Certified by an appropriate specialty Board, unless such Chair is in a licensure category that does not have Board Certification.

12.5.2 Selection and Tenure

Each Chair shall be elected by the voting Members of the Department for a three (3) year term subject to approval of the MEC.

A Nominating Committee, elected by the voting Department Members, shall select qualified candidates for Department Chairs. Nominations also may be made from the floor if the nominee(s) agree(s). Election shall be by majority vote in a secret ballot, for a three (3)-year term, subject to approval by a majority of the MEC. A Chair may be appointed to successive terms, to serve up to a total of three (3) terms.

12.5.3 Removal

Removal of a Chair during such Chair's term of office for cause may be initiated by a two-thirds majority vote of all voting Active Staff Members of the Department, but no such removal shall be effective unless and until it has been ratified by a two-thirds (2/3) vote of the MEC. Causes for removing a Department Chair from such position include failure to carry out the Chair's duties, or failure to meet any of the threshold requirements for Medical Staff membership or the position.

12.5.4 Responsibilities

The Chair of a Medical Staff Department or the Chair's delegate in the absence of the chair is responsible for:

(a) all clinically related activities of the Department;

(b) all administratively related activities of the Department, unless otherwise provided by the Hospital;

(c) FPPE and OPPE of the professional performance of all individuals in the Department who have delineated Clinical Privileges or Practice Prerogatives;

(d) recommending to the Medical Staff the criteria for Clinical Privileges/Practice Prerogatives that are relevant to the care provided in the Department;

(e) recommending Clinical Privileges for each Member of the Department, and Practice Prerogatives for each AHP assigned to the Department;

(f) assessing and recommending to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the Department or organization;

(g) integration of the Department into the primary functions of the organization;

(h) coordination and integration of interdepartmental and intradepartmental services;

(i) development and implementation of policies and procedures that guide and support the provision of care, treatment and services;

(j) recommending a sufficient number of qualified and competent persons to provide care, treatment and services;

(k) determining the qualifications and competence of Department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services;

(l) conducting continuous assessment and improvement of the quality of care, treatment and services;

(m) maintenance of quality control programs, as appropriate;

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

(o) recommending space and other resources needed by the Department; and

(p) enforcement of Medical Staff and Hospital Bylaws, rules and policies, including but not limited to the Department or Division implementation of a call schedule if required by a Department or Division, within the Chair's Department.

12.6 DIVISION CHAIRS

12.6.1 Qualifications

Each Division Chair shall be a Member of the Medical Staff qualified by training, experience, and demonstrated administrative and clinical ability for the position. In addition, each Chair shall be or have been Board Certified by an appropriate specialty Board, unless such Chair is in a licensure category that does not have Board Certification.

12.6.2 Selection and Tenure

Each Division Chair shall be appointed for a three (3)-year term by the Department Chair, subject to approval of the MEC. A Division Chair may be appointed to successive terms without limitation.

12.6.3 Removal

Removal of a Division Chair during such Chair's term of office may be initiated by a two-thirds (2/3) majority vote of all voting Active Members of the Division, but no such removal shall be effective unless and until it has been ratified by the MEC. Causes for removing a Division Chair from such position include failure to carry out the Chair's duties, failure to meet any of the threshold requirements for Medical Staff membership or the position or the Department's loss of confidence in the Division Chair.

12.6.4 Responsibilities

Each Division Chair shall assist the Department Chair in Peer Review Activities, which may include, but not be limited to FPPE, OPPE, and other duties as requested.

12.7 ASSIGNMENT TO DEPARTMENTS

12.7.1 Initial Assignment

On recommendation of the relevant clinical Department, the Credentials Committee, the MEC and the Board shall assign each Medical Staff Member and AHP to one clinical Department only.

12.7.2 Multiple Assignments

A Medical Staff Member or AHP may, however, belong to and request and be granted Clinical Privileges or Practice Prerogatives consistent with their training and/or experience within other Departments.

ARTICLE XIII
COMMITTEES AND FUNCTIONS

13.1 GENERAL

13.1.1 Establishment of Committees

There shall be a MEC and such other standing and special or ad hoc committees of the Medical Staff as may be necessary and desirable to carry out the Medical Staff's functions. The MEC may establish a Medical Staff committee to perform any necessary Medical Staff functions, and committees may establish subcommittees with approval of the MEC. Any standing, special, or ad hoc committee or subcommittee that is performing all or any part of a Medical Staff function in accordance with these Bylaws shall be deemed a duly authorized committee of the Medical Staff. Those functions requiring participation of, rather than direct oversight by, the Medical Staff may be discharged by Medical Staff representation on Hospital management and/or Board committees.

13.1.2 Accountability

All Medical Staff committees and subcommittees are accountable to the MEC, which in turn is accountable to the Board.

13.1.3 Appointment of Committee Members, Chairs and Vice Chairs

Except as otherwise specified in these Bylaws, the Chair and members of each committee shall be appointed by, and may be removed by, the Chief of Staff, subject to consultation with and approval by the MEC. In addition to Providers, committee members may include representatives from Hospital departments such as Administration and Nursing (who shall be selected in consultation with the CEO or designee), as well as community representatives and persons with special expertise. The Chair of each standing committee shall appoint a Vice-Chair to assist the Chair and serve in the Chair's absence, with approval of the MEC.

13.1.4 Ex Officio Committee Members

The Chief of Staff and the CEO or designee are ex officio members of all Medical Staff committees and subcommittees, without vote. The Medical Staff officers, including the Department Chairs, are ex officio members of the MEC. Other Medical Staff leaders may be ex officio members of the MEC and/or other committees as specified. A person who is an ex officio member of a committee by virtue of more than one position shall have only one vote on that committee.

13.1.5 Committee Members

A member of a Medical Staff committee who is not a Medical Staff Member shall serve without vote, unless otherwise specified in these Bylaws with respect to the particular committee on which such member serves.

13.1.6 Terms of Committee Members

Except as otherwise specified, a committee member shall be appointed for a term of three (3) years, may serve unlimited consecutive terms (unless removed), and shall serve until the end of the committee member's term or until a successor has been appointed, unless such committee member resigns or is removed sooner.

13.1.7 Removal of Committee Members

Unless otherwise specified in these Bylaws, a committee member may be removed by the Chief of Staff or by a majority vote of the MEC, except for an ex officio member, who may be removed only by the process for removing that person from such office.

13.1.8 Vacancies

Except as otherwise specified in these Bylaws, a vacancy on any committee shall be filled in the same manner as for an original appointment to that committee.

13.1.9 Records and Reports

Committees shall maintain complete and accurate records of their meetings, deliberations and recommendations, and shall submit reports of their activities to the MEC periodically.

13.1.10 Conflicts of Interest

To maintain the integrity of Medical Staff decision-making, committee members' actual and potential conflicts of interest shall be disclosed and handled in accordance with the Medical Staff's conflict-of-interest policy.

13.2 STANDING COMMITTEES

13.2.1 Medical Executive Committee

(a) Authority: The organized Medical Staff delegates authority to the MEC to carry out the Medical Staff's work within the context of the organization functions of governance, leadership, and performance improvement. The MEC has the primary authority for activities related to self-governance of the Medical Staff and for performance improvement of the professional services provided by Providers granted Privileges or Practice Prerogatives through the Medical Staff process.

(b) Composition: A majority of the voting MEC members shall be licensed Physicians actively practicing in the Hospital. All Members of the Medical Staff are eligible to serve on the MEC regardless of discipline or specialty. In accordance with Section 13.1.3, non-physicians may be appointed to serve on the MEC.

(1) The voting members of the MEC shall be:

- the Medical Staff officers as listed in Section 11.1, which include the Department Chairs;
- the Chairs of following committees: Credentials, Quality, and Patient Safety, and Professional Review;

(2) The non-voting members shall be:

the Chief Executive Officer, Chief Medical Officer, Chief Nurse Executive, Chief Operating Officer and any other MEC members who are not listed as voting members above.

(c) Duties: The duties of the MEC, as delegated to the MEC by the Medical Staff, include all of the following (without limitation):

(1) function as a peer review committee to maintain the professional, behavioral and ethical standards established by the Medical Staff Bylaws, Rules & Regulations and policies for the Providers engaged in practice at the Hospital;

(2) function as a quality improvement committee to supervise, monitor and evaluate patient care, and to identify, analyze, and correct deficiencies and seek improvements in the patient care delivery process;

(3) review and act on reports of Medical Staff committees, Departments, Divisions and other assigned activity groups;

(4) make recommendations regarding the mechanisms designed to review credentials and delineate individual Clinical Privileges, including cross-specialty Privileges, and Practice Prerogatives;

(5) review the credentials of applicants for appointment and delineated Clinical Privileges or Practice Prerogatives;

(6) make recommendations to the Board for Medical Staff membership, AHP appointment, and delineated Clinical Privileges and Practice Prerogatives;

(7) make recommendations to the Board regarding the Medical Staff structure;

(8) make recommendations to the Board on medical-administrative matters;

(9) organize the Medical Staff's quality assessment and improvement activities, and establish and implement mechanisms designed to conduct, evaluate and revise such activities;

(10) ensure that appropriate evaluation occurs in any instance where there is doubt about a Provider's ability to perform Clinical Privileges or Practice Prerogatives sought or granted;

(11) initiate FPPE (FPPE is not an Investigation or corrective action) and/or corrective action where indicated;

(12) ensure that the Medical Staff has an effective mechanism by which Medical Staff membership or AHP appointment may be terminated;

(13) formulate, implement and oversee Medical Staff fair hearing procedures;

(14) implement policies of the Medical Staff not otherwise the responsibility of the Departments;

(15) provide a liaison between and among the Medical Staff, the CEO or designee and the Board;

(16) recommend action to the CEO or designees in matters of a medico-administrative nature;

(17) recommend action on Hospital management matters (*e.g.*, long-range planning) to the Board through the CEO or designees;

(18) report regularly to the Board on Medical Staff activities, including but not limited to the results of quality improvement programs, and account to the Board for the medical care rendered to patients in the Hospital;

(19) assist the Hospital in maintaining accreditation, and ensure that the Medical Staff is kept abreast of the Hospital's accreditation program and status;

(20) take all reasonable steps to ensure inter- and intra-departmental cooperation, ethical conduct and competent clinical performance on the part of all Members of the Medical Staff and AHPs,

including the initiation of and/or participation in the Medical Staff review and/or remedial/corrective measures when warranted;

(21) participate in the selection and approval of qualified Providers whenever vacancies occur in existing or in newly created positions;

(22) take reasonable steps to develop a continuing medical education (CME) program and ensure that professional education programs provided in the Hospital incorporate the results and recommendations of Medical Staff quality assessment and improvement activities;

(23) report at each general Medical Staff meeting;

(24) ensure that the Medical Staff Bylaws, Rules & Regulations and policies encompass all elements required by applicable law and accreditation standards, and necessary for the Medical Staff to fulfill its functions, by formulating and recommending revisions to such documents to the Board;

(25) with the assistance of the Chief of Staff, implement and enforce the Medical Staff Bylaws, Rules & Regulations and policies; approved Hospital bylaws, rules and policies as they relate to the Medical Staff; and applicable laws and accreditation standards;

(26) establish and implement as necessary mechanisms for the management of conflicts between and among Medical Staff groups and between the MEC and the Board;

(27) consistent with the Hospital's and the Medical Staff's mission, cooperate in identifying community health needs and implementing programs to meet those needs;

(28) establish annual dues, application fees (if any), and guidelines for expenditure of monies collected by the Medical Staff;

(29) act for the Medical Staff in the intervals between Medical Staff meetings, consistent with the MEC's authority as established by these Bylaws; and

(30) fulfill such other duties as the Medical Staff has delegated or may delegate to the MEC.

(d) Meetings: The MEC shall meet at least ten (10) times per year and maintain minutes reflecting attendance and actions taken.

(e) Removal of Delegated Authority of the MEC: The Medical Staff may remove a specific aspect of the MEC's delegated authority temporarily, as appropriate to protect the Medical Staff's interests, by a vote of at least three-quarters (3/4) of the membership. Otherwise, the MEC's authority to carry out any of its duties as set forth in these Bylaws may be removed only by amending the Bylaws through the process set forth in Article XVII.

13.2.2 Cancer Committee

The Cancer Committee shall be responsible for leadership in the planning, initiation, and assessment of all cancer-related activities.

The membership of the Cancer Committee is multidisciplinary as defined by current cancer treatment program accreditation standards. The Cancer Committee shall, at a minimum, consist of Physicians from the diagnostic and treatment specialties and non-physicians from administration and supportive services.

Ancillary members shall include at a minimum: The Cancer Program Administrator, an Oncology Nurse, a Social Worker or Case Manager, the Certified Tumor Registrar, a Quality Management representative, and a Palliative Care Physician.

The Committee shall meet at least quarterly and report periodically to the MEC.

13.2.3 Credentials Committee

The Credentials Committee shall consist of:

(a) the Chair, who shall be appointed by the Chief of Staff;

Chair Qualifications:

(1) Member of the Medical Staff for at least the previous five (5) years and in good standing throughout term as Chair; failure to maintain such status shall immediately create a vacancy;

(2) Is or has been Board Certified unless the Chair's licensure category is one that does not have Board Certification; and

(3) previous service as a Credentials Committee member, Medical Staff officer or Department Chair; and

(b) a representative from each Medical Staff Department.

Responsibilities:

The Credentials Committee is a peer review committee and shall be responsible

for the evaluation of all applicants, Medical Staff Members and AHPs. The Credentials Committee shall do the following:

(a) review the credentials of all new applicants for Medical Staff membership and Privileges;

(b) review credentials of AHPs requesting Practice Prerogatives;

(c) review the credentials and Privileges/Practice Prerogatives, including FPPE and OPPE, of all applicants for reappointment and reinstatement;

(d) evaluate staff status and make recommendations for the advancement from provisional status to regular staff status;

(e) collect recommendations from the Chairs of the appropriate Departments regarding the FPPE requirements for each applicant;

(f) either approve or disapprove recommendations received from the Chairs of appropriate Departments and forward them to the MEC;

(g) evaluate reports from the MEC concerning the qualifications, ethics, and competence of Medical Staff Members or AHPs; and

(h) report to the MEC all proceedings as a result of the above reviews. These reports shall include the Credentials Committee's recommendations for the granting and curtailment of Privileges and Practice Prerogatives, and the assignment and reappointment of Providers to the various Departments.

13.2.4 Multidisciplinary Committees

Establishment and Abolition:

Standing Hospital-wide multidisciplinary committees may be established and/or abolished through the joint action of the MEC and the CEO or designee. The Chair and members of each multidisciplinary committee not specifically described in these Bylaws shall be appointed jointly by the Chief of Staff, CEO or designee and Chief Nurse Executive with the approval of the MEC**.**

Authority, Duties and Accountability:

The purpose(s), duties and authority of each Hospital-wide multidisciplinary committee shall be determined and/or modified by the MEC and CEO or designee. All reports and recommendations shall be made jointly to the MEC and CEO or designee.

Meetings:

Each Hospital-wide multidisciplinary committee not specifically described in these Bylaws shall meet at the call of or on a schedule set by the Chair, as often as necessary to accomplish its purposes and fulfill its duties.

13.2.5 Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics Committee shall consist of members appointed by the Chief of Staff, including a Chair.

Duties:

(a) maintain a formulary of drugs for use in the Hospital;

(b) create treatment guidelines in cooperation with Medical Staff and nursing personnel for specific medications;

(c) monitor and evaluate the process to reduce medication errors, including adverse drug reactions, drug/drug interactions and need for pharmacist interventions;

(d) perform drug usage evaluations of specific medications;

(e) approve policies and procedures relating to procurement, storage, disposal, distribution, use, safety, diversion detection and prevention and other matters relating to medication use;

(f) develop and support safe medication use processes throughout the organization including:

1) prescribing/ordering;

2) preparing and dispensing;

3) administration; and

4) monitoring;

(g) analyze and profile data regarding medication usage by service and Provider, as appropriate;

(h) provide routine summaries of the above analyses to the MEC and other Medical Staff Departments, Divisions and committees as appropriate, recommending process improvement when opportunities are identified;

(i) serve as an advisor to the Medical Staff pertaining to the choice of available medications;

(j) establish standards concerning the use and control of investigational medications, including how these medications are safely controlled, administered and destroyed; and

(k) meet at least quarterly and as often as necessary to fulfill its duties.

13.2.6 Provider Assistance Committee

The Provider Assistance Committee (PAC) shall consist of:

(a) a Chair appointed by the chief of staff; and

(b) at least two other Providers, including either a psychologist or psychiatrist knowledgeable in the area of impairment.

The members, including the Chair, shall not be members of the Medical Staff leadership, nor members of the Credentials Committee or any other committee that evaluates Providers for appointment, reappointment, and/or corrective action.

Responsibilities:

(a) initial assessment of a provider suspected of impairment;

(b) referral of the Provider for evaluation as appropriate;

(c) recommendation for a program of treatment and/or accommodation as often as necessary, as appropriate;

(d) monitoring of the impaired Provider to assure compliance with the recommendations, but at least quarterly;

(e) referral of the Provider to the appropriate peer review or credentialing body for corrective action, in cases where the Provider refuses to cooperate with the recommendations for therapy and monitoring;

(f) assuring that the committee's responses are rehabilitative in nature whenever possible, rather than disciplinary; and

(g) providing and/or arranging for education of Medical Staff Members

periodically on Provider health, well-being, impairment (including how to recognize and report known or suspected impairment) and other related topics.

13.2.7 Quality, Patient Safety and Utilization Management Committee

The Quality, Patient Safety and Utilization Management Committee shall be comprised of:

(a) Members of the Medical Staff, including but not limited to representatives from the Hospitalist Service, Anesthesiology, Critical Care Medicine, Emergency Medicine, and Radiology;

(b) Hospital personnel including but not limited to the CEO or designees; CMO; Vice President of Clinic Operations; Director of OR; Director, Clinical Service Line; Director(s) of Risk Management; and Director of Quality;

(c) Other Providers appointed at the discretion of the Chief of Staff.

Responsibilities

a) develop a Quality Management Plan to assure the accountability of the Medical Staff and the Hospital for the care provided;

b) implement the Hospital's quality management program, including annual reappraisal of the quality management program, problem identification, problem assessment, problem correction and problem correction monitoring; and

c) provide leadership in the area of utilization and resource management;

d) develop, implement and monitor the Utilization Management Plan;

e) identify and review utilization trends and reports, and take appropriate performance improvement actions;

f) assure mechanisms are in place to move patients along the continuum of care;

g) evaluate and improve utilization resources in the Hospital; and

h) meet regularly and as often as necessary to fulfill its responsibilities, and report to the MEC periodically on the Utilization Review Committee's activities.

13.3 SPECIAL OR AD HOC COMMITTEES

Upon a motion adopted by the MEC, a special or ad hoc committee shall be appointed by the Chief of Staff as necessary to carry out specified duties of the Medical Staff and MEC. Such a committee shall limit its activities to the purposes for which the committee was appointed, and shall report to the MEC. A special or ad hoc committee shall not have power of action unless such authority has been delegated to the committee expressly by the MEC in its motion.

ARTICLE XIV
MEETINGS, ACTION WITHOUT A MEETING

14.1 MEETINGS OF THE MEDICAL STAFF

14.1.1 Annual Meeting

There shall be at least one (1) meeting of the Medical Staff during each Medical Staff Year. The meeting designated as the "Annual Meeting" shall be held at the call of the Chief of Staff, who shall present a report on significant actions taken by the MEC since the last Annual Meeting, as well as other matters of interest and value to the membership.

14.1.2 Other Regular Medical Staff Meetings

Other regular meetings of the Medical Staff shall be held as determined by the MEC. The Chief of Staff shall determine the agenda and order of business at such meetings, and shall provide appropriate written notification, which shall be delivered to all voting Medical Staff Members, any other Members who have asked to received such notification, and the CEO or designee, in accordance with Section 14.4.

14.1.3 Order of Business and Agenda at Regular Medical Staff Meetings

The order of business at a regular Medical Staff meeting shall be determined by the Chief of Staff. The agenda shall include:

(a) reading and acceptance of the minutes of the last Annual Meeting and any regular or special meetings held since the last meeting;

(b) reading of communications to and from the Medical Staff since the last regular meeting;

(c) presentation of administrative reports from the CEO or designee, the Chief of Staff, and others;

(d) election of officers and other Medical Staff leaders as and when required by these Bylaws;

(e) presentation of reports by responsible officers, Departments, Divisions and committees on the overall results of performance improvement and other quality management activities of the Medical Staff, and on the fulfillment of other required Medical Staff functions, as appropriate;

(f) recommendations for improving patient care within the Hospital;

(g) unfinished business; and

(h) new business.

14.1.4 Special Meetings

A special meeting of the Medical Staff may be called at any time by the Board, the Chief of Staff, the MEC, or at least twenty-five percent (25%) of the voting Members of the Active Staff in a written request stating the purpose of such meeting. The special meeting shall be held within a reasonable time after receipt of the request, at the time and place designated in the meeting Notice issued by the Chief of Staff, which also shall include the purpose of the meeting. No business shall be transacted at any special meeting except that stated in the meeting Notice.

14.2 DEPARTMENT, DIVISION AND COMMITTEE MEETINGS

14.2.1 Regular Meetings of Departments, Divisions and Committees

Each Department, Division and committee may establish and disseminate to its Members the time for holding the group's regular meetings (*e.g.*, at noon on the second Tuesday of each month) and no other notification shall then be required. Each Division shall hold meetings at least quarterly to review and evaluate the performance of Providers within the Division.

14.2.2 Special Meetings of Departments, Divisions and Committees

A special meeting of any Department, Division or committee may be called by its Chair, the Board, the Chief of Staff, or by one-third (1/3) of the group's current voting Members, with Notice to be provided in accordance with Section 14.4. The special meeting shall be held within a reasonable time after receipt of the request, at the time and place designated in the meeting notice issued by the Chair. No business shall be transacted at any special meeting except that stated in the meeting Notice, unless all voting Members waive this restriction.

14.3 COMBINED OR JOINT MEETINGS

The Medical Staff and its Departments, Divisions and committees may participate in combined or joint meetings with Members of other HPH Medical Staffs, provided that precautions shall be taken to ensure that no confidential Medical Staff information is disclosed except as appropriate

and permitted by law and these Bylaws, and that this Medical Staff maintains access to and authority to approve all minutes prepared in connection with any such meetings.

14.4 NOTICE OF MEETINGS

Except as otherwise provided herein, Notice stating the date, time and place of a meeting shall be delivered either personally or by mail, facsimile or e-mail to each person entitled to be present not less than three (3) days and not more than fourteen (14) days before the date of such meeting. If mailed, the Notice of the meeting shall be deemed delivered twenty-four (24) hours after deposit, postage prepaid, in the United States mail addressed to each person entitled to such notice at their address as it appears on the records of the Hospital. Attendance at a meeting shall constitute a waiver of Notice of such meeting, except for attendance for the purpose of objecting to sufficiency of Notice.

14.5 QUORUM

14.5.1 Medical Staff Meetings

The presence of twenty-five percent (25%) of the voting Members of the Active Staff at any meeting of the Medical Staff shall constitute a quorum.

14.5.2 Department, Division and Committee Meetings

A quorum for a Department, Division or committee meeting shall consist of at least three (3) voting members present, except for meetings of the MEC, which shall require that at least fifty percent (50%) of the MEC members be present to constitute a quorum.

14.6 MANNER OF ACTION

14.6.1 Action by Majority Vote

Except as otherwise provided 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 initially is present may continue to transact business after some members leave, so long as any action taken is approved by a least a majority of the required quorum for that meeting, or such greater number as is required under these Bylaws. The meeting Chair shall refrain from voting except to break a tie.

14.6.2 Action Without a Meeting

Action may be taken without a meeting by the Medical Staff or a Department, Division or committee by mail or e-mail ballot stating the action to be approved, with an affirmative vote of a majority of return ballots or votes communicated to the Medical Staff Office by telephone and documented, provided that Notice of the proposed action was given to all members entitled to vote within a reasonable time prior to the vote.

14.7 MINUTES

Minutes of each meeting shall be prepared by the person responsible, and shall include a record of attendance. Copies of such minutes shall be signed by the presiding officer, and forwarded to the MEC. A file of the minutes of each group's meetings shall be maintained.

14.8 ATTENDANCE REQUIREMENTS

Members are encouraged to be involved participants in the Medical Staff and to attend meetings regularly. A Member's level of meeting attendance and participation may be considered in evaluating whether the Member qualifies for a leadership position. Specific meeting attendance requirements may be established by Departments, Divisions and committees for their members.

14.9 SPECIAL APPEARANCE REQUIREMENT

14.9.1 Special Notice of Requirement to Appear

Whenever an apparent or suspected deviation from sound clinical practice or other standards of conduct for Medical Staff Members and AHPs is scheduled to be discussed at a meeting, Special Notice shall be given to the Provider involved, stating the issue(s) to be reviewed and informing the Provider that Provider's appearance at the meeting is mandatory. The Chair shall give the Provider at least three (3) days' advance notice of the date time and place of the meeting.

14.9.2 Consequences of Unexcused Failure to Appear

Failure of a Provider to appear at any meeting with respect to which he was given Special Notice to appear shall, unless excused by Chair of the meeting or the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the Provider's Clinical Privileges or Practice Prerogatives as the MEC may direct. Such automatic suspension shall remain in effect until the matter is resolved pursuant to these Bylaws, including but not limited to by corrective action.

14.9.3 Procedure in the Event of Excused Absence

If the Chair or the MEC finds the Provider had good cause for being unable to attend the meeting as originally scheduled, the meeting may be postponed to no later than the next regularly scheduled meeting of the group, or the matter may be presented and discussed as originally scheduled, without the presence of the affected Provider.

14.10 RULES OF ORDER

The rules contained in the most recently revised edition of Robert's Rules of Order, Revised, shall govern the conduct of meetings in all instances where they are applicable and not inconsistent with the Medical Staff Bylaws and Rules & Regulations. Chairs of Departments and Divisions, Chairs of committees, and other Hospital leaders should familiarize themselves with

these rules. However, technical failure to comply with these rules at a meeting shall not invalidate any action otherwise properly taken.

ARTICLE XV
CONFIDENTIALITY, IMMUNITY, AND RELEASES/AUTHORIZATIONS

15.1 SCOPE

By applying for and/or accepting or exercising membership, AHP appointment, and/or Clinical Privileges or Practice Prerogatives at this Hospital, a Provider acknowledges that the provisions of this Article are express conditions to applying for appointment, the granting or continuation of such appointment, and/or to exercising Clinical Privileges or Practice Prerogatives at this Hospital, and the Provider agrees to be bound by these provisions.

15.2 CONFIDENTIALITY OF INFORMATION

15.2.1 Confidentiality

Medical Staff proceedings, minutes, files, and records, including but not limited to information regarding any Provider, are confidential, and will be maintained as such to the fullest extent permitted by law. Participants in peer review shall limit their communications regarding such matters to the formal avenues established by these Bylaws. This confidentiality also extends to credentialing and peer review information provided by third parties, which will become a part of the Medical Staff files and not part of any particular patient's record or of general Hospital records. Such information and records will be disseminated only when expressly required by law, or pursuant to officially adopted policies of the Medical Staff, or—where no officially adopted policy exists—only with the express approval of the MEC or its designee and the Hospital's CEO or designee.

15.2.2 Breach of Confidentiality

Because effective credentialing, quality improvement, peer review, and evaluation of the qualifications of Providers to perform specific procedures and/or functions must be based on free and candid discussions, and because Providers and others participate in credentialing, quality improvement, and Peer Review Activities with the reasonable expectation that this confidentiality will be preserved and maintained, any breach of the confidentiality of discussions or deliberations of the Medical Staff or its Departments, Divisions or committees, except in conjunction with other healthcare entity, professional society, or licensing authority peer review activities, is outside the appropriate standards of conduct for this Medical Staff and the Hospital's AHP personnel, and will be deemed conduct that undermines a culture of safety. If the MEC determines that such a breach has occurred, the MEC may initiate such corrective action as it deems appropriate,

which may include termination of appointment and Privileges or Practice Prerogatives.

15.3 IMMUNITY

15.3.1 Privileged Communications

Any act, communication, report, recommendation or disclosure with respect to a Provider, performed or made in good faith and without malice, by or at the request of an authorized representative of this or any other healthcare facility, for the purpose of achieving and maintaining quality patient care in this or any other healthcare facility, shall be privileged or otherwise protected to the fullest extent permitted by law.

15.3.2 Scope of Privileges

Such privileges and protections shall extend to Members of the Hospital's Medical Staff, appointed AHPs, the Hospital's Board, its CEO, CMO, and COO and their representative(s), to other Hawai`i Pacific Health hospitals and their medical staffs, and to third parties who supply information to any of the foregoing authorized to receive, release or act upon the same. For the purpose of this Article XV, the term "third parties" means both individuals and organizations from which information has been requested by any authorized representative of the Board or of the Medical Staff.

15.3.3 Immunity from Civil Liability

With respect to the entities and persons mentioned in Section 15.3.2 above, there shall be, to the fullest extent permitted by law, absolute immunity from civil liability arising from any such act, communication, report, recommendation or disclosure, even where the information involved would otherwise be deemed privileged.

15.3.4 Scope of Immunity

Such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other healthcare entity's activities related but not limited to: (a) applications for appointment and/or Clinical Privileges or Practice Prerogatives; (b) periodic reappraisals for reappointment and/or renewal or addition of Clinical Privileges or Practice Prerogatives; (c) investigations; (d) corrective action, including but not limited to summary suspensions or restrictions; (e) hearings and appellate reviews; (f) quality monitoring and/or improvement activities, including FPPE, OPPE and patient care audits and evaluations; (g) utilization reviews; (h) mortality and morbidity reviews; (i) reports and queries to the National Practitioner Data Bank and/or the state licensing agency and other similar queries and reports; and (j)

other Hospital, Department, Division, service or committee activities related to quality patient care and professional conduct.

15.3.5 Activities and Information Covered

The acts, communications, reports, recommendations and disclosures referred to in this Article XV may relate to a Provider's professional qualifications, clinical competency, judgment, character, mental or emotional stability, physical and mental condition, emotional stability, ethics, conduct in the Hospital or the community, or any other matter that might directly or indirectly have an effect on patient care.

15.3.6 Cumulative Effect with Other Protections

The consents, authorizations, releases, rights, privileges and immunities provided by these Bylaws, the Medical Staff and Hospital application forms, and applicable law for the protection of this Hospital's Providers, other appropriate Medical Staff and Hospital officials and personnel and third parties, in connection with applications for initial appointment and reappointment as well as FPPE, OPPE and other Peer Review Activities, shall be fully applicable to the activities and procedures covered by this Article XV. Nothing in these Bylaws or any other Hospital or Medical Staff document shall in any way limit such protections.

15.4 RELEASES

In furtherance of the foregoing, each Provider shall, upon request of the Hospital or the Medical Staff, execute releases and/or authorizations in accordance with the tenor and import of this Article XV in favor of the individuals and organizations specified in Section 15.3, subject to such requirements including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this state. However, execution of such releases is not a prerequisite to the effectiveness of this Article XV or other applicable protections.

ARTICLE XVI

RULES & REGULATIONS AND POLICIES

16.1 MEC AUTHORITY TO ADOPT AND AMEND RULES & REGULATIONS AND POLICIES

The Medical Staff Rules & Regulations and policies cover the details of numerous major responsibilities of the Medical Staff and AHPs, and supplement the Medical Staff Bylaws and Hospital policies. Medical Staff Rules & Regulations and policies, as well as Hospital policies that impact patient care and are binding on the Medical Staff Members and AHPs, may be adopted or amended by a majority vote of the MEC, subject to approval by the Board. Adoption

and amendment of Hospital policies shall be accomplished in consultation and cooperation with Hospital Administration.

16.2 DEPARTMENT, SERVICE AND ADMINISTRATION INPUT INTO FORMULATION OF RULES & REGULATIONS AND POLICIES

Medical Staff Rules & Regulations applying to a particular Department or service may be developed by the Department or service and shall be effective upon approval by the MEC and Board. Additionally, Hospital Administration may develop and recommend proposed Rules & Regulations and policies, and in any case should be consulted as to the impact of any proposed Rules & Regulations and policies on Hospital operations and feasibility.

16.3 NO UNILATERAL AMENDMENT

Neither the Board nor the Medical Staff may unilaterally amend the Medical Staff Rules & Regulations or policies.

16.4 BYLAWS PREVAIL IN THE EVENT OF A CONFLICT WITH THE RULES & REGULATIONS OR POLICIES

If there is a conflict between the Bylaws and the Rules & Regulations or any policy, the Bylaws shall prevail.

16.5 DIRECT AMENDMENT BY THE MEDICAL STAFF OF RULES & REGULATIONS

The Medical Staff may recommend amendments to the Rules & Regulations directly to the Board for adoption, under the circumstances and by the process described in Section 16.6.

16.6 METHODOLOGY FOR DIRECT ADOPTION/AMENDMENT OF RULES & REGULATIONS

A proposal for a new Rules & Regulations provision or an amendment to existing Rules & Regulations provision (a "proposed Rule") may be submitted to the MEC by any Medical Staff, Division, Department, committee or officer, or by petition signed by at least twenty-five percent (25%) of the voting Members of the Medical Staff, and identifying three (3) Active Medical Staff Members who will serve as representatives and act on behalf of the petitioners in the processes described below (including any conflict management process), as follows:

16.6.1 Except as provided in section 16.6.4 with respect to circumstances requiring urgent action, the MEC shall not act on the proposed Rule until the Medical Staff has had a reasonable opportunity to review and comment.

16.6.2 MEC approval is required, unless the proposed Rule is one generated by petition of at least twenty-five percent (25%) of the voting Members of the Medical Staff. In this latter circumstance, if the MEC fails to approve the proposed Rule, it shall notify the Medical Staff. The MEC and the petitioners' representatives, acting on

behalf of the Medical Staff, each have the option of invoking or waiving the conflict management provisions of Section 16.9.

(a) If the conflict management process is not invoked within 30 days, it shall be deemed waived. In this circumstance, the Medical Staff's proposed Rule shall be submitted for vote, and if approved by the Medical Staff pursuant to section 16.6.2(c), the proposed Rule shall be forwarded to the Board for action. The MEC may forward comments to the Medical Staff and the Board regarding the MEC's reasons if it declined to approve the proposed Rule.

(b) If the conflict management process is invoked, the proposed Rule shall not be voted upon or forwarded to the Board until the conflict management process has been completed, and the results of the conflict management process shall be communicated to the Medical Staff and the Board.

(c) With respect to a proposed Rule generated by petition of the Medical Staff, approval of the Medical Staff requires the affirmative vote of a majority of the Medical Staff Members voting on the matter by mailed ballot, provided at least fourteen (14) days' advance written Notice has been given, accompanied by the proposed Rule.

16.6.3 Following approval by the MEC or the voting Medical Staff as described above, a proposed Rule shall be forwarded to the Board for approval, which approval shall not be withheld unreasonably. The Rule shall become effective immediately following Board approval, or automatically within 60 days if no action is taken by the Board. If the Board disapproves the proposed Rule, the MEC or Medical Staff may initiate the conflict management process set forth in Article XVIII for management of conflicts between the Medical Staff or MEC and the Board.

16.6.4 Where urgent action is required to comply with law or regulation, the MEC is authorized to adopt a Rule provisionally and forward it to the Board for approval and immediate implementation. However, if the Medical Staff did not receive prior notice of the proposed Rule (as described in section 16.6.1, the Medical Staff shall be notified of the provisionally adopted and approved Rule, and may, by petition signed by at least twenty five percent (25%) of the voting Members of the Medical Staff, require the Rule to be submitted for possible recall. The approved Rule shall remain effective until such time as a superseding Rule meeting the requirements of the law or regulation that precipitated the initial urgency has been approved per any applicable provision of this section 16.6.

16.7 DIRECT MEDICAL STAFF RECOMMENDATION OF POLICIES TO THE BOARD

The Medical Staff may recommend policies or amendments to policies for adoption by the Board. Proposed policies or policy amendments shall not be inconsistent with the Medical Staff

Bylaws, Rules & Regulations or other policies, and upon adoption shall have the force and effect of the Medical Staff Bylaws.

16.8 METHODOLOGY FOR DIRECT MEDICAL STAFF RECOMMENDATION OF POLICIES TO THE BOARD

Proposals for new policies, or amendments to existing policies, may be submitted to the MEC for review and action by any Medical Staff Department, Division, committee or officer, or by petition signed by at least twenty- five percent (25%) of the voting Members of the Medical Staff and identifying three (3) active Medical Staff Members who will serve as representatives and act on behalf of the petitioners in the processes described below (including any conflict management process), as follows:

16.8.1 MEC approval is required, unless the proposed policy is one generated by petition of at least twenty-five percent (25%) of the voting Members of the Medical Staff. In this latter circumstance, if the MEC fails to approve the proposed policy, it shall notify the Medical Staff. The MEC and the petitioners' representatives, acting on behalf of the Medical Staff, each shall have the option of invoking or waiving the conflict management provisions of section 16.9.

(a) If the conflict management process is not invoked within 30 days, it shall be deemed waived. In this circumstance, the Medical Staff's proposed policy shall be submitted for vote, and if approved by the Medical Staff pursuant to section 16.8.1(c), the proposed policy shall be forwarded to the Board for action. The MEC may forward comments to the Medical Staff and the Board regarding the reasons if the MEC declined to approve the proposed policy.

(b) If the conflict management process is invoked, the proposed policy shall not be voted upon or forwarded to the Board until the conflict management process has been completed, and the results of the conflict management process shall be communicated to the Medical Staff and the Board.

(c) With respect to proposed policies generated by petition of the Medical Staff, approval of the Medical Staff requires the affirmative vote of a majority of the Medical Staff Members voting on the matter by mailed ballot, provided at least fourteen (14) days' advance written notice has been given, accompanied by the proposed policy.

16.8.2 Following approval by the MEC or the voting Medical Staff as described above, a proposed policy shall be forwarded to the Board for approval, which approval shall not be withheld unreasonably. The policy shall become effective immediately following Board approval, or automatically within 60 days if no action is taken by the Board. If the Board disapproves the proposed policy, the MEC or Medical Staff group may initiate the conflict management process set

forth in Article XVIII for management of conflicts between the Medical Staff or MEC and the Board.

16.8.3 The Medical Staff shall be notified of the approved policy, and may, by petition signed by at least twenty five percent (25%) of the voting Members of the Medical Staff, require the policy to be submitted for possible recall. The approved policy shall remain effective until such time as it is repealed or amended pursuant to any applicable provision of this section 16.8.

16.9 CONFLICT MANAGEMENT

In the event of a conflict between the MEC and the Medical Staff (as represented by at least twenty-five percent (25%) of the voting Members) regarding a proposed or adopted Rule or policy, or other issue of significance to the Medical Staff, the CEO or designee shall convene a meeting of the MEC with the petitioners' representatives. The MEC shall be represented by an equal number of MEC members. The MEC's and the petitioners' representatives shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the MEC, and the safety and quality of patient care at the Hospital. Resolution via this process requires a majority vote of the petitioners' representatives. The proposed resolution reached, and/or any unresolved differences, shall be submitted to the Board for its consideration in making its final decision with respect to the proposed Rule, policy, or issue.

ARTICLE XVII

ADOPTION AND AMENDMENT OF BYLAWS

17.1 MEDICAL STAFF RESPONSIBILITY AND AUTHORITY

The Medical Staff shall have the initial responsibility and authority to formulate, adopt and recommend to the Board Medical Staff Bylaws and amendments thereto which shall be effective when approved by the Board. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally professionally recognized level of quality and efficiency and of maintaining a harmony of purpose and effort with the Board and with the community. The Medical Staff shall review the Bylaws at least annually, to ensure that they reflect the Medical Staff's and Hospital's current practices with respect to the Medical Staff's organization and functions, as well as current law and Joint Commission standards. Neither the Board nor the Medical Staff may unilaterally amend the Bylaws.

17.2 METHODOLOGY FOR ADOPTION OF MEC-APPROVED BYLAWS AMENDMENTS

17.2.1 Proposals for Bylaws Amendments

Any Medical Staff Department, Division or committee, or Hospital leader or other interested person, may submit a written suggestion for a proposed Bylaws amendment to the MEC, which may consider such suggestions at its discretion.

17.2.2 Sequence of Action for Approval of Bylaws Amendments

(a) Medical Staff Approval: Following approval by the MEC, the Medical Staff may approve a proposed Bylaws amendment by an affirmative majority vote at a meeting at which a quorum of voting Members is present, provided at least twenty (20) days written Notice of the intention to take such action has been given to the voting Members, accompanied by the proposed Bylaws and/or amendments. Alternatively, a vote of the eligible Members may be obtained by mailed ballot, provided the requirements listed above are met and voting Members have had an opportunity to ask questions of a representative of the Bylaws Committee. Of the mailed ballots, twenty-five percent (25%) must be returned of which a majority must be affirmative to pass the amendment.

(b) Board Approval: Following approval by the Medical Staff as provided in Section 17.2.2(a) above, a proposed amendment may be finally approved by an affirmative vote of a majority of the Board.

17.2.3 Board Initiation in the Event of Medical Staff Failure to Act

In the event that the Medical Staff fails to fulfill its responsibility and exercise its authority as required by Section 17.1, and after Notice from the Board regarding amendments it considers necessary for compliance with laws or accreditation requirements or for effective operation of the Hospital, including a reasonable period of time for the Medical Staff to respond, the Board may initiate Medical Staff Bylaws amendments. The Board shall consider and give great weight to Medical Staff recommendations and views during the Board's deliberations and in its actions, and will initiate the conflict management process set forth in Article XVIII for management of conflicts between the Medical Staff or MEC and the Board if necessary prior to taking final action on such proposed Medical Staff.

17.3 METHODOLOGY FOR DIRECT MEDICAL STAFF PROPOSAL OF BYLAWS AMENDMENTS TO THE BOARD

In addition to the mechanisms set forth in Section 17.2 regarding adoption of MEC-approved amendments to the Medical Staff Bylaws, the Medical Staff may recommend amendments to the Bylaws for adoption by the Board without MEC support, only in accordance with the following procedure:

17.3.1 Petition to Amend the Medical Staff Bylaws

A proposal to amend the Bylaws may be initiated by submitting to the Medical Staff Office a petition signed by at least twenty-five percent (25%) of voting Members proposing a specific Bylaws amendment or amendments, which will constitute notice to the MEC of such proposed bylaws amendment(s). Any such petition must identify three (3) Active Staff Members who will serve as representatives and act on behalf of the petitioners in the processes described below (including any conflict management process).

17.3.2 MEC Review

Upon submission of such a petition, the MEC will determine whether it supports the proposed bylaws amendment(s), and if so, the proposed bylaws amendment(s) shall be submitted for vote by the voting Members and Board according to the methodology set forth in Section 17.2.

17.3.3 Notice to the Medical Staff of Proposed Amendments the MEC Has Declined to Approve; Invocation or Waiver of the Conflict Management Process

If the MEC does not support the proposed Bylaws amendment(s), the MEC will notify the designated representatives in writing, and they will have thirty (30) days from receipt of the Notice to invoke the conflict management process described in Section 16.9. If the conflict management process is not invoked within thirty (30) days, it shall be deemed waived and the proposed bylaws amendment(s) will be deemed withdrawn.

17.3.4 Submission to the Medical Staff for Vote

If the conflict is not resolved by withdrawal of the proposed Bylaws amendment(s), or MEC support of the proposed Bylaws amendment(s) as modified in the conflict management process, then the proposed Bylaws amendment(s) will be submitted (in original form, or if applicable, as modified in the conflict management process) to the Medical Staff for a vote. The proposed Bylaws amendment(s) will be submitted to the Board if a majority of voting Members cast their ballots in favor of the proposed Bylaws amendment(s).

17.3.5 Submission to the Board

A copy of the MEC's written statement of its decision and reasons issued at the conclusion of the conflict management process shall be provided to the Board along with any proposed Bylaws amendment(s) submitted to the Board after such process.

17.3.6 Final Action

Such proposed Bylaws amendment(s) will become effective immediately if approved by the Board. If the Board does not approve the amendments, the

petitioners may initiate the conflict management process set forth in Article XVIII for management of conflicts between the Medical Staff or MEC and the Board.

17.4 EDITORIAL CORRECTIONS

The MEC shall have the authority to adopt non-substantive changes to the Medical Staff Bylaws, Rules & Regulations and policies, such as reorganization or renumbering, or technical corrections made necessary because of errors in punctuation, spelling, grammar or syntax, and/or inaccurate or missing cross-references. Such changes shall not affect the interpretation or intent of the sections being changed. The MEC may take action to make such non-substantive changes by motion, in the same manner as any other motion before the MEC. After approval by the MEC, the technical changes shall be communicated promptly in writing to the Board. Such corrections are subject to approval by the Board, which approval shall not be withheld unreasonably. Following approval by the Board, editorial corrections shall be communicated to the Medical Staff within a time that is reasonable under the circumstances (which may be when the Medical Staff is notified of the next substantive changes to the Bylaws, Rules & Regulations or policies affected).

17.5 EXCLUSIVITY

The mechanisms described in these Bylaws shall be the exclusive methods for the initiation, adoption, amendment or repeal of the Medical Staff Bylaws, Rules & Regulations and policies.

ARTICLE XVIII
MISCELLANEOUS PROVISIONS

18.1 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws.

18.2 EXCLUSIVE MECHANISMS FOR PROVIDING PROFESSIONAL SERVICES AT THE HOSPITAL

These Bylaws provide the exclusive mechanisms by which Providers may be authorized to deliver professional services at the Hospital. No Provider shall deliver any such services at the Hospital unless such Provider has been granted Clinical Privileges or Practice Prerogatives to do so pursuant to these Bylaws.

18.3 DUES OR ASSESSMENTS AND APPLICATION FEES

Subject to approval of the Board, the MEC shall have the power to establish reasonable annual dues (if any) for each Staff Category, and application fees, to arrange for the collection of such dues and fees, and to determine how the funds received are expended, consistent with the mission of the Hospital and the Medical Staff.

18.4 FORMS

Application forms and any other forms required for use in connection with Medical Staff appointments, reappointments, delineation of Privileges or Practice Prerogatives, corrective action, Notices, recommendations, reports and other Medical Staff activities described in these Bylaws or the Rules & Regulations shall be approved by the MEC and the Board. Upon approval, such forms shall be deemed part of the Rules & Regulations or policies. They may be revised by approval of the MEC and the Board.

18.5 TRANSMITTAL OF REPORTS

Where these Bylaws require the Medical Staff to transmit reports or other information to the Board, such transmittal may be accomplished by delivery to the CEO or designee.

18.6 NOTICES TO THE MEDICAL STAFF OR ITS OFFICERS

Notice to the Medical Staff or officers, Departments, Divisions or committees thereof, shall be addressed as follows:

Name and proper title of addressee, if known or applicable
c/o Supervisor
Medical Staff Office
Straub Medical Center
888 South King Street
Honolulu, HI 96813

18.7 CONSEQUENCES OF ACTION WITHOUT AUTHORITY

Any Member and AHP who acts in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the MEC may deem appropriate.

18.8 DISCLOSURE OF INTERESTS

All Medical Staff Members and AHPs shall disclose relevant financial and other interests that might affect their participation in Medical Staff activities and affairs in accordance with the Medical Staff Conflict of Interest Policy.

18.9 NOMINATION OF MEDICAL STAFF REPRESENTATIVES

Candidates for positions as Medical Staff representatives to local, state and national hospital Medical Staff organizations should be filled by such selection process as the Medical Staff may determine. Nominations for such positions shall be made by a nominating committee appointed by the MEC.

18.10 EXCLUSIVE CONTRACTING AND ADDITION OR ELIMINATION OF SERVICES

18.10.1 Exclusivity Policy

In recognition of the Hospital's policy that certain Hospital facilities will be used on an exclusive basis in accordance with contracts between the Hospital and professionals selected by the Hospital and the Board, applications for appointment to staff status under Article VI and for Clinical Privilege/Practice Prerogatives under Article VII relating to such exclusive Hospital facilities and services will not be accepted for processing, except for applications by professionals who have been granted exclusive rights under a contract with the Hospital, and professionals employed or engaged by the professionals holding such exclusive rights to perform services under a contract with the Hospital.

18.10.2 Facilities and Services Subject to the Exclusivity Policy

The Board reserves the right, after consultation with the MEC, from time to time, in its sole discretion, to make certain Hospital facilities and services subject to the exclusivity policy and to exclusive contractual arrangements with Providers. The CEO is empowered to exercise this exclusive authority by entering into one or more contractual arrangements or by the adoption of such policies, rules, regulations or measures as the CEO deems reasonable, subject only to the approval of the Board.

18.10.3 Effect of Contract Expiration or Termination

The effect of expiration or termination of a contract between a Provider and the Hospital on a Practitioner's Medical Staff membership and Clinical Privileges or AHPs appointment and Practice Prerogatives shall be governed by the terms of the Provider's contract with the Hospital. No action, recommendation or decision by the Hospital or the Board with regard to the expiration, termination or failure to renew any contract with a Provider shall be subject to or conditioned upon any proceedings or exercise of rights under Article X of these Bylaws.

18.10.4 Medical Staff's Consultative Role

The MEC shall be consulted and may make recommendations to the Board regarding quality of care issues related to exclusive contractual arrangements for

professional services and the addition or deletion of services to be provided in the Hospital.

18.11 HISTORY AND PHYSICAL EXAMINATION REQUIREMENTS

18.11.1 Completing the Medical H&P

A medical H&P must be completed and documented for each patient no more than thirty (30) days before or within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical H&P must be completed and documented by a Physician, Oral/ Maxillofacial Surgeon, or other qualified licensed Provider in accordance with Hawai'i law and the Medical Staff Rules & Regulations.

18.11.2 Updating the Medical H&P

Whenever the medical H&P have been completed before admission or registration (which may occur only as permitted in accordance with this section and applicable law and accreditation requirements), an updated examination of the patient, including any changes in the patient's condition since the H&P, must be completed and documented by an appropriate Provider within 24 hours after admission or registration, but prior to surgery or any procedure requiring anesthesia services, as defined above.

18.11.3 Additional Requirements for H&Ps in the Rules & Regulations

Additional requirements for completing the medical history and physical examination for each patient are set forth in the Medical Staff Rules & Regulations.

18.12 GRADUATE MEDICAL EDUCATION

18.12.1 Medical Staff Supervision of Medical Professionals in Training

Medical students, residents and/or fellows ("medical professionals in training") rotating through the Hospital will be credentialed and receive delineated Privileges through their university training program, subject to approval by the MEC and the Board. Their competency and duties will be established in an Affiliation Agreement between the Hospital and the university, and must be consistent with the scope of their medical licensure and level of education. Each medical professional in training shall function at the Hospital under the direct supervision of a Medical Staff Member, and must comply with these Medical Staff Bylaws and the Rules & Regulations. The mechanisms by which medical professionals in training are supervised by Medical Staff Members are described in the Graduate Education Program policy.

18.12.2 Medical Staff Review of Affiliation Agreements

The Chief of Staff or CEO's designee will review all proposed university Affiliation Agreements and make recommendations to the Board, which will determine final approval or disapproval of such agreements.

18.12.3 Directors of Medical Education

A Director of Medical Education shall do the following:

(a) assume responsibility for the direction and supervision of their respective training program within the Hospital;

(b) submit the annual budget for the residency training program for which he is responsible, and review the budget of the relevant outpatient department;

(c) recruit and recommend appointment of physicians, in conjunction with the MEC, which must approve all such appointments subject to final approval of the Board, including the Director(s) of Resident Education, Medical Director(s) of Ambulatory Services, and other existing or newly created Medical Director positions that impact substantially upon the Hospital's teaching programs;

(d) serve as medical supervisor of the relevant outpatient department and formulate policies and procedures for the delivery of services, including the establishment of priorities in their area with the approval of the MEC;

(e) serve as a representative of the Medical Staff on any committee that has as its primary purpose medical education; and

(f) A Director of Medical Education shall be designated by the Chief of Staff to supervise the Medical Library.

18.13 MANAGEMENT OF CONFLICTS BETWEEN THE MEDICAL STAFF OR MEC AND THE BOARD OR HOSPITAL ADMINISTRATION

Any dispute between the MEC or a group of at least twenty-five percent (25%) of the voting Medical Staff, and the Board or Hospital Administration, concerning proposals for amendments to the Medical Staff Bylaws, Rules & Regulations or policies, or aspects of the Medical Staff's or MEC's authority or functions, shall be addressed through the following process if it cannot be resolved through informal discussions:

18.13.1 Initiation of the Conflict Management Process

Either party (or both parties) to the dispute may submit written Notice(s) to the other requesting initiation of this conflict management process and stating the nature of the dispute. Within three (3) days following receipt of such a request, each party shall appoint representatives to a Joint Conference Committee ("JCC") as provided below.

18.13.2 Composition of the Joint Conference Committee

A JCC shall be comprised of three (3) members appointed by the Board and three (3) members appointed by the MEC or the Medical Staff group. The six (6) JCC members shall appoint by mutual agreement a seventh neutral member, who may be an outside professional mediator, to serve as the JCC Chair (without vote). If the Chair is an outside mediator, the cost of the mediator shall be divided equally between the parties.

18.13.3 Joint Conference Committee Process

The JCC shall convene as quickly as possible and review the written request(s) for initiation of the process. The JCC may obtain such assistance as it deems necessary to gather relevant information and evaluate the opposing viewpoints. The JCC shall meet and confer in good faith and attempt to formulate a recommendation for resolution of the dispute. The JCC's efforts shall continue for up to sixty (60) days, at the end of which the Chair shall prepare a report of the JCC's findings and recommendations and transmit the report to the parties. Alternatively, if the JCC has not reached consensus, the JCC may ask the parties for additional time to consider the matter, and a specific additional deliberation period may be granted if both parties agree, or the Chair may submit a report outlining areas of agreement and remaining issues, without any recommendations. Following receipt of the Chair's report, the parties may adopt the JCC's recommendations (if any), agree to some alternative resolution of the dispute, or refer the dispute back to the JCC with instructions for further efforts. Unless requested by the parties to continue its deliberations, the JCC shall dissolve thirty (30) days after the Chair has made the Chair's report to the parties. The matter shall then be referred to the Board for final action, along with the written record of the dispute and all resolution efforts to that point, including the Chair's report and recommendations (if any).

18.13.4 Final Decision

The Board shall make its determination in light of its ultimate responsibility for the safety of patients and the quality of care provided in the Hospital. The decision of the Board following completion of this process shall be final.

18.14 BYLAWS/RULES NOT A CONTRACT

Neither these Bylaws nor the Medical Staff Rules & Regulations constitute a contract between the Hospital or the Board and the Medical Staff, nor between the Hospital, the Board or the Medical Staff and any applicant, Medical Staff Member or AHP.
