

East Hawaii Region
Hawaii Health Services Corporation

Unified Medical Staff
Bylaws

MEDICAL STAFF BYLAWS, RULES AND REGULATIONS

PREAMBLE	1
DEFINITIONS	1
ARTICLE 1: NAME AND PURPOSE	3
ARTICLE 2: MEMBERSHIP	3
2.1 NATURE OF MEDICAL STAFF MEMBERSHIP	3
2.2 QUALIFICATIONS FOR MEMBERSHIP	3
2.2.1 GENERAL QUALIFICATIONS	3
2.3 EFFECT OF OTHER AFFILIATIONS	4
2.4 NONDISCRIMINATION	4
2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP	4
ARTICLE 3: MEDICAL STAFF CATEGORIES.....	5
3.1 CATEGORIES	5
3.2 ACTIVE STAFF	5
3.2.1 REQUIREMENTS.....	5
3.2.2 PREROGATIVES.....	6
3.2.3 FAILURE TO MEET MINIMUM REQUIREMENTS	6
3.3 AFFILIATE STAFF	6
3.3.1 REQUIREMENTS.....	6
3.3.2 RESPONSIBILITIES	6
3.3.3 PREROGATIVES.....	7
3.3.4 FAILURE TO MEET MINIMUM REQUIREMENTS	7
3.4 CONSULTING MEDICAL STAFF	7
3.4.1 REQUIREMENTS.....	7
3.4.2 PREROGATIVES.....	8
3.4.3 FAILURE TO MEET MINIMUM QUALIFICATIONS.....	8
3.5 ALLIED ADVANCED PRACTICE PROFESSIONALS	8
3.5.1 QUALIFICATIONS	8
3.5.2 PREROGATIVES.....	8
3.5.3 FAILURE TO MEET MINIMUM REQUIREMENTS	9
3.6 HONORARY STAFF	9
3.6.1 REQUIREMENTS.....	9
3.6.2 PREROGATIVES.....	9
3.6.3 DURATION OF APPOINTMENT	9
ARTICLE 4: APPOINTMENT AND REAPPOINTMENT.....	9
4.1 GENERAL	9
4.2 TIMELY PROCESSING OF APPLICATIONS	9
4.3 ATTESTATION	10
4.4 OBLIGATION OF PRODUCING INFORMATION	10
4.5 CREDENTIALS PROCESS	10

4.5.1	DIVISION AND DEPARTMENT ACTION.....	12
4.5.2	CREDENTIALS COMMITTEE ACTION.....	12
4.5.3	MEDICAL EXECUTIVE COMMITTEE ACTION	13
4.5.4	ACTION ON THE APPLICATION	13
4.5.5	NOTICE OF FINAL DECISION	13
4.5.6	REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION	14
4.6	APPOINTMENT AUTHORITY	14
4.7	DURATION OF APPOINTMENT AND REAPPOINTMENT.....	14
4.8	REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES	14
4.9	LEAVE OF ABSENCE	14
ARTICLE 5:	CLINICAL PRIVILEGES	15
5.1	EXERCISE OF PRIVILEGES.....	15
5.2	DELINEATION OF PRIVILEGES	15
5.3	PRIVILEGING PROCESS	15
5.3.1	REQUEST FOR PRIVILEGES.....	15
5.3.2	BASIS FOR PRIVILEGES DETERMINATION.....	15
5.3.3	ALLIED ADVANCED PRACTICE PROFESSIONALS.....	15
5.4	PROCTORING.....	16
5.5	TEMPORARY PRIVILEGES	16
5.5.1	CIRCUMSTANCES.....	16
5.5.2	EXERCISING TEMPORARY PRIVILEGES.....	16
5.5.3	TERMINATION	16
5.5.4	RIGHTS OF THE PRACTITIONER	16
5.5.5	EMERGENCY PRIVILEGES.....	17
5.5.6	DISASTER PRIVILEGES.....	17
ARTICLE 6:	CORRECTIVE ACTION	17
6.1	CORRECTIVE ACTION	17
6.1.1	COLLEGIAL INTERVENTION.....	17
6.1.2	CRITERIA FOR INITIATION.....	18
6.1.3	INITIATION OF INVESTIGATION.....	18
6.1.4	INVESTIGATION	18
6.1.5	MEDICAL EXECUTIVE COMMITTEE ACTION	20
6.1.6	SUBSEQUENT ACTION	21
6.1.7	BOARD OF DIRECTORS' ACTION	22
6.2	SUMMARY RESTRICTION OR SUSPENSION	23
6.2.1	CRITERIA FOR INITIATION.....	23
6.2.2	WRITTEN NOTICE OF SUMMARY SUSPENSION OR RESTRICTION	23
6.2.3	ACTION	24
6.2.4	PROCEDURAL RIGHTS.....	25
6.3	AUTOMATIC ADMINISTRATIVE REVOCATION, SUSPENSION, OR LIMITATION	26
6.3.1	LICENSURE	26
6.3.2	CONTROLLED SUBSTANCES	27
6.3.3	MEDICAL RECORDS.....	27
6.3.4	FAILURE TO PAY DUES/ASSESSMENTS.....	27

6.3.5	FAILURE TO MEET QUALIFICATIONS OF MEMBERSHIP CATEGORY	27
6.3.6	EXCLUSION FROM MEDICARE/MEDICAID	27
6.3.7	PROFESSIONAL LIABILITY INSURANCE.....	28
6.3.8	DUTY TO NOTIFY OF PENDING CLAIMS, LAWSUITS, OR INVESTIGATIONS	28
ARTICLE 7:	HEARINGS AND APPELLATE REVIEW	28
7.1	GENERAL PROVISIONS	28
7.1.1	RIGHT TO ONE HEARING	28
7.1.2	EXHAUSTION OF REMEDIES	28
7.1.3	TIMELY COMPLETION OF PROCESS	28
7.1.4	FINAL ACTION	28
7.2	GROUND FOR HEARING	28
7.3	REQUEST FOR HEARING	29
7.3.1	NOTICE OF ACTION OR PROPOSED ACTION	29
7.3.2	REQUEST FOR HEARING	30
7.3.3	TIME AND PLACE FOR HEARING	30
7.3.4	NOTICE OF HEARING	30
7.3.5	HEARING COMMITTEE	31
7.3.6	POSTPONEMENTS, EXTENSIONS AND AMENDMENTS.....	31
7.3.7	FAILURE TO APPEAR OR PROCEED	31
7.4	HEARING PROCEDURE	32
7.4.1	PREHEARING PROCEDURE.....	32
7.4.2	REPRESENTATION.....	34
7.4.3	CHAIR OF THE HEARING COMMITTEE.....	34
7.4.4	GENERAL PROCEDURAL RULES.....	34
7.4.5	RECORD OF THE HEARING.....	35
7.4.6	RIGHTS OF THE PARTIES.....	35
7.4.7	BURDEN OF PRESENTING EVIDENCE AND PROOF	35
7.4.8	ADJOURNMENT AND CONCLUSION	35
7.4.9	BASIS FOR DECISION.....	35
7.4.10	DECISION OF THE HEARING COMMITTEE	36
7.4.11	DECISION OF THE MEDICAL EXECUTIVE COMMITTEE OR BOARD OF DIRECTORS.....	36
7.4.12	NOTICE OF RIGHT TO APPEAL	37
7.5	APPEAL.....	38
7.5.1	TIME FOR APPEAL.....	38
7.5.2	GROUND FOR APPEAL	38
7.5.3	DATE, PLACE, AND NOTICE.....	38
7.5.4	THE BOARD OF DIRECTORS	38
7.5.5	APPEAL PROCEDURE	39
7.6	CONFIDENTIALITY	40
ARTICLE 8:	OFFICERS	40
8.1	OFFICERS OF THE MEDICAL STAFF	40
8.1.1	IDENTIFICATION	40
8.1.2	QUALIFICATIONS	40
8.1.3	NOMINATIONS	40
8.1.4	ELECTIONS	41

8.1.5	TERM OF ELECTED OFFICE.....	41
8.1.6	REMOVAL OF OFFICERS AND MEC MEMBERS	41
8.1.7	VACANCIES IN ELECTED OFFICE.....	41
8.2	DUTIES OF OFFICERS	41
8.2.1	CHIEF OF STAFF	41
8.2.2	CHIEF ELECT	42
8.2.3	SECRETARY	42
8.2.4	TREASURER.....	43
8.2.5	HOSPITAL REPRESENTATIVE	43
ARTICLE 9:	MEDICAL STAFF HOSPITALS, DEPARTMENTS, AND CLINICAL	
DIVISIONS	43	
9.1	ORGANIZATION OF MEDICAL STAFF HOSPITALS	43
9.1.1	QUALIFICATIONS OF THE HOSPITAL REPRESENTATIVE	44
9.1.2	SELECTION	44
9.1.3	TERM OF OFFICE.....	44
9.1.4	REMOVAL	44
9.1.5	DUTIES	44
9.2	ORGANIZATION OF MEDICAL STAFF DEPARTMENTS.....	45
9.3	CURRENT DEPARTMENTS AND CLINICAL DIVISIONS	45
9.4	ASSIGNMENT TO DEPARTMENTS	46
9.5	FUNCTIONS OF DEPARTMENTS	46
9.6	FUNCTIONS OF CLINICAL DIVISIONS	47
9.7	DEPARTMENT CHIEFS.....	47
9.7.1	QUALIFICATIONS	47
9.7.2	SELECTION	48
9.7.3	TERM OF OFFICE.....	48
9.7.4	REMOVAL	48
9.7.5	DUTIES.....	48
9.8	DIVISION CHAIRS	49
9.8.1	QUALIFICATIONS	49
9.8.2	SELECTION	49
9.8.3	TERM OF OFFICE.....	49
9.8.4	REMOVAL	49
9.8.5	DUTIES	50
ARTICLE 10:	COMMITTEES.....	50
10.1	DESIGNATION	50
10.2	GENERAL PROVISIONS	50
10.3	MEDICAL EXECUTIVE COMMITTEE (MEC).....	51
10.3.1	COMPOSITION	51
10.3.2	VOTING.....	51
10.3.3	DUTIES	51
10.3.4	MEETINGS.....	52
10.4	CREDENTIALS COMMITTEE.....	52
10.5	QUALITY COMMITTEE	52

ARTICLE 11: MEETINGS	52
11.1 MEETINGS	52
11.1.1 GENERAL STAFF AND ANNUAL MEETING.....	52
11.1.2 AGENDA.....	53
11.1.3 SPECIAL MEETINGS.....	53
11.1.4 VOTING.....	53
11.2 COMMITTEE AND DEPARTMENT/DIVISION MEETINGS	53
11.2.1 REGULAR MEETINGS	53
11.2.2 SPECIAL MEETINGS.....	53
11.3 QUORUM/VOTING.....	54
11.4 MINUTES	54
11.5 CONDUCT OF MEETINGS	54
11.6 EXECUTIVE SESSION	54
ARTICLE 12: CONFIDENTIALITY, IMMUNITY, AND RELEASES.....	54
12.1 AUTHORIZATION AND CONDITIONS	54
12.2 CONFIDENTIALITY OF INFORMATION	54
12.2.1 GENERAL.....	54
12.2.2 BREACH OF CONFIDENTIALITY	55
12.3 IMMUNITY FROM LIABILITY	55
12.3.1 FOR ACTION TAKEN.....	55
12.3.2 FOR PROVIDING INFORMATION.....	55
12.4 ACTIVITIES AND INFORMATION COVERED.....	55
12.4.1 ACTIVITIES	55
12.5 RELEASES.....	56
12.6 CUMULATIVE EFFECT	56
12.7 SPECIAL LITIGATION COVENANT	56
12.8 SPECIAL ISSUES OF CONFIDENTIALITY.....	56
ARTICLE 13: GENERAL PROVISIONS	56
13.1 ADMISSION	56
13.2 HISTORY AND PHYSICAL.....	56
13.3 CONSENT FOR MEDICAL AND SURGICAL PROCEDURES	56
13.4 DUES OR ASSESSMENTS.....	57
13.5 CONSTRUCTION OF TERMS AND HEADINGS	57
13.6 DISCLOSURE OF INTEREST	57
13.7 CONFLICT MANAGEMENT	57
13.7.1 BETWEEN MEDICAL STAFF AND MEDICAL EXECUTIVE COMMITTEE	57
13.7.2 BETWEEN LEADERSHIP GROUPS	57
ARTICLE 14: ADOPTION AND AMENDMENT OF BYLAWS	57
14.1 ACTION.....	58
14.2 APPROVAL.....	58
14.3 EFFECT OF THESE BYLAWS.....	58
14.4 DISUNIFICATION FROM THE UNIFIED MEDICAL STAFF	59
14.5 EFFECT OF DISUNIFICATION ON THESE BYLAWS	59

14.6 AMENDMENTS IN URGENT OR EMERGENT CONDITIONS	59
ARTICLE 15: MEDICAL STAFF ROLE IN CLINICAL CONTRACTING	59
ARTICLE 16: ADOPTION AND AMENDMENT OF POLICY AND PROCEDURES OR ORGANIZATIONAL PROTOCOLS AND ADDITIONAL ISSUES	59
16.1 PROCEDURE.....	60

**MEDICAL STAFF BYLAWS, RULES AND REGULATIONS
HAWAII HEALTH SERVICES CORPORATION EAST HAWAII REGION
PREAMBLE**

Hilo Medical Center, Hale Ho'ola Hamakua, and Kau Hospital with their affiliated clinical facilities and outpatient clinics comprise the East Hawaii Region (referred to herein as "the Region") of Hawaii Health Systems Corporation ("HHSC") under the governance of the Board of Directors of the East Hawaii Region of Hawaii Health Systems Corporation. In recognition of this common governance and shared mission, the Medical Staff of the Region shall have a single organization responsible for the governance of professional services within the health care facilities of the Region. This Medical Staff organization has the authority and responsibility to ensure the quality of the professional services provided by privileged providers including credentialing and privileging of providers, directing the structure and quality of clinical services, and providing quality improvement, conflict resolution, and self-regulation.

These Bylaws are adopted to define the organization of the Medical Staff of the Region and to provide a framework for self-governance through which the Medical Staff can fulfill its responsibilities to meet high standards for ethical patient care and medical excellence.

These Bylaws, as well as the Policies and Procedures for each facility, provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Governing Body, and relations with applicants to and members of the Medical Staff.

DEFINITIONS

1. ADMINISTRATOR means the person appointed by the Governing Body to serve in an administrative capacity of the medical facility or his/her designee.
2. ADVANCED PRACTICE PROFESSIONAL ("APP") means a licensed health care provider other than a physician, dentist, or podiatrist. Please refer to "Health Care Provider" for further clarification.
3. ALLIED ADVANCE PRACTICE PROFESSIONALS ("Allied APP") means a licensed health care provider who must, under state statute, practice under the supervision of another licensed provider.
4. ATTENDING PRACTITIONER means the privileged practitioner providing direct care to the patient.
5. BOARD OF DIRECTORS means the Board of Directors for East Hawaii Region of HHSC.
6. CALENDAR YEAR means the period from January 1 to December 31.
7. CHIEF EXECUTIVE OFFICER ("CEO") means the Chief Administrator for the Region.
8. CHIEF OF STAFF ("COS") means the Chief Officer of the Medical Staff elected by members of the Medical Staff in accordance to these Bylaws.
9. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to licensed practitioners to provide patient care and includes access to those medical center resources, including equipment, facilities, medications, and medical center personnel, which are necessary to effectively exercise those privileges.
10. COMMITTEE means a group of persons elected or appointed to perform some service or function or to act upon a particular matter of the Medical Staff.
11. DENTIST means an individual with a D.D.S. or D.M.D. degree who is licensed to practice dentistry in the State of Hawaii.
12. DEPARTMENT CHIEF shall be a member of the active Medical Staff and will be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the department.
13. DIVISION CHAIR shall be a member of the active Medical Staff and will be qualified by training, experience, and demonstrated ability in the clinical areas covered by the division.

14. EAST HAWAII REGION means the hospitals, facilities, and outpatient clinics of the East Hawaii Region of the HHSC. This shall be referred to as “the Region” within this document.
15. FOCUSED PROFESSIONAL PRACTICE EVALUATION (“FPPE”) means the time-limited evaluation of a Member’s or APP’s competence in performing specific clinical privilege(s) or clinical duties and professional behavior.
16. GOVERNING BODY means the Regional System Board of Directors for East Hawaii Region. This term is synonymous with BOARD OF DIRECTORS above.
17. HALE HO’OLA HAMAKUA (“HHH”) means the Critical Access Hospital and associated facilities located in Honoka’a, Hawaii.
18. HEALTH CARE PROVIDER means a doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or a clinical social worker who is authorized to practice by the State and performing within the scope of their practice as defined by state law.
19. HOSPITAL REPRESENTATIVE means a member of the active staff at Ka’u Hospital or HHH that is elected to serve as a voting member of the Medical Executive Committee.
20. HILO MEDICAL CENTER (“HMC”) means Hilo Hospital and its facilities and clinics.
21. INDEPENDENT ADVANCED PRACTICE PROFESSIONALS means APPs who under state law may practice medicine independently within their scope of practice.
22. KA’U HOSPITAL means the Critical Access Hospital located in Pahala, Hawaii, and its affiliated clinics throughout the Region.
23. MEDICAL DIRECTOR is the official appointed by the Administrator of Regional CEO to oversee Medical Staff affairs for one of the hospitals of the Region.
24. MEDICAL EXECUTIVE COMMITTEE (“MEC”) means the executive committee of the Medical Staff, which constitutes the governing organization of the Medical Staff as described in these Bylaws.
25. MEDICAL STAFF OR STAFF means the formal organization of all duly licensed practitioners of the Region who have been granted privileges as members of the Medical Staff pursuant to the terms of these Bylaws.
26. MEMBER means, unless otherwise expressly limited, any physician (M.D. or D.O.), dentist, podiatrist, or health care professional holding a current license to practice within the scope of his or her license who is a member of the Medical Staff.
27. ORGANIZED HEALTH CARE ARRANGEMENT (“OHCA”) means an organized health care arrangement as defined under HIPAA regulations which allows an affiliated group of providers who care for a common set of patients increased latitude in sharing protected health information with less regulatory constraint.
28. PATIENT means any person presented to any facility of the Region for medical treatment.
29. PEER REVIEW means the process by which the clinical activity of practitioners at the Medical Center is evaluated by other practitioners at the Medical Center.
30. PHYSICIAN means an individual with a M.D. or D.O. degree who is currently licensed to practice medicine in the state of Hawaii.
31. PODIATRIST means an individual with a D.P.M. degree who is currently licensed to practice medicine in the state of Hawaii.
32. PRACTITIONER means any physician, dentist, podiatrist, or APP who has met the qualifications for and has been granted Medical Staff appointment and/or clinical privileges at the Medical Center.
33. REGION means the East Hawaii Region of the HHSC.
34. SURROGATE/DECISION MAKER means a family member or other person who is responsible to make decisions for a patient who is unable to make his/her own decisions.
35. TJC means the Joint Commission for Accreditation of Hospitals.

ARTICLE 1: NAME AND PURPOSE

The name of this organization is the **Unified Medical Staff of the East Hawaii Region**.

The purpose of the Unified Medical Staff is to create an organized Medical Staff that participates in policy and planning for the hospitals within the Region in order to:

1. Support and perpetuate the shared mission of all facilities within the Region;
2. Support the individual facility-specific mission for each entity within the Region;
3. Assure that patients receive high-quality, safe care from all privileged healthcare practitioners;
4. Conduct ongoing quality improvement activities and peer review;
5. Provide health education and support activities for the public;
6. Support and provide continuing medical education for the Medical Staff; and
7. Provide effective self-governance within a defined, fair, and accountable process.

ARTICLE 2: MEMBERSHIP

2.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff is extended solely to professionally competent practitioners who meet and maintain the qualifications, standards, and requirements in these Medical Staff Bylaws.

Appointment to and membership on the Medical Staff confers on the member only such clinical privileges and prerogatives as granted by the Medical Staff and approved by the Governing Body in accordance with these Bylaws. No practitioner will admit, provide services to, or discharge patients from the Medical Center unless the practitioner is a member of the Medical Staff and has been granted these privileges in accordance with the procedures in these Bylaws.

Resident physicians are not credentialed or privileged by the Medical Staff and are not members of the Medical Staff. They may not practice without supervision as specified in Medical Staff policies nor are they entitled to any of the privileges, processes, or remedies afforded within these Bylaws.

APPs are credentialed and privileged by the Medical Staff. Privileges and supervision for APPs are governed by the State of Hawaii and the policies and procedures of the facility in which they practice. APPs who may practice independently under state law ("Independent APPs") are members of the Medical Staff and are voting members of their respective hospitals, clinical divisions, and departments. Allied APPs, who cannot practice independently under state law, are members of the Medical Staff but are not voting members of their respective hospitals, clinical divisions, and departments.

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2.1 GENERAL QUALIFICATIONS

Practitioners who qualify for Medical Staff membership are physicians, dentists, podiatrists, and APPs who:

1. Document and maintain:

- a. current licensure, certification, registration, or recognition by a licensing board or agency of the state of Hawaii or certification by a professional organization where authorized by law;
 - b. adequate experience, education, and training, which includes, at a minimum, successful completion of accredited osteopathic, medical, dental, podiatry, or nursing school and such residency or post-graduate training programs as appropriate to the practitioner's specialty;
 - c. current professional competence; and
 - d. physical and mental health sufficient to their clinical practice.
2. Are committed to:
 - a. adhere to the Code of Ethical Conduct of the Licensing Board of the State of Hawaii and the Region Code of Conduct;
 - b. work cooperatively with other practitioners and hospital staff in the provision of patient care;
 - c. keep as confidential, as required by law, all information or records received in the physician-patient relationship; and
 - d. participate in and properly discharge those responsibilities determined by the Medical Staff under these Bylaws.
 3. Have not been excluded from participation with Medicare/Medicaid;
 4. Maintain continuous professional liability insurance with coverage not less than the minimum amounts as determined by the Governing Body; and
 5. Are determined by the Medical Staff and Governing Body, following processes in these Bylaws, to possess qualifications for membership to the Medical Staff.

2.3 EFFECT OF OTHER AFFILIATIONS

Membership to the Medical Staff is only granted through the procedures defined in these Bylaws and Medical Staff Policies and Procedures. Membership to the Medical Staff shall not be granted summarily because a practitioner holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at another health care facility. Medical Staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in contracts with a third party which contracts with any facility in the Region.

2.4 NONDISCRIMINATION

Medical Staff membership and clinical privileges shall not be denied or abridged based on gender, sexual orientation, race, creed, or national origin. Medical Staff membership and clinical privileges shall not be denied or abridged due to physical or mental disability that does not compromise the quality of patient care. Reasonable accommodation, as determined by the Medical Staff, shall be made for providers with disabilities when appropriate.

2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

The responsibilities of each member of the Medical Staff include:

1. providing patients with the quality of care that meets the professional standards of the Medical Staff of the Region;
2. abiding by the Medical Staff Bylaws, Rules and Regulations, and Medical Staff policies;
3. discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership, including committee assignments;
4. preparing and completing medical records for all patients to whom the member provides care in the Region within time requirements established in Medical Staff policy;
5. abiding by the ethical principles adopted by the Medical Staff;
6. participating in any Medical Staff approved educational programs for medical students, interns, resident physicians, resident dentists, staff physicians and dentists, nurses, and other personnel;
7. working cooperatively with members of the Medical Staff and the various hospitals' staff to provide high-quality care;
8. making appropriate arrangements for coverage of patients as determined by Medical Staff policy;
9. participating in emergency service coverage or consultation panels as may be required by Medical Staff policy;
10. discharging other staff obligations as determined by Medical Staff policy or the Medical Executive Committee;
11. attending all meetings scheduled as required in Article 6 of these Bylaws at which the member's clinical practice or conduct will be reviewed and discussed. Failure of a member to appear at such meeting(s) to which the Medical Staff member was given proper notice, unless excused by the MEC upon a showing of good cause, will be a basis for corrective action;
12. participating in the OHCA for the Region, as defined in the HIPAA Privacy Rule at 45 CFR 164.501, and agreeing to abide by the terms of the joint notice of privacy practices with respect to protected health information created or received as part of participating in the organized health care arrangement; and
13. providing proctoring for new physicians or physicians requesting new privileges as requested by the Chair of their Clinical division, in keeping with Regional Medical Staff policy on proctoring, unless excused by the MEC for documented conflict of interest.

ARTICLE 3: MEDICAL STAFF CATEGORIES

3.1 CATEGORIES

The categories of the Medical Staff shall include the following: active, affiliate, consulting, telemedicine, associated APP, and honorary.

3.2 ACTIVE STAFF

3.2.1 REQUIREMENTS

The active Medical Staff shall consist of those physicians, dentists, podiatrists, and APPs who:

1. meet the general qualifications for membership;
2. use a facility of the Region as their primary source of inpatient care, emergency department care, or long-term care;

3. have offices or residences which, in the opinion of the MEC, are located close enough to the inpatient or residential facility to provide appropriate continuity of high-quality, safe care;
4. attend, admit, or are involved in the treatment, including history and physical examinations, of an adequate number of patients per year to demonstrate clinical competence; and
5. participate in Medical Staff activities and governance according to these Bylaws and Medical Staff policies.

3.2.2 PREROGATIVES

Except as otherwise provided, the prerogatives of an active Staff Member will be to:

1. exercise such clinical privileges as are granted;
2. attend meetings of the Medical Staff and the department to which the member is assigned, including open committees and educational programs. The active Staff Member shall have voting rights in the members division, department, hospital, and general Medical Staff meetings; and
3. hold staff or department office and serve as a voting member of committees to which the active Staff Member is appointed or elected by the Medical Staff or the MEC.

3.2.3 FAILURE TO MEET MINIMUM REQUIREMENTS

If a member of the active staff fails to meet the requirements specific to active staff membership, or if, after two (2) consecutive years, a member of the active staff fails to attend, admit, or be involved in the treatment of an adequate number of patients per year as determined by departmental requirements, that individual's active membership will be administratively modified, limited, or terminated upon recommendation of the MEC and approval by the Governing Body.

3.3 AFFILIATE STAFF

3.3.1 REQUIREMENTS

The Affiliate Medical Staff shall consist of those physicians, dentists, podiatrists, and advanced practice professionals who desire to be affiliated with one or more hospitals and who have active practices within the Region. This affiliation is primarily intended for practitioners with practices that are exclusively or primarily office-based within the Region. Practitioners who are not primarily based in the Region may receive affiliate privileges but may be required to demonstrate appropriate coverage of patient care when they are physically absent.

3.3.2 RESPONSIBILITIES

Appointees to this category shall:

1. meet and maintain the general qualifications for membership; and
2. contribute to the organizational and administrative affairs of the clinical service to which they are appointed and contribute to the Medical Staff organization by fulfilling assignments and attending meetings as requested.

3.3.3 PREROGATIVES

The Affiliate Staff shall be entitled to:

1. attend meetings of the general staff, department or division with the right to vote after one year of membership, but may not hold Medical Staff office;
2. accept assignment to hospital and/or medical staff committees and vote as a committee member, and may be appointed as Chair or Vice Chair of certain committees as identified by the MEC;
3. use the facilities of the hospital to provide care for their patients with the privileges of admitting to short-stay unit and outpatient oncology, including pre-procedural history and physical examinations, and ordering all diagnostic tests and therapeutic interventions appropriate for the outpatient service as specified in Policies and Procedures;
4. make rounds on those acute patients cared for in the practitioner's private practice and have access to their medical records;
5. may request long-term care privileges to admit and care for their patient to the SNF/ICF status; and
6. may voluntarily accept post-acute patient referrals for outpatient care.

The Affiliate Staff shall not be entitled to:

1. admit patients to acute status in any hospital of the Region, or
2. write orders on patients admitted to any of the inpatient units.

Members of the Active Staff who request, and are granted, a change of category from Active to Affiliate will retain the right to vote at the time of the status change but shall only be entitled to the prerogatives specifically designated for Affiliate Staff above.

3.3.4 FAILURE TO MEET MINIMUM REQUIREMENTS

If a member of the Affiliate Staff fails to meet the requirements specific to Affiliate Staff membership, that individual's membership will be administratively modified, limited, or terminated upon recommendation of the MEC and approval by the Governing Body.

3.4 CONSULTING MEDICAL STAFF

3.4.1 REQUIREMENTS

The Consulting Medical Staff ("CMS") will consist of physicians, dentists, podiatrists, or advanced practice professionals who:

1. meet the general qualifications for Medical Staff membership;
2. are members in good standing of the active Medical Staff of another hospital accredited by an accrediting body recognized by CMS;
3. show adequate clinical activity at another facility to ensure current proficiency;
4. are credentialed and privileged in their specialty or sub-specialty by the EHR Centralized Credentials Committee; and

5. are willing to provide clinical care personally or through telemedicine at the designated hospital and ready to respond when called to render clinical services within their area of competence.

3.4.2 PREROGATIVES

Except as otherwise provided, the CMS member will be entitled to exercise such clinical privileges as are granted and attend meetings of the General Medical Staff, department or division. Admitting privileges will be determined by the Credentials Committee and on-call status determined by Medical Staff policy. He or she may vote in meetings of his or her division and department and general staff meetings after one year of membership but may not hold office.

3.4.3 FAILURE TO MEET MINIMUM QUALIFICATIONS

If a member of the consulting staff fails to meet the requirements specific to consulting staff membership, that individual's membership will be administratively modified, limited, or terminated upon recommendation of the MEC and approval by the Governing Body.

3.5 ALLIED ADVANCED PRACTICE PROFESSIONALS

3.5.1 QUALIFICATIONS

Allied APP are licensed health care professionals as recognized by the Professional and Vocational Licensing Division of the Hawaii State Department of Commerce and Consumer Affairs who are not permitted by statute to practice independently and who:

1. meet the general qualifications as outlined in Section 2.2.1, as applicable to their education, training, licensure, and practice; and
2. desire to provide professional service in the Region medical hospitals, facilities, and/or clinics.

3.5.2 PREROGATIVES

Except as otherwise provided, Allied APPs are entitled to:

1. provide care for patients in the hospital, long-term care facilities, and clinics within clearly defined delineation of privileges under the supervision of a member of the Medical Staff. Such privileges shall be stated on initial application and approved by the Governing Body and shall be subject to the rules and regulations of the division to which the practitioner is assigned, and to the authority of the Division Chair or Chief of Staff, and
2. attend meetings of the Medical Staff and the division to which the practitioner is assigned, including open committees and educational programs, but shall have no right to vote at such meetings except within committees when the right to vote is specified at the time of appointment.

3.5.3 FAILURE TO MEET MINIMUM REQUIREMENTS

If a member of the Allied Advanced Practice Professional staff fails to meet the requirements specific to Allied APP staff membership, that individual's membership will be administratively modified, limited, or terminated upon recommendation of the MEC and approval by the Governing Body.

3.6 HONORARY STAFF

3.6.1 REQUIREMENTS

The Honorary Medical Staff members will consist of medical, dental, podiatry, or advanced practice professionals who were members of the Medical Staff but have resigned from the Medical Staff and who have:

1. provided exemplary service at one or more facility of the Region,
2. an outstanding reputation, and
3. the recommendation of a member of the Medical Staff and approval by a majority vote of the Medical Staff or MEC and approval by the Governing Body.

3.6.2 PREROGATIVES

The Honorary Medical Staff members are entitled to:

1. attend any Medical Staff meetings without voting rights, and
2. serve on committees and projects by appointment of the Chief of Staff or MEC.

3.6.3 DURATION OF APPOINTMENT

Appointment to the Honorary Medical Staff is for the lifetime of the practitioner.

ARTICLE 4: APPOINTMENT AND REAPPOINTMENT

4.1 GENERAL

No person will exercise clinical privileges in any facility of the Region until that person receives approval of privileges from the Credentials Committee and appointment to the Medical Staff from the Governing Body or is granted temporary privileges through processes established in these Bylaws and Policies and Procedures.

4.2 TIMELY PROCESSING OF APPLICATIONS

Applications for staff appointments will be considered in a timely manner by the Medical Staff Services Department, the department to which the applicant will be assigned, the Credentials Committee, and the Medical Executive Committee. While special or unusual circumstances may constitute good cause and warrant exceptions, applications will be acted upon at the first Credentials Committee after they are complete, the first Medical Executive Committee meeting following Credentials Committee recommendations, and the first meeting of the Governing Body following MEC recommendations. This

process for clean and complete applications should take no longer than ten weeks. Applications that require further information and deliberation may take substantially longer depending on the circumstances.

There is no expedited process for appointment and reappointment to the Medical Staff. All applications for appointment and reappointment require approval by the Governing Body of the Region.

4.3 ATTESTATION

All members and applicants of the Medical Staff agree to the authority of these Bylaws and Medical Staff policies and procedures to determine the governance of the Medical Staff. This authority shall include all properly adopted amendments or additions. The Bylaws and Policies are binding whether or not the Medical Staff member has direct knowledge of specific regulations. Members of the Medical Staff are encouraged to familiarize themselves with the Bylaws and Policies. Bylaws and Policies are published and easily accessible.

4.4 OBLIGATION OF PRODUCING INFORMATION

Applicants will have the obligation of producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, resolving any reasonable doubts about these matters, and satisfying requests for information.

This obligation may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate by the MEC. The applicant's failure to fulfill this obligation will cause the application to be considered incomplete and the file closed pursuant to Medical Staff policy.

4.5 CREDENTIALS PROCESS

1. The following information must be submitted on an approved initial or reappointment application form:
 - a. The applicant's qualifications, professional training and experience, current Hawaii licensure, current Drug Enforcement Administration (DEA) registration, current Hawaii Narcotic Enforcement Division registration, Board Certification, and continuing medical education information related to the clinical privileges to be exercised by the applicant;
 - b. Peer references familiar with the applicant's professional competence and ethical character;
 - c. Documented evidence of current competence in the form of procedure logs from residency programs or recent hospital/surgical center affiliations and performance profiles;
 - d. Past or pending professional disciplinary action including licensure and registration limitations or relinquishment;
 - e. Professional liability claims history and experience (lawsuits, claims, and settlements) regardless of outcome whether it be a past, pending, or potential claim during the last seven years, including a consent for release of information by his/her present or past liability insurance carrier(s);
 - f. Professional liability coverage as required under 2.2(4) of these Bylaws;

- g. Documentation of applicant's mental and physical ability to practice within their privileges or scope of practice requested;
 - h. Requests for membership categories, departments and/or clinical privileges;
 - i. Absence of current drug or alcohol dependency;
 - j. PPD testing results, or if a positive reaction, the completion of a chest x-ray;
 - k. Board certification status;
 - l. No conviction of a felony;
 - m. A written plan for office location and for using the hospital, when applicable; and
 - n. A supervisory agreement for Allied Advanced Practice Professionals.
2. The Credentials Committee and the Medical Executive Committee have the authority to request further documentation regarding the current physical and mental health of the applicant as it applies to the performance requirements of the applicant. These assessments include requirements for late career practitioners, immunization documentation, and tuberculosis screening as specified in relevant Medical Staff policy.
 3. The applicant has the responsibility to provide adequate information for a proper evaluation of his or her experience, training, current competency, and health status. The applicant has the responsibility to resolve any doubts about these, or any of the qualifications required for staff membership, department assignment, or clinical privileges. The applicant must satisfy any reasonable requests for information or clarifications, including health examination, made by the appropriate Medical Staff or Governing Body authorities. An application is considered incomplete and will not be processed until all requests for information have been resolved.
 4. Upon receipt of the application, the Medical Staff Services Department will review the information submitted, noting any deficiencies. The following steps will be followed in processing an application for Medical Staff membership and clinical privileges:
 - a. Enter the information in the Medical Staff Services Credentials database after verifying the practitioner's identity;
 - b. Verify all licenses, active and inactive, utilizing primary sources if applicable;
 - c. Verify liability insurance via current and former insurance companies including a request for past claims history information for a minimum of seven (7) years;
 - d. Verify board certification status as applicable;
 - e. Verify completion of education and training programs via approved primary sources if possible and applicable;
 - f. Verify all current and past hospital affiliations/surgical centers for the past seven (7) years;
 - g. Elicit responses from the professional references;
 - h. Query the National Practitioner's Data Bank; and
 - i. Query the Office of the Inspector General and Excluded Parties List for sanction information.

The Medical Staff Services Department shall make the first attempt to obtain the verification as required. If, after two weeks, the first attempt remains unanswered, Medical Staff Services will attempt a second request of the outstanding verifications. If the second attempt remains unanswered at the end of the subsequent two weeks, Medical Staff Services will attempt a third

and final request for the outstanding verification. The applicant will be notified that assistance is needed in obtaining the required information at the time of the third and final request. Medical Staff Services will inform the applicant that if no response has been received within one (1) additional week, Medical Staff Services will take no further action and that the applicant is then solely responsible for obtaining the outstanding verifications. Upon obtaining the aforementioned items, the file will be forwarded for action by the appropriate clinical division and department. The application will be considered incomplete and returned to the applicant if the required information has not been obtained within six (6) months of initial application.

4.5.1 DIVISION AND DEPARTMENT ACTION

Upon receipt of the application, the Division Chair, or designee, will review the application and supporting documentation and may conduct a personal interview. The Chair may seek additional information if he or she feels inadequate information is available to make a thorough evaluation. The Chair, or designee, shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges requested, and shall transmit to the Department Chief a written report regarding the adequacy of the applicant's qualifications. This report should include:

1. privileges requested by the practitioner,
2. qualification for requested privileges,
3. recommendation for or against appointment,
4. membership category,
5. primary hospital affiliation,
6. department affiliation,
7. division affiliation,
8. clinical privileges to be granted, and
9. any special conditions of appointment.

4.5.2 CREDENTIALS COMMITTEE ACTION

The Credentials Committee shall review the application and evaluate and verify the supporting documentation, the Division Chair and Department Chief report and recommendations, and other relevant information. The Credentials Committee may elect to interview the applicant and seek additional information. As soon as practicable, the Credentials Committee shall transmit to the Medical Executive Committee a written report and its recommendations as to appointment or reappointment. This report should include:

1. recommended action on appointment or reappointment,
2. membership category,
3. primary hospital affiliation,
4. department affiliation,
5. division affiliation,
6. clinical privileges to be granted, and
7. special conditions to be attached to the appointment.

4.5.3 MEDICAL EXECUTIVE COMMITTEE ACTION

The Credentials Committee will submit its report and recommendations to the executive session of the next regularly scheduled meeting of the Medical Executive Committee. Upon receipt, MEC shall consider the report and all other relevant information. The MEC may, at its discretion, request additional information on the applicant, return the application to the Credentials Committee for further investigation, and/or elect to interview an applicant. The Medical Executive Committee will submit a written report of all final determinations on appointment to the Regional CEO for prompt transmittal to the Governing Body. A copy of the recommendations will also be sent to the Hospital Administrators for Ka'u and HHH, as appropriate. This report should include:

1. recommended action on appointment or reappointment,
2. membership category,
3. primary hospital affiliation,
4. department affiliation,
5. division affiliation,
6. clinical privileges to be granted, and
7. special conditions to be attached to the appointment.

4.5.4 ACTION ON THE APPLICATION

The Governing Body shall consider the report and any other relevant information at the next regular meeting after receipt of the medical executive committee report and recommendation or as soon thereafter as practical. The Governing Body may accept the recommendation of the medical executive committee or may refer the matter back to the medical executive committee for further consideration, stating the purpose for such referral and setting a reasonable time limit for making a subsequent recommendation. Upon receipt of a subsequent recommendation, the Governing Body may take final action by accepting, rejecting, or modifying the terms of the appointment. If the action is adverse for an applicant who is already a member of the Medical Staff, he or she is entitled to due process under Section 7.2 of these Bylaws. New applicants who have received an adverse decision are entitled to a fair hearing as defined in Medical Staff policy.

4.5.5 NOTICE OF FINAL DECISION

Notice of the final decision will be distributed to the Chief of Staff, the medical executive and the credentials committees, the Chief of the department concerned, and the applicant via written letter from the Chief Executive Office within seven (7) days of notification of Governing Body decision and prior to the expiration of an appointment period, if applicable. The notice to appoint or reappoint shall include:

1. recommended action on appointment or reappointment,
2. membership category,
3. primary hospital affiliation,
4. department affiliation,
5. division affiliation,
6. clinical privileges to be granted, and

7. special conditions to be attached to the appointment.

Notice of final approved clinical privileges shall be posted to the hospital's intranet via scanned approved documents in PDF format with privilege expiration dates clearly visible.

In the event of a decision adverse for the applicant, a written notice will be sent to the applicant via certified mail from the CEO. Existing Medical Staff members receiving an adverse decision will be provided information regarding rights to fair hearing and appeal as specified in these Bylaws. New applicants who receive an adverse decision are entitled to a fair hearing as defined in Medical Staff policy.

4.5.6 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of two (2) years. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the applicant now meets all requirements for Medical Staff membership and that the basis for the earlier adverse action no longer exists.

4.6 APPOINTMENT AUTHORITY

Initial appointments, including provisional and conditional appointments, reappointments, denials, and revocations of appointments to the Medical Staff will be made by the Governing Body of the Region. Medical Staff privileges will be granted, continued, modified, or terminated by the Governing Body of the Region. Temporary privileges are provided as per these Medical Staff Bylaws, Section 5.5.

4.7 DURATION OF APPOINTMENT AND REAPPOINTMENT

Appointments and reappointments will be for a period of up to two (2) years unless a shorter appointment is recommended by the MEC and approved by the Governing Body. Initial appointments are granted on a provisional status for a period of up to twelve (12) months. The Governing Body may extend provisional status at their discretion for a period not to exceed an additional twelve months. The provisional period is completed once the member completes his or her initial FPPE and has met departmental standards. For practitioners in consulting categories, reports from other TJC credentialed facilities are acceptable validation of performance at the discretion of the applicable division, department, the Credentials Committee, and the MEC on a case-by-case basis.

4.8 REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

Request for modification of staff status, category, or privileges will be as defined in Medical Staff policy.

4.9 LEAVE OF ABSENCE

Leave of absence will be governed by Medical Staff policy.

ARTICLE 5: CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

Clinical privileges must be appropriate to the practice location within the Region and are only granted through the demonstration of current clinical competence. Members of the Medical Staff will be entitled to exercise only those privileges specifically granted by the Governing Body.

5.2 DELINEATION OF PRIVILEGES

Delineation of privileges will be defined by Medical Staff policy.

5.3 PRIVILEGING PROCESS

Clinical privileges will be requested and granted through the process delineated below.

5.3.1 REQUEST FOR PRIVILEGES

Every application for staff appointment and reappointment must contain a request for the specific clinical privileges desired by the applicant. Applications for modification or addition of clinical privileges may be submitted to the Credentials Committee in writing at any time following Medical Staff Policy. The application shall specify the specific clinical privileges desired and the applicant's relevant recent training and/or experience. The applicant shall have the burden of establishing the qualifications and current competency in the requested clinical privileges.

5.3.2 BASIS FOR PRIVILEGES DETERMINATION.

Clinical privileges will only be granted for care and procedures that can be safely conducted and supported at the facility for which they have been requested. The evaluation of requests for clinical privileges shall be based upon the applicant's education, license, training, experience, health status, judgment, demonstrated current competence, references, and other relevant information. Redetermination of clinical privileges and the increase or curtailment of same shall be based upon multiple determinants of competence including direct observation of care provided, review of the patient records at this or other hospitals, review of the records of the Medical Staff, and of any committees thereof that document the evaluation of the member's participation in the delivery of medical care.

5.3.3 ALLIED ADVANCED PRACTICE PROFESSIONALS

The Allied APP shall practice within their license, scope of practice, and clinical privileges as approved by the Board of Directors and be responsible for the care of patients within the areas the practitioner's current competence. Privileges granted to an Allied APP, described per Medical Staff policy, shall be based on training, experience, demonstrated current competence and judgment, and the privileges of the supervising physician. The scope and extent of clinical care and procedures that each APP may perform shall be specifically delineated and granted in the same manner as all other clinical privileges.

5.4 PROCTORING

A period of FPPE will be implemented for all privileges granted on initial application and for all privileges subsequently added by request. The process of FPPE is specified in the relevant Medical Staff Services policy.

5.5 TEMPORARY PRIVILEGES

5.5.1 CIRCUMSTANCES

The CEO, or authorized designee, upon recommendation of the Chair of the Credentials Committee, the applicable Division Chair, applicable Department Chief, and the Chief of Staff, may grant temporary privileges in the following circumstances:

1. Pendency of Application for a new applicant: after receipt of a complete application for Medical Staff appointment, the MEC and Governing Body may grant a practitioner in the state of Hawaii with documented competence temporary privileges for a period not to exceed one hundred twenty (120) days while the application is awaiting review and approval.
2. Patient Care Need: Temporary privileges may be granted for the purpose of fulfilling an important patient care need as per Medical Staff policy.

5.5.2 EXERCISING TEMPORARY PRIVILEGES

A practitioner who has been granted temporary privileges is not concurrently granted membership in the Medical Staff. When exercising temporary privileges, the practitioner is restricted only to those privileges specifically granted and acts under the sponsorship and supervision of the Chair of the Clinical division to which the practitioner is assigned.

5.5.3 TERMINATION

Upon the discovery of any information or the occurrence of an event, which raises question about a practitioner's professional qualifications, ability, or competence to exercise the privileges granted, the CEO or designee, after consultation with the Chief of Staff and the appropriate Department Chair, may terminate the practitioner's temporary privileges. Where the life or well-being of a patient is determined to be endangered by continued treatment by the practitioner, the Chief of Staff, Division Chair, Department Chief or the CEO (or the designee of any of these four) may summarily terminate the practitioner's privileges. In the event of termination of temporary privileges, the appropriate Division Chair assigns any patients under the direct care of the practitioner to a Medical Staff member. The wishes of the patient, guardian, or responsible person may be considered in selecting a substitute practitioner. Unless the practitioner withdraws his application at the point of termination of temporary status, the application continues as described in Medical Staff policy.

5.5.4 RIGHTS OF THE PRACTITIONER

A practitioner granted temporary privileges is not a member of the Medical Staff and is not entitled to the procedural rights as provided in these Bylaws because the practitioner's request

for temporary status is refused or because all or any portion of his temporary status is terminated. The practitioner is entitled to a fair hearing, upon request, as defined in Medical Staff Policy.

5.5.5 EMERGENCY PRIVILEGES

An “emergency” is defined as a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger. In the case of an emergency, and for the duration of such emergency, any practitioner, to the degree permitted by his license and regardless of department affiliation, staff status, or clinical privileges, is permitted to do everything possible to save the life of a patient or to save a patient from serious harm. When the emergency situation no longer exists, and when the appropriate Medical Staff become available, care of the patient must be transferred to a practitioner privileged to provide the needed care.

5.5.6 DISASTER PRIVILEGES

A disaster is defined as any officially declared disaster, whether it is local, state or national, and when any hospital or facility of the Region is unable to meet immediate patient needs. In the event of a disaster, all licensed independent practitioners who do not possess clinical privileges in the Region and who request disaster privileges may receive temporary privileges for the duration of the disaster according to Medical Staff Policy and Procedure.

ARTICLE 6: CORRECTIVE ACTION

6.1 CORRECTIVE ACTION

6.1.1 COLLEGIAL INTERVENTION

These Bylaws encourage the use of progressive steps by Medical Staff leaders and hospital administration to address questions relating to an individual’s clinical practice and/or professional conduct, beginning with collegial intervention and educational efforts. Collegial intervention as a first step is encouraged, but is not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders. The goal of collegial intervention is to arrive at voluntary, responsive actions by the practitioner to resolve questions or concerns that have arisen.

Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, referral for physical or mental health assessment, and additional training or education. All collegial intervention efforts by Medical Staff leaders and hospital administration are part of the hospital’s protected quality assurance and professional and peer review activities.

Documentation of collegial intervention including the original documentation, practitioner’s response, and interventional efforts shall be included in a practitioner’s confidential file. The practitioner will have an opportunity to review his or her documentation and respond in writing. The response shall be maintained in that individual’s file along with the original documentation.

6.1.2 CRITERIA FOR INITIATION

A Division Chair, Department Chief, the Chief of Staff, the Medical Executive Committee, the Regional CEO, Hospital Administrator for Ka'u and HHH, or the Board of Directors may initiate a request for an investigation or action concerning any privileged practitioner of the Medical Staff when reliable information indicates that a practitioner has been convicted of a crime substantially related to the qualification, functions or duties of a privileged practitioner, or the practitioner may have exhibited acts, demeanor, or conduct or furnished professional care which is reasonably likely to be:

1. detrimental to patient safety;
2. detrimental or disruptive to the delivery of quality patient care within the hospital, including, but not limited to, acts or conduct which constitute and/or may be perceived as verbal or physical abuse or harassment;
3. contrary to recognized principles of ethics of the member's profession;
4. contrary to the Code of Conduct for the Region;
5. contrary to the Medical Staff Bylaws;
6. contrary to hospital or Medical Staff policy; or
7. below standards of care in the practitioner's profession.

6.1.3 INITIATION OF INVESTIGATION

A request for investigation or action by any of the aforementioned parties must be submitted to the MEC in writing and supported by reference to the specific activities or conduct in question. If the Medical Executive Committee initiates the request, such request shall be made by motion and reflected in the minutes of the executive session together with a record of the reasons for investigation. The Chief of Staff will notify the regional CEO promptly of all requests for investigation and shall keep the regional CEO informed of all action taken in conjunction with the subsequent investigation.

6.1.4 INVESTIGATION

A request for investigation may be presented and considered at a regular session of the Medical Executive Committee meeting. Requests for investigation not presented at a regular meeting of the MEC will be deemed to be received by the Medical Executive Committee at the first regular or special meeting of the Medical Executive Committee after the request is submitted. The request, and all additional information considered by the Medical Executive Committee, will be heard in executive session and will be protected confidential peer review records. The Medical Executive Committee shall review and discuss the request and may, at its discretion, consider gathering additional information, referring the matter back to the appropriate division or department for appropriate action, or to proceed on existing evidence. The Medical Executive Committee shall determine if the request will be managed by the MEC or should be referred to the practitioner's division for review as specified in the Medical Staff policy on FPPE. If discussion on the issue had already occurred at the division or department level, the Medical Executive Committee shall decide whether or not to initiate an investigation. If the Medical Executive Committee concludes that further information or consideration is appropriate, including, but not limited to, consideration of collegial action, before deciding whether or not to initiate an investigation, it may, by vote of a majority of the members present of the Medical

Executive Committee, defer the matter for up to thirty-one (31) days. The Medical Executive Committee may appoint one or more of its members to obtain additional information and to furnish such information to the Medical Executive Committee at its next regular or special meeting. The Medical Executive Committee shall decide whether or not to initiate an investigation within thirty-one (31) days of when the Medical Executive Committee receives the request.

The Medical Executive Committee may request the practitioner to take specific actions, or refrain from taking action, during the period when the Medical Executive Committee explores further information. The requested actions or inactions may include, but are not limited to, mental or physical examination and/or treatment, continuing education, refraining from performing specified procedures or privileges, and avoiding contact with specified individuals. The gathering of additional information to assist the Medical Executive Committee in deciding whether to initiate an investigation is not considered a formal investigation but is part of the FPPE Policy. The practitioner's actions or inaction during this exploratory period may be considered by the Medical Executive Committee in deciding whether or not to initiate an investigation and/or to recommend corrective action.

1. INVESTIGATION NOT WARRANTED

If the Medical Executive Committee concludes that an investigation is not warranted, it shall give a written report to the Regional CEO which includes the information received and considered by the Medical Executive Committee and which states its reasons for not conducting an investigation.

2. INVESTIGATION WARRANTED

If the Medical Executive Committee concludes an investigation is warranted, it shall direct that an investigation be undertaken.

- a. Within ten (10) calendar days of determining that an investigation should be initiated, the Medical Executive Committee shall appoint an investigator or an investigative committee. The investigator or the members of the investigative committee may be members of the Medical Staff or may be practitioners who are not members of the Medical Staff. The investigator or investigative committee shall proceed with the investigation in a prompt manner. If a committee is investigating, the Medical Executive Committee shall appoint one of its investigative committee members as Chairperson.
- b. The Medical Executive Committee will provide the investigator or investigative committee and the practitioner with copies of the request for investigation and supporting information. The practitioner under investigation shall be given written notification and an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The request and supporting documents may be redacted to avoid revealing the identity of persons who provided information based on a request that their identity be kept confidential.
- c. The Medical Staff practitioner under investigation shall be offered an opportunity to meet with the investigating committee or investigator before the investigation is completed. The

individual or body investigating the matter may also conduct interviews with other persons involved. Meetings with the practitioner or other witnesses shall not constitute a “hearing” as that term is used in Article 7, nor shall the procedural rules with respect to hearings or appeals apply.

- d. The investigator or investigative committee shall complete the investigation within thirty (30) days of being appointed. At the request of the practitioner, or in the discretion of the investigator or investigative committee, the investigation may be extended for no more than an additional thirty (30) days. Upon completion of the investigation, the investigator or investigative body shall promptly forward a written report of the investigation to the Medical Executive Committee. The report may include recommendations for appropriate corrective action.

3. FAILURE TO INVESTIGATE ADEQUATELY

If the Medical Executive Committee does not initiate and conduct a thorough or expeditious investigation, the Regional CEO may notify the Regional Board of Directors and, under their direction, appoint an ad hoc investigating committee. This ad hoc committee must be convened within fourteen (14) days of notification to the MEC and may be composed of either Medical Staff members or other practitioners. The ad hoc committee shall conduct its investigation in the manner described in 6.1.4(2)(b) above and, within sixty (60) days of being appointed, shall submit a written report to the Regional CEO, who shall then forward the report to the Medical Executive Committee for action in accordance with Section 6.1.4(2)(d). The Regional CEO will also provide a copy of the report to the Board of Directors.

4. WARRANTED ACTION

The Medical Executive Committee, the Division Chair, Department Chief, the Chief of Staff, the Regional CEO, and the Board of Directors shall retain authority, at all times and irrespective of status of the investigation, to take any action the circumstances and these Bylaws require, including, but not limited to, suspension or summary suspension.

The Medical Executive Committee or Regional Board of directors may terminate any investigation that a body has initiated if the body deems such termination appropriate. Summary terminations shall be with prejudice and no further action on that specific complaint. The body that terminates the investigation shall forward to the Regional CEO a report containing the reasons for the termination.

6.1.5 MEDICAL EXECUTIVE COMMITTEE ACTION

Within fourteen (14) calendar days after the conclusion and receipt of any necessary reports, the Medical Executive Committee shall determine, without limitation:

- (1) that the matter did not meet the criteria for initiation of corrective action. The Medical Executive Committee shall include this finding in the practitioner’s file;
- (2) that for a reasonable time, action shall be deferred under specified circumstances, including, but not limited to:

- (a) conditions requiring the practitioner to undertake an evaluation or assessment and authorize the Medical Executive Committee to receive the results of said evaluation or assessment;
 - (b) the practitioner obtaining further professional education;
 - (c) the practitioner participating in a program, plan, or agreement with a physician health committee; and/or
 - (d) other reasonable conditions.
- (3) that a formal letter of admonition, censure, reprimand, or warning should be issued. In the event such letters are issued, the affected practitioner may make a written response, which, after review and comment, if any, by the Medical Executive Committee, shall be placed in the practitioner's file;
- (4) that terms of special limitation be recommended upon continued Medical Staff membership or exercise of clinical privileges, including, among other things, requirements for co-admission, mandatory consultation, or monitoring;
- (5) that reduction, modification, suspension, or revocation of clinical privileges should be recommended;
- (6) that reduction of membership status or limitation of any prerogatives directly related to the practitioner's delivery of patient care should be recommended;
- (7) that suspension, revocation or probation of Medical Staff membership and clinical privileges should be recommended; and
- (8) that other action, not specified above, as appropriate under the circumstances should be taken.

The Chief of Staff shall promptly inform the Regional CEO, and the practitioner under investigation by certified mail, return receipt requested, of any decision and/or recommendation and the reasons for any decision of the Medical Executive Committee, including providing the practitioner with a copy of the report of the investigator or any investigative committee. The report shall be redacted to avoid revealing the identity of persons who provided information based on a request that their identity be kept confidential.

6.1.6 SUBSEQUENT ACTION

- a. If corrective action as set forth in Article 7, Section 7.2(a) through (j) is recommended by the Medical Executive Committee, that recommendation shall be transmitted to the Board of Directors through the Regional CEO and notice shall be given to the practitioner by the Chief of Staff as provided under Article 7, Section 7.3.1.
- b. If the practitioner does not request a hearing as provided in Article 7, Section 7.3.2, this shall be deemed a waiver of any objection to the recommended action, and the Board of Directors may accept and act upon the recommendation of the Medical Executive Committee or it may take any action described below.
- c. If corrective action as set forth in Article 7, Section 7.2(a) through (j) is not recommended by the Medical Executive Committee, then the practitioner shall not be entitled to a hearing under Article 7, or to an appeal to the Board of Directors.

6.1.7 BOARD OF DIRECTORS' ACTION

- a. If the Medical Executive Committee fails to investigate, to otherwise act, or to recommend adequate disciplinary action appropriate to the weight of the evidence, the Board of Directors may direct the Medical Executive Committee to initiate an investigation, or to reconsider its recommendation for disciplinary action.
- b. If the Medical Executive Committee fails to take action in response to the Board of Directors' direction, the Board of Directors may appoint a review committee composed of at least three (3) practitioners who may or may not be members of the Medical Staff.
- c. The review committee shall appoint one of its members to act as Chairperson. The review committee may consider in whole or in part any report from any investigating body together with such other and further information as it considers appropriate including, but not limited to, information submitted by the practitioner, interviews with the practitioner and others, or other relevant information.
- d. The review committee shall proceed in compliance with Article 6, Section 6.1 with the exception that its report shall be delivered to the Board of Directors.
- e. Within thirty (30) calendar days of being appointed, the review committee shall meet to make written recommendations to the Board of Directors of any action under Article 6, Section 6.1. Notice of the review committee's findings and recommendations shall be given to the Medical Executive Committee. The practitioner shall be notified of the findings and recommendations by the Regional Chief of Staff by certified mail, return receipt requested.
- f. If the review committee does not recommend corrective action as set forth in Section 7.2(a) through (i), then the practitioner shall not be entitled to a hearing under Article 7 or an appeal to the Board of Directors.
- g. If the review committee recommends corrective action as set forth in Article 7, Section 7.2(a) through (i), the practitioner shall be notified in compliance with Article 7, Section 7.3.1.
- h. If the practitioner does not request a hearing under Article 7, Section 7.3 within fourteen (14) calendar days, the Board of Directors may accept the review committee's recommendation or take such other action as is appropriate. Notice of such action shall be provided in writing to the practitioner and the Medical Executive Committee.
- i. If the practitioner makes a request for hearing within fourteen calendar days, the Board of Directors shall direct the Medical Executive Committee to appoint a Hearing Committee, which shall be appointed in compliance with Section 7.3.5 of Article 7. If the Medical Executive Committee fails to appoint the Hearing Committee within ten (10) calendar days, the Board of Directors shall appoint a Hearing Committee.
- j. All proceedings involving the Hearing Committee shall be in compliance with Article 7, Sections 7.3.3 through 7.4.10, with the exception that if the Hearing Committee is

appointed by the Board of Directors pursuant to Section 6.1.6(i) all findings, reports and/or recommendations shall be delivered to the review committee rather than the Medical Executive Committee.

6.2 SUMMARY RESTRICTION OR SUSPENSION

6.2.1 CRITERIA FOR INITIATION

- a. Whenever there is a reasonable belief that a practitioner's conduct or competency requires immediate action to protect the life or well-being of, or poses an imminent danger to the life, health or safety of, any patient, prospective patient, staff member, or other person, immediate action may be taken by the Board of Directors, the Regional CEO, the Chief of Staff, the Medical Executive Committee, the Department Chief, or the head of the division in which the practitioner holds privileges. This immediate action may consist of summary restriction or suspension of the Medical Staff membership or clinical privileges of such practitioner. Unless otherwise stated, summary restriction or suspension shall become effective immediately upon imposition, and the person or body who initiates this action shall promptly give oral notice to Regional CEO and to the practitioner if circumstances permit, then shall promptly give written notice to the Regional CEO, the Medical Executive Committee, and the Board of Directors.
- b. The affected practitioner shall be provided with a written notice of the action as specified in Article 6, Section 6.2.2 below. The summary restriction or suspension may be limited in duration and shall remain in effect for a specified period of time or, if none, until resolved as set forth herein.
- c. The practitioner's patients shall be promptly assigned to another practitioner, unless otherwise indicated by the terms of the summary restriction or suspension. This re-assignment will be done by the Division Chair, Department Chief, or the Chief of Staff, and shall consider, when feasible, the wishes of the patient in the choice of a substitute practitioner.

6.2.2 WRITTEN NOTICE OF SUMMARY SUSPENSION OR RESTRICTION

Within two (2) working days of imposition of a summary suspension or restriction, the Chief of Staff shall notify the Regional CEO and give the affected practitioner written notice of such suspension or restriction by having the notice personally delivered to the practitioner, to his or her place of business or residence, or by mailing the notice to the practitioner via certified mail with return receipt requested. This initial written notice shall include a statement of facts specifying why the suspension or restriction was necessary, including a summary of one or more particular incidents giving rise to the need for summary suspension or restriction.

This initial notice shall not substitute for, but is in addition to, the notice required under Article 7, Section 7.3.1 which applies in all cases where the Medical Executive Committee does not immediately terminate the summary suspension or restriction. The notice under Article 7, Section 7.3.1 may supplement the initial notice provided under this section by including any additional relevant information supporting the need for summary restriction or suspension or other corrective action.

6.2.3 ACTION

a. Medical Executive Committee Action

1. Within three (3) working days after the date a summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee shall be convened to review and consider the action. The Chief of Staff shall promptly notify the practitioner either orally or in writing of the time and place of the meeting. The practitioner may appear and make a statement concerning the issues under investigation and on such terms and conditions as the Medical Executive Committee may impose. The meeting of the Medical Executive Committee, with or without the practitioner, does not constitute a “hearing” within the meaning of Article 7, and the procedural rules with respect to hearings or appeals do not apply.
2. The Medical Executive Committee may modify, continue, or terminate the summary suspension or restriction. The Medical Executive Committee shall also consider initiating an investigation under Section 6.1, recommend corrective action described in Section 7.2, or both, based on the acts and conduct which gave rise to the summary suspension or restriction. If necessary, the Medical Executive Committee may defer a decision on corrective action for no more than fourteen (14) calendar days from the date after which summary suspension was imposed. The Medical Executive Committee, through the Regional CEO, shall furnish the practitioner with notice of its decision within two (2) calendar days of the meeting, along with notice of right of hearing as described in Section 7.3.1, if applicable. The Regional CEO will concurrently provide the Board of Directors with notice of the Medical Executive Committee’s decision.
3. The information received by the Medical Executive Committee in conjunction with these summary suspension or restriction proceedings may be used to satisfy in whole or in part the investigation specified in Section 6.1.3 and may be the basis for taking action or making the recommendation under Section 6.1.4.

b. Board of Directors’ Action

1. The Board of Directors may impose summary restriction or suspension or take other actions under such conditions as it deems appropriate if the Medical Executive Committee fails to hold the meeting described above within three working days, or if the Medical Executive Committee modifies, continues, or terminates the summary suspension or restriction in a manner or under such terms as the Board of Directors, in its discretion, determines to be inappropriate. Within three (3) working days of the Board of Directors’ action, and after consultation with the Chief of Staff, the Board of Directors shall appoint a committee of three (3) or more practitioners licensed to practice in the State to review the propriety of the summary suspension or restriction imposed by the Board of Directors.

2. The committee appointed by the Board of Directors shall hold one or more meetings. It shall hold one (1) meeting as described in relevant part of 6.2.3 above, and the Chief of Staff shall promptly notify the practitioner in writing of the time and place of the meeting. The practitioner shall be given an opportunity to make a statement as described in 6.2.3(a) above. Any such meeting, with or without the practitioner, shall not constitute a “hearing” within the meaning of Article 7, nor shall the procedural rules with respect to hearings or appeals apply.
3. The committee may conduct any investigation it deems appropriate, and shall give a report to the Board of Directors no later than fourteen (14) days after the summary suspension or restriction, recommending the continuation, modification, or termination of the summary suspension or restriction.
4. Within two (2) working days of receiving the recommendation of the committee, the Board of Directors shall direct that the summary restriction or suspension be continued, modified, or terminated, and shall promptly furnish the practitioner with notice of its decision and, if applicable, the notice described in Section 7.3.1.
5. The failure to meet any deadline above shall not invalidate any of the activities of the Board of Directors or the committee, provided the Board of Directors issues an interim decision within fourteen (14) calendar days of the practitioner’s initial summary suspension or restriction. This fourteen (14)-day period may be extended upon a finding by the Board of Directors that good cause exists, provided that the final decision is issued no later than 28 days after the initial summary suspension or restriction.

6.2.4 PROCEDURAL RIGHTS

- a. The practitioner shall be entitled to a hearing under Article 7, and shall be provided with the notice described in Section 7.3.1 unless the Medical Executive Committee or the Board of Directors promptly terminates the summary suspension or restriction within fourteen (14) calendar days,
- b. When a recommendation for corrective action described in Section 7.2 is made by the Medical Executive Committee or the Hearing Committee within fourteen (14) days of the initial summary restriction or suspension, the summary restriction or suspension shall remain in effect until the Board of Directors takes action under Section 6.1.7, unless the Medical Executive Committee decides to remove any suspension or restriction.
- c. The hearing under Article 7 referred to above shall be concerned solely with whether or not restriction or suspension shall continue in effect until conclusion of the proceedings for corrective action unless the Medical Executive Committee has made a recommendation for corrective action.

- d. The body conducting the Article 7 hearing may combine, in a single proceeding, the hearing on summary restriction or suspension and the hearing on any corrective action, provided that the conditions and time limits set forth in these Bylaws are met or are waived by the practitioner whose conduct is under consideration.
- e. The practitioner's summary restriction or suspension shall automatically expire and the practitioner shall be appropriately reinstated if no recommendation for corrective action, as specified above, is made within fourteen (14) days of the practitioner's initial summary restriction or suspension.

6.3 AUTOMATIC ADMINISTRATIVE REVOCATION, SUSPENSION, OR LIMITATION

The practitioner's privileges or membership may be automatically revoked, suspended, or limited in the instances outlined in this section. It is the responsibility of the Medical Staff member to self-report the events as defined in sections 6.3.1 through 6.3.9 below. This notification must be submitted in writing to the Regional CEO and Chief of Staff. Failure to inform the Regional CEO and the Chief of Staff within fourteen (14) calendar days of any event described below that could result in automatic revocation, suspension, or limitation shall constitute grounds for corrective action.

Review of automatic revocation by the Medical Executive Committee, if requested by the Medical Staff member, shall be limited to the question of whether events requiring automatic revocation, suspension, or limitation, as set forth below, have occurred.

After action is taken or warranted as described in Sections 6.3.1 through 6.3.9, the Medical Executive Committee shall review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth commencing at Section 6.1.1.

6.3.1 LICENSURE

- a. Revocation: Whenever a practitioner's license authorizing practice in this state is revoked, Medical Staff membership and clinical privileges shall be automatically revoked on the date the revocation is effective.
- b. Suspension: Whenever a practitioner's license authorizing practice in this state is suspended, the practitioner's Medical Staff membership shall be likewise suspended. This suspension takes effect on the date the suspension of license becomes effective and throughout the duration of suspension.
- c. Restriction: Whenever a practitioner's license authorizing practice in this state is limited or restricted by the applicable licensing authority, any clinical privileges which the practitioner has been granted in the Region which are within the scope of the specified limitation or restriction shall be automatically limited or restricted in a similar manner. The limitation or restriction shall be in effect on the date the restriction becomes effective and shall remain throughout the duration of the restriction.
- d. Probation: Whenever a practitioner is placed on probation by the applicable licensing authority, his or her membership status and clinical privileges shall automatically

become subject to the same terms and conditions of the probation on the date such action becomes effective and throughout its term.

6.3.2 CONTROLLED SUBSTANCES

Whenever a practitioner's state narcotics license or DEA certificate lapses or is revoked, limited, suspended, or subject to probation, the practitioner's right to prescribe medications covered by such certificate shall automatically become suspended, limited or subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

6.3.3 MEDICAL RECORDS

Practitioners are required to complete medical records in compliance with the Medical Staff's policies. If a practitioner fails to complete the medical records within the time frame specified in the Medical Staff Policies, in the form of withdrawal of admitting and other related privileges until medical records are completed, shall be imposed by the Regional CEO along with the notice of delinquency for failure to complete medical records within such period. For the purpose of this section, "related privileges" means scheduling surgery, assisting in surgery, consulting on hospital cases, and providing professional services within the hospital for future patients. The suspension shall continue until lifted by the Regional CEO.

Vacation, formal leave of absence, or prolonged illness may constitute an excuse, subject to Medical Staff policy with approval, when necessary, by the Medical Executive Committee.

Suspension of privileges for failure to complete medical records is not a reportable event for licensure or the National Physician Database. The suspension of the practitioner for failure to complete medical records as described above on three (3) separate occasions within a twelve (12)-month period may result in corrective action under section 7 of these Bylaws, which may include revocation of the practitioner's clinical privileges.

6.3.4 FAILURE TO PAY DUES/ASSESSMENTS

Failure to pay dues or assessments within six months after written warning of the delinquency as required under Medical Staff Policies and Procedures shall be grounds for automatic suspension of a practitioner's clinical privileges.

6.3.5 FAILURE TO MEET QUALIFICATIONS OF MEMBERSHIP CATEGORY

When a practitioner no longer meets the requirements specific to that individual's membership category as provided in these Bylaws, the practitioner's appointment will be modified, limited, or terminated as recommended by the Medical Executive Committee. This section shall not apply while a practitioner is on authorized leave of absence.

6.3.6 EXCLUSION FROM MEDICARE/MEDICAID

When a practitioner has been excluded from participation with Medicare or Medicaid, this exclusion shall be grounds for automatic suspension of a practitioner's clinical privileges

6.3.7 PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance in amounts determined by the Board of Directors shall result in automatic suspension of a practitioner's clinical privileges. The practitioner's clinical privileges shall be reinstated upon proof that the practitioner has obtained the required professional liability insurance.

6.3.8 DUTY TO NOTIFY OF PENDING CLAIMS, LAWSUITS, OR INVESTIGATIONS

It is the duty of all members of the Medical Staff to notify the Credentials Committee and Medical Executive Committee of the pendency and findings of Medical Claims Conciliation Panel (MCCP) hearings, malpractice claims, investigations by the Center for Medicare and Medicaid Services, and the Hawaii State Board of Medical Examiners. None of these pending actions and investigations are cause for automatic suspension, however, failure of the Medical Staff member to notify the Credentials Committee and Medical Executive Committee of these pending investigations or findings within thirty (30) calendar days of notification of such action is cause for automatic suspension.

ARTICLE 7: HEARINGS AND APPELLATE REVIEW

7.1 GENERAL PROVISIONS

7.1.1 RIGHT TO ONE HEARING

A practitioner shall be entitled to only one evidentiary hearing and only one appellate review on any matter which shall have been the subject of adverse action or recommendation under these Bylaws.

7.1.2 EXHAUSTION OF REMEDIES

The applicant, practitioner with clinical privileges, or member must exhaust all remedies afforded by these Bylaws before initiating legal action.

7.1.3 TIMELY COMPLETION OF PROCESS

The hearing and appeal process shall be completed within six (6) months from the adverse action.

7.1.4 FINAL ACTION

Recommended adverse actions described in Section 7.2 shall become final only after the hearing and appellate rights set forth in these Bylaws have either been exhausted or waived.

7.2 GROUNDS FOR HEARING

One (1) or more of the following listed actions or recommended actions by the Medical Executive Committee or a Hearing Committee appointed by the Board of Directors based on competent or professional conduct shall be deemed an actual or potential adverse action, except as otherwise

specified in these Bylaws. This action shall constitute grounds for a hearing limited to laws for competence or conduct:

- a. Denial of Medical Staff reappointment based on competence or conduct;
- b. Change to a more restrictive Medical Staff category or membership status;
- c. Suspension of staff membership;
- d. Revocation of Medical Staff membership or appointment;
- e. Denial of requested clinical privileges;
- f. Involuntary reduction of current clinical privileges;
- g. Suspension of clinical privileges except as listed in Article 6.3;
- h. Termination of clinical privileges; or
- i. Involuntary imposition of significant consultation or monitoring requirements that restrict the practitioner's ability to exercise clinical privileges excluding monitoring incidental to provisional status.

7.3 REQUEST FOR HEARING

7.3.1 NOTICE OF ACTION OR PROPOSED ACTION

When an action has been taken or a recommendation made for corrective action as set forth in Section 7.2, the Chief of Staff shall notify the Regional CEO and give the practitioner prompt written notice by certified mail, return receipt requested, of:

- a. The action or the recommendation for final proposed action and that such proposed action, if adopted by the Board of Directors, shall be reported to the Department of Commerce and Consumer Affairs of the State of Hawaii and the National Practitioner Data Bank, as required by statute;
- b. The reason(s) for the action or proposed action including the acts or omissions with which the practitioner is charged;
- c. The right to request a hearing pursuant to Section 7.3.2 within fourteen (14) calendar days of notification;
- d. The right to a hearing before a committee appointed by the Medical Executive Committee or by the Board of Directors composed of at least three (3) practitioners, none of whom shall be in direct economic competition with the practitioner; and

- e. The right to be represented at the practitioner's expense by an attorney, another member of the Medical Staff, a representative of the practitioner's professional society, or other person of the practitioner's choosing.

If the recommendation or final proposed action would adversely affect the clinical privileges of a practitioner for a period longer than thirty (30) days and is based on competence or professional conduct, said written notice shall state that the action if adopted by the Board of Directors will be reported to the Department of Consumer Affairs of the State of Hawaii and the National Practitioner Data Bank. In addition, if the practitioner is under suspension for reasons of his or her competence or professional conduct, the practitioner shall be notified that if the suspension lasts more than thirty (30) days it shall be reported to the National Practitioner Data Bank through the Board of Medical Examiners, Department of Commerce, and Consumer Affairs.

7.3.2 REQUEST FOR HEARING

The practitioner shall have fourteen calendar (14) days following receipt of notice of such action or proposed action to request a hearing. The request shall be in writing and delivered by certified mail, return receipt requested, or by hand delivery to the Chief of Staff with a copy to the Regional CEO. In either case, the request for hearing must be received by the Regional CEO and the Chief of Staff no later than fourteen (14) calendar days following receipt by the practitioner of the notice of action or proposed action.

Should the practitioner fail to request a hearing within the time and in the manner described above, the practitioner shall be deemed to have waived all rights to a hearing and to an appeal, and to have accepted the recommendation or action involved.

7.3.3 TIME AND PLACE FOR HEARING

Within fourteen (14) calendar days of receipt of a request for hearing, the Chief of Staff shall set a hearing date. Unless extended by the Chair of the Hearing Committee, the hearing shall commence not less than thirty (30) days from the date of receipt by the Chief of Staff and Regional CEO of the request for hearing.

A practitioner who is under summary suspension or restriction may ask for an expedited hearing to be held no sooner than seven calendar (7) days and no later than fourteen (14) calendar days from the date of receipt by the Chief of Staff and Regional CEO of the request for hearing. The Chief of Staff shall, within three (3) calendar days of receiving the request for an expedited hearing, set a hearing date.

7.3.4 NOTICE OF HEARING

Within fourteen (14) calendar days of receipt of a request for hearing, or within three (3) calendar days after receipt of a valid request for expedited hearing, the Chief of Staff shall give notice in writing to the practitioner by certified mail, return receipt requested, or by hand delivery, of the time, place, and date of the hearing. The Chief of Staff shall concurrently provide a list of any witnesses expected to testify at the hearing in support of the action or recommendation, and a list of any relevant documents. The content of these lists is subject to update pursuant to Section 7.3.7.

7.3.5 HEARING COMMITTEE

- a. When a hearing is requested, the Medical Executive Committee or the Board of Directors, as appropriate, shall appoint a Hearing Committee. The Hearing Committee shall be composed of an odd number of not less than three (3) members of the Medical Staff and shall designate one of its members as Chair. The Chair shall preside over the meetings and shall also vote on all decisions before the Hearing Committee.
- b. No member of the Hearing Committee shall be in direct economic competition with the practitioner who is the subject of the proceeding. Furthermore, no member of the Hearing Committee shall have acted as an accuser, investigator, fact finder, and initial decision maker or have otherwise actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Hearing Committee.
- c. The Chief of Staff may not sit on the Hearing Committee.
- d. In the event that it is not feasible to appoint a Hearing Committee solely from members of the Medical Staff, the Medical Executive Committee may appoint practitioners who are not members of the Medical Staff as long as they have current active privileges at a hospital in the State.
- e. Membership on a Hearing Committee shall consist of at least one (1) member who shall have the same professional licensure as the practitioner under investigation and, where feasible, include another individual practicing the same specialty as the practitioner under investigation.
- f. The Hearing Committee may obtain the services of an attorney or other qualified person to advise it during any stage of the proceedings.
- g. Within seven (7) calendar days of selection of the Hearing Committee, the Chief of Staff shall inform the Regional CEO and shall inform the practitioner in writing by certified mail, return receipt requested, or by hand delivery the names of the members of the Hearing Committee.

7.3.6 POSTPONEMENTS, EXTENSIONS AND AMENDMENTS

Once a request for hearing is initiated, postponements and extensions beyond the times required in these Bylaws may be granted on the discretion of the Chair on a showing of good cause or upon agreement of the parties. Upon good cause or upon agreement of the parties, the Chair may allow the Chief of Staff or Regional CEO to add witnesses or documents to any list provided in accordance with Section 7.3.4.

7.3.7 FAILURE TO APPEAR OR PROCEED

Failure of the practitioner to attend the scheduled hearing in person without an extension per 7.3.6 shall be deemed a waiver of the right to a hearing, a waiver of the right to an appeal, and an acceptance of the recommendations or actions involved. The Board of Directors may accept and act upon the recommendation of the Medical Executive Committee or take other action it believes warranted based on the available information.

7.4 HEARING PROCEDURE

7.4.1 PREHEARING PROCEDURE

- a. The Medical Executive Committee shall select a member to represent the MEC during the proceedings including the review and presentation of evidence and exhibits and the examination and cross-examination of witnesses during the hearing. The Representative shall also present the closing oral and written summaries of evidence. This Representative shall not be the Chief of Staff and the appointment is not subject to challenge by the practitioner.
- b. The practitioner shall furnish to the Chief of Staff a written list of the names and addresses of the individuals, so far as is reasonably known or anticipated, who are expected to give testimony or evidence in support of the practitioner at the hearing, along with a summary of each witness' proposed testimony. At the same time, the practitioner shall provide to the Chief of Staff copies of any documents expected to be used at the hearing in support of the practitioner's case. The lists of names and documents shall be submitted no later than seven (7) calendar days before the hearing or no later than five (5) calendar days in the case of an expedited hearing for a practitioner who is under summary suspension or restriction.
- c. The practitioner requesting the hearing is entitled to the following, subject to the condition that all documents and information be maintained as confidential and not disclosed or used for any purpose outside of the hearing:
 1. copies, at the practitioner's expense, of, or reasonable access, to the extent appropriate under federal law, to all patient medical records referred to in the statement of reasons;
 2. reports of experts relied upon by the Medical Executive Committee; and
 3. the right to inspect and copy, at the practitioner's own expense, documents expected to be presented at the hearing in support of the charges against the practitioner, and to review any other evidence upon which the charges are based including any known evidence in the possession of the hospital or Medical Staff that tends to negate the charges against the practitioner under investigation.
 4. The provision of the information listed above does not waive any privilege under the State peer review protection statute. The documents inspected or produced may be redacted to avoid revealing the identity of patients or of persons who provided information based on a request that their identity be kept confidential.

- d. The practitioner shall have no right to discovery beyond the above information.
- e. Prior to the hearing, on dates set by the Presiding Officer or agreed upon by both sides, each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses or objections to members of the Hearing Committee, compliance with notice requirements, and/or other procedural issues under these Bylaws, to the extent then reasonably known, shall be submitted in writing in advance of the prehearing conference. The Hearing Committee Chair shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.
- f. Evidence unrelated to the reasons for the recommendation or to the practitioner's qualifications for appointment or the relevant clinical privileges shall be excluded.
- g. Neither the practitioner, nor the practitioner's attorney, nor any other person acting on behalf of the individual shall contact employees of the Region concerning the subject matter of the hearing, unless specifically agreed upon between the practitioner and the practitioner's counsel and the Medical Executive Committee and/or its counsel.
- h. The failure by either party to provide access to the information as described in (a) above shall constitute good cause for a continuance, or for exclusion of the evidence or the testimony at the discretion of the Chair of the Hearing Committee. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable members, other than the practitioner under review.
- i. The Chair shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice require. In so doing, the Chair shall consider:
 - 1. whether the information sought may be introduced to support or defend the charges;
 - 2. the incriminating or exonerating nature of the information sought, if any;
 - 3. the burden imposed on the party in possession of the information sought, if access is granted; and
 - 4. any previous requests for access to information submitted or resisted by the parties to the same proceeding.
- j. The practitioner shall be entitled to a reasonable opportunity to question and challenge the impartiality of any Hearing Committee member. The Chair shall hear and rule challenges to the impartiality of any Hearing Committee member. The Chief of Staff shall hear and rule on any challenges to the impartiality of the Chair of the Hearing Committee.
- k. It shall be the duty of the practitioner and the Medical Executive Committee or the Hearing Committee to exercise reasonable diligence in notifying the Chair of the Hearing Committee of any actual or anticipated procedural disputes as far in advance of the

scheduled hearing as possible. Prompt notification is required so that decisions concerning these matters may be made in advance of the hearing. Objections to any prehearing decisions may be succinctly made at the hearing.

- I. The Chair may hold a prehearing conference in person or by telephone with all parties, their representatives, or both, to discuss any procedural matter related to the hearing including disputes, challenges to the participation of any member of the Hearing Committee, agreements as to how the hearing shall proceed, the names of witnesses expected to testify, the expected length of any testimony, the submission of prehearing and posthearing memoranda, and any other matters concerning the conduct of the hearing. The determination of the Chair on any procedural matter shall be final.

7.4.2 REPRESENTATION

The practitioner who is the subject of the proceedings shall be entitled in any and all phases of the proceeding to be represented by an attorney or any other person of his or her choosing, at practitioner's own expense. The practitioner shall receive notice of the right to obtain such representation as specified by these Bylaws. The Medical Executive Committee and its appointed Representative shall have the right to be represented, at any and all stages of the proceedings, by an attorney at law or other person of its choosing. The Board of Directors or Regional CEO will retain counsel to advise and represent the Hearing Committee upon request of the committee.

7.4.3 CHAIR OF THE HEARING COMMITTEE

The Chair of the Hearing Committee shall preside over the hearing to determine the order of procedure, to rule upon the admissibility of evidence, to assure that all participants in the hearing have a fair opportunity to present relevant oral and documentary evidence, and to maintain decorum. The Chair's decisions on such matters shall be final. If the Chair determines that either side in a hearing is not proceeding in good faith and in an expeditious manner, the Chair may take such discretionary action as the Chair deems warranted by the circumstances.

7.4.4 GENERAL PROCEDURAL RULES

- a. There shall be at least three (3) appointed members of the Hearing Committee present during the hearing.
- b. The Hearing Committee Chair may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.
- c. 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. All relevant evidence, including hearsay, shall be heard, regardless of the admissibility of such evidence in a court of law, if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs. The Hearing Committee may interrogate the witnesses and may call additional witnesses if it deems such action appropriate.

- d. The Hearing Committee may, at its discretion, require or permit both sides to file written arguments.

7.4.5 RECORD OF THE HEARING

A shorthand reporter shall be present to make a record of the hearing proceedings and may be utilized at the prehearing proceedings if deemed appropriate by the Chair. The cost of attendance of the shorthand reporter shall be borne by the hospital, but the cost of the transcript, if any, shall be borne by the party requesting it.

7.4.6 RIGHTS OF THE PARTIES

Within reasonable limitations, each party shall have the right to:

- (a) call and examine witnesses;
- (b) introduce exhibits;
- (c) cross-examine any witnesses on any matter relevant to the issues;
- (d) impeach any witness;
- (e) rebut any evidence; and
- (f) submit written closing statements.

If the staff practitioner who is the subject of the proceedings does not testify on his or her own behalf, the practitioner may be called and examined by the Representative of the Medical Executive Committee.

7.4.7 BURDEN OF PRESENTING EVIDENCE AND PROOF

- a. At the hearing, the Representative of the Medical Executive Committee has the initial duty to present evidence for each case or issue in support of the action or recommendation of the MEC. The practitioner may then present evidence in response.
- b. The Representative of Medical Executive Committee shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that the action or recommendation of the Medical Executive Committee is reasonable and warranted.

7.4.8 ADJOURNMENT AND CONCLUSION

The Chair may adjourn and reconvene the hearing 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. The parties may submit written statements at the close of the hearing. Upon conclusion of the presentation of oral and written evidence and upon the receipt of closing written arguments, if submitted, the hearing shall be closed.

7.4.9 BASIS FOR DECISION

The decision of the Hearing Committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony.

Only members present during the entire hearing or who have read the transcripts of the entire hearing shall be entitled to participate in deliberations, determinations, and recommendations. A vote of a majority of not less than three (3) of the members entitled to vote shall constitute the determination of the Hearing Committee.

7.4.10 DECISION OF THE HEARING COMMITTEE

Within fourteen (14) calendar days after closing of the hearing, or within seven (7) calendar days if the practitioner is under suspension, the Hearing Committee shall issue a report in writing making specific findings as to:

- a. whether or not the practitioner in question has exhibited acts, demeanor, or conduct reasonably likely to be:
 1. detrimental to patient safety or to the delivery of quality patient care within the hospital;
 2. disruptive to the delivery of quality patient care within the hospital;
 3. contrary to recognized principles of ethics of the practitioner's profession;
 4. contrary to the HHSC Bylaws, East Hawaii Regional Board Bylaws, or Medical Staff Bylaws;
 5. contrary to HHSC, East Hawaii Regional Board, hospital or Medical Staff policy;
or
 6. below applicable professional standards of care in the practitioner's profession;
or
- b. whether the practitioner has been convicted of a crime substantially related to the qualifications, functions, or duties of a practitioner; or
- c. whether the applicant has met the requirements for the clinical privileges applied for based on competence or professional conduct; or
- d. if the proceedings pertain in whole or in part to the practitioner's summary restriction or suspension, whether facts exist to support the practitioner's restriction or suspension until conclusion of any proceedings for corrective action, including any appeal; and
- e. in addition to any of the above, any suggested action to be taken by the Medical Executive Committee or the Board of Directors, whichever is appropriate.

The report of the Hearing Committee shall cite specific incidents and shall explain how the incidents support the Hearing Committee's determination. The report, including the determination and recommendation, shall be delivered, along with all documents and other evidence produced at the hearing, to the Medical Executive Committee or to the Board of Directors as appropriate. A copy of said report, including the determination and recommendation, also should be forwarded to the Chief of Staff and the Regional CEO. The Chief of Staff shall send the report to the practitioner by certified mail, return receipt requested.

7.4.11 DECISION OF THE MEDICAL EXECUTIVE COMMITTEE OR BOARD OF DIRECTORS

- a. After reviewing the report, the Medical Executive Committee or the Board of Directors shall affirm, modify, or reverse its original action or recommendation and shall forward its final recommendation to the Board of Directors through the Chief of Staff and Regional CEO. The Chief of Staff shall then mail the recommendation by certified mail, return receipt requested, to the practitioner whose conduct was the subject of the proceedings.
- b. If the practitioner is under restriction or suspension, the Medical Executive Committee or the Board of Directors may continue the restriction or suspension under such terms as it deems appropriate until the conclusion of any pending corrective action or until the conclusion of any appeal.
- c. If the practitioner is not under restriction or suspension, the Medical Executive Committee or the Board of Directors may impose such restriction or suspension as it deems appropriate until the Board of Directors takes action.
- d. If the practitioner does not exercise the appellate rights in the manner and within the time described in Section 7.5 below, the Board of Directors may accept and act upon their own recommendation or the recommendation of the Medical Executive Committee, whichever is applicable.

7.4.12 NOTICE OF RIGHT TO APPEAL

- a. In all cases under Section 7.4.11 in which a practitioner's restriction or suspension has been continued or a recommendation for adverse action has been made as set forth in Section 7.2, the Chief of Staff shall notify the Regional CEO and shall give the practitioner prompt written notice by certified mail, return receipt requested, of:
 1. the action or the recommendation for final proposed action and that such proposed action, if adopted by the Board of Directors, shall be reported to the Department of Commerce and Consumer Affairs of the State of Hawaii and/or the National Practitioner Data Bank, if required;
 2. the reasons for the action or proposed action, including the acts or omissions with which the practitioner is charged;
 3. the right within fourteen (14) calendar days of receipt of the notice to request that the decision be reviewed on appeal by the Board of Directors; and
 4. the right to be represented, at the practitioner's expense, by an attorney, another member of the Medical Staff, a representative of the practitioner's professional society, or other person of the practitioner's choosing.
- b. When the recommendation or final proposed action would adversely affect the clinical privileges of a practitioner for a period longer than thirty (30) days and is based on competence or professional conduct, said written notice shall state that the action, if adopted by the Board of Directors, will be reported to the National Practitioner Data Bank. In addition, if the practitioner is under suspension for reasons of his competence

or professional conduct, the practitioner shall be notified that if the suspension is intended to or in fact lasts more than thirty (30) days it shall be reported to the National Practitioner Data Bank.

7.5 APPEAL

7.5.1 TIME FOR APPEAL

The practitioner may request an appellate review within fourteen (14) calendar days after receipt of any notice of right to appeal described in Section 7.4.12. A written request for such review shall be mailed by certified mail, return receipt requested, or by hand delivery to the Chief of Staff or the Regional CEO within the time prescribed above.

7.5.2 GROUNDS FOR APPEAL

A written request for an appeal shall include a specification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The only grounds for appeal from the hearing shall be:

- a. substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice; or
- b. the lack of substantial evidence to support the action or recommendation based upon the hearing record or such additional information as may be permitted pursuant to Section 7.5.5.

7.5.3 DATE, PLACE, AND NOTICE

- a. When an appellate review is to be conducted, the Board of Directors shall, within fourteen (14) calendar days after receipt of a request for appeal, schedule a review date and cause each side to be given notice of the time, place, and date of the appellate review.
- b. The date of appellate review shall not be more than thirty (30) days from the date of such notice, provided however, that when a request for appellate review concerns a practitioner who is under restriction or suspension, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed fifteen (15) calendar days from the date of the notice. The Board of Directors may, for good cause, extend the date for appellate review.

7.5.4 THE BOARD OF DIRECTORS

The Board of Directors may hear the appeal or it may appoint an Appeal Committee which shall be composed of no fewer than three (3) persons authorized to practice within the state who may or may not be members of the Medical Staff and who shall not be in direct economic competition or conflict of interest with the practitioner involved. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Committee, so long as that person did not act as accuser, investigator, fact finder, initial decision maker, or

have otherwise actively participated in the consideration of the matter leading up to the recommendation or action. The Appeal Committee shall designate one of its members as Chair and may request appointment of an attorney to assist it in the proceeding.

7.5.5 APPEAL PROCEDURE

- a. The proceeding on appeal, either before the Board of Directors or the Appeal Committee, shall be in the nature of an appellate hearing based upon the record of the hearing before the Medical Executive Committee or Hearing Committee below, provided that the Board of Directors or the Appeal Committee may accept additional oral or written evidence, subject to a foundational showing that in the exercise of reasonable diligence such evidence could not have been made available to the Hearing Committee below and subject to the same rights of cross-examination or confrontation provided at the hearing below.
- b. In the alternative, the Board of Directors or the Appeal Committee may remand the matter to the Medical Executive Committee or the Hearing Committee, whichever is appropriate, for the taking of further evidence and for further proceedings before being returned to the Board of Directors for action.
- c. The Board of Directors, its designee, or the Chair of the Appeal Committee shall meet with representatives of the parties to set schedules for briefing, appellate procedures, and other matters related to the appeal.
- d. Each party shall have the right to be represented by legal counsel, or by any other representative of the party's choosing; to present a written statement in support of his or her position on appeal; and, in the discretion of the Board of Directors or the Appeal Committee, to personally appear and make oral argument. Each party will bear financial responsibility for the legal counsel or representation of their choosing.
- e. All documents presented to the Board of Directors or the Appeal Committee shall be served upon the opposing party by certified mail, return receipt requested, or by hand delivery.
- f. The Board of Directors or the Appeal Committee shall conduct deliberations outside the presence of the parties and their representatives. If an Appeal Committee has been appointed, within fourteen (14) calendar days it shall present to the Board of Directors a written recommendation as to whether the Board of Directors should affirm, modify, or reverse the recommendation of the Medical Executive Committee or the Hearing Committee, whichever is appropriate, or remand the matter to the Medical Executive Committee or the Hearing Committee for further review and decision.
- g. The Board of Directors shall promptly deliver a copy of any report or recommendation of the Appeal Committee to the practitioner by certified mail, return receipt requested.

7.6 CONFIDENTIALITY

The proceedings and the records of any committee or investigative body under Articles 6 and 7, including recordings, transcripts, minutes, summaries, and reports of committee meetings or investigations and conclusions contained therein, are confidential and shall be disclosed only to duly appointed officers and members of the Medical Staff for the sole purpose of discharging their Medical Staff responsibilities to persons appointed to sit on committees or to investigate under Articles 6 and 7, for the sole purpose of discharging their responsibilities to the Board of Directors and its designated representatives and to such other persons as may be required by federal or state laws. The Board shall support Medical Staff who, in their roles and in good faith, release information to other healthcare agencies.

ARTICLE 8: OFFICERS

8.1 OFFICERS OF THE MEDICAL STAFF

8.1.1 IDENTIFICATION

The officers of the Unified Medical Staff will be the Chief of Staff, Chief of Staff Elect, Treasurer, and Secretary.

8.1.2 QUALIFICATIONS

Officers of the Medical Staff must be Doctors of Medicine or Osteopathy (MD, DO), Doctors of Dentistry (DDS, DDM), or Doctors of Podiatry (DPM) as required by CMS. Officers must be members of the active Medical Staff at the time of their nominations and election and must remain members in good standing during their term of office.

8.1.3 NOMINATIONS

- a. The Medical Staff election will be held every two (2) years. A nominating committee will be appointed by the MEC and convene no later than one hundred twenty (120) days prior to the annual staff meeting or at least forty-five (45) days prior to any special election. The nominating committee shall consist of three active Medical Staff members, at least one who is not then a member of the Medical Executive Committee, and one who works primarily at a facility other than HMC. The nominating committee will nominate one (1) or more nominees for each office and three (3) for at-large MEC positions. The nominations of the committee will be reported to the MEC at least sixty (60) days prior to the annual meeting and will be delivered to the voting members of the Medical Staff at least thirty (30) days prior to the election.
- b. The failure to meet any deadline stated above will not invalidate any of the activities of the MEC or the nominating committee, providing the nominations are delivered to the voting members of the Medical Staff at least thirty (30) days prior to the election.
- c. Additional nominations may be made for any office by any voting member of the Medical Staff, provided that the name of the candidate is submitted in writing to the Chair of the nominating committee, is endorsed by the signature of at least ten (10%)

percent of other members who are eligible to vote, and bears the candidate's written consent. These nominations will be delivered to the Chair of the nominating committee at least twenty (20) days prior to the date of election. Any nominations made in this manner will be communicated to the voting members of the Medical Staff at least ten (10) days prior to the meeting.

8.1.4 ELECTIONS

The Medical Staff officers, hospital representatives and three at-large members will be elected at the meeting of the Medical Staff, which falls in December of the election year. Voting will be by secret written ballot. A nominee will be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election will be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the MEC will decide the election by secret written ballot at its next meeting or a special meeting called for that purpose.

8.1.5 TERM OF ELECTED OFFICE

The term of each elected office is two (2) years, commencing on the first calendar day of the year following election. Each officer and at-large member will serve until the end of that officer's or at-large member's term, or until a successor is elected, unless that officer or at-large member resigns or is removed from office.

8.1.6 REMOVAL OF OFFICERS AND MEC MEMBERS

Reasons for removal from office will be based upon: failure to perform the duties of the office as described in these Bylaws, health, impairment, or any extraordinary cause determined by the MEC. Removal of a member of the MEC will be initiated by the MEC and considered at a special meeting called for that purpose. Removal will require a two-thirds (2/3) vote of the MEC exclusive of the member under review. See section 9.7.4 for removal of Department Chief.

8.1.7 VACANCIES IN ELECTED OFFICE

Vacancies, other than that of the Chief of Staff and Chief Elect, will be filled by appointment by the MEC until the next regular election. If there is a vacancy in the office of Chief of Staff, then the Chief Elect shall serve out that remaining term and the MEC will immediately appoint a nominating committee to decide promptly upon nominees for the office of Chief Elect. A special election to fill the position will occur at the next regular Medical Staff meeting. For a vacancy in the office of Chief Elect, the Secretary shall temporarily fill the vacancy and the MEC will similarly appoint a nominating committee and hold a special election to fill the position at the next regular Medical Staff meeting.

8.2 DUTIES OF OFFICERS

8.2.1 CHIEF OF STAFF

The Chief of Staff serves as the chief administrative officer of the Unified Medical Staff and will:

- a. act in coordination and cooperation with the CEO, or designee and Governing Body in all matters of mutual concern within the Region;
- b. call, preside at, report at, and establish the agenda for, all general and special meetings of the Unified Medical Staff and the Medical Executive Committee;
- c. serve as a non-voting member of all other Medical Staff committees;
- d. be responsible for the enforcement of the Medical Staff Bylaws and Medical Staff Policies and Procedures;
- e. support, with assistance from facility and corporate resources, Medical Staff compliance with procedural safeguards where corrective action has been requested;
- f. appoint practitioners, as required, to serve on appropriate committees;
- g. present the views, policies, needs and concerns of the Medical Staff to the CEO, or designee and to the Governing Body;
- h. receive and implement policies from the Governing Body concerning the Medical Staff;
- i. represent the Medical Staff in external professional matters;
- j. participate in the long-range planning activities of the Region; and
- k. review and enforce compliance with standards of ethical conduct and professional demeanor among practitioners in their relations with each other, the CEO, or designee, Governing Body, other professional and support staff, and the community the Region serves.

8.2.2 CHIEF ELECT

The Chief Elect will be a member and officer of the Medical Executive Committee. The Chief Elect will assume all duties and authority of the Chief of Staff in the absence or incapacity of the Chief of Staff. The Chief Elect will be a member of the Medical Executive Committee, Joint Conference Committee of the East Hawaii Regional Board, Chair of the Quality Management Committee, and member of the Credentials Committee, and will perform other duties as the Chief of Staff or MEC may assign. Acceptance of this position implies preparation to become Chief of Staff.

8.2.3 SECRETARY

The Secretary will be a member and officer of the Medical Executive Committee. The Secretary will assume all duties and authority of the Chief of Staff in the absence or incapacity of both the Chief of Staff and the Chief of Staff Elect. The duties of the Secretary will include, but not be limited to:

- a. acting as a resource to the officers of the MEC for matters where additional information or data is needed to be obtained for the MEC to make decisions or establish policy;
- b. coordinating the initial and annual Medical Staff review of Contracts for Clinical Services at the facilities of the Region per Medical Staff policy; and
- c. reporting the findings of the reviews of Contracts for Clinical Services to the MEC.

8.2.4 TREASURER

The Treasurer will be a member of the MEC. The duties of the Treasurer will include, but not be limited to:

- a. acting as an authorized signatory of Medical Staff funds;
- b. reviewing and reporting the accounting of funds; and
- c. performing other duties as may be assigned from by the Chief of Staff or MEC.

8.2.5 HOSPITAL REPRESENTATIVE

HHH and Ka'u Hospital shall have a Hospital Representative to represent their facility as a member of the MEC. The qualifications, selection, and duties of the Hospital Representative are defined in Section 9.1 below.

ARTICLE 9: MEDICAL STAFF HOSPITALS, DEPARTMENTS, AND CLINICAL DIVISIONS

9.1 ORGANIZATION OF MEDICAL STAFF HOSPITALS

The Unified Medical Staff will be organized into three hospitals: HHH, HMC, and Ka'u Hospital.

- a. HHH includes all privileged providers who hold active privileges at HHH and its associated facilities and clinics and have designated HHH as their primary hospital.
- b. HMC includes all privileged providers who hold active privileges at HMC and its associated facilities and clinics and have designated HMC as their primary hospital.
- c. Ka'u Hospital includes all privileged providers who hold active privileges at Ka'u Hospital and its associated facilities and clinics and have designated Ka'u Hospital as their primary hospital.

A privileged provider who holds active privileges at more than one hospital in the Region shall designate the one hospital to which he or she wishes to be assigned as a Medical Staff member. This designation of membership may be changed, upon request, at each biennial reappointment to the Medical Staff.

9.1.1 QUALIFICATIONS OF THE HOSPITAL REPRESENTATIVE

HHH and Ka'u Hospital will have a Hospital Representative who shall be elected from members of the active Medical Staff at that hospital.

9.1.2 SELECTION

The Hospital Representative will be elected by voting members of their primary hospital under the process defined in Section 8.1.4.

9.1.3 TERM OF OFFICE

Each Hospital Representative shall serve a term of two (2) years commencing on the first calendar day of the year following the election. Hospital Representatives shall be eligible to succeed themselves.

9.1.4 REMOVAL

Any Hospital Representative may be removed from position for valid cause including, but not limited to, gross neglect, dishonesty, or abuse of power. Removal of a Hospital Representative can be initiated by a petition signed by a simple majority of the members of the Representative's primary hospital or by the Medical Executive Committee.

Any Hospital Representative vacancy shall be filled by an eligible provider nominated by the Chief of the Unified Medical Staff and approved by the MEC. Appointed providers shall serve until the next medical officer election and may stand for election and succeed themselves.

9.1.5 DUTIES

Each Hospital Representative will have the following authority, duties and responsibilities:

- a. report to the MEC and to the Chief of Staff regarding all professional and administrative activities specific to the representative's hospital;
- b. monitor the quality, safety, and appropriateness of patient care and professional performance rendered by practitioners with clinical privileges in the representative's hospital;
- c. recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in their primary hospital;
- d. be a voting member of and attend meetings of the MEC;
- e. endeavor to enforce the Medical Staff Bylaws, Rules and Regulations, and Medical Staff policies within their primary hospital;
- f. transmit information from the MEC to members of the representative's hospital;

- g. participate as needed to solve disputes and ensure the delivery of high-quality, safe, and appropriate patient care in accordance with Unified Medical Staff policies; and
- h. perform other duties which commensurate with the office as requested by the Chief of Staff or the MEC.

9.2 ORGANIZATION OF MEDICAL STAFF DEPARTMENTS

- a. The Unified Medical Staff will be organized into two clinical departments and the number of clinical divisions as determined under Medical Staff policy.
- b. A department is a broad category of privileged providers who share general common elements of training and practice. Each department will be organized as a separate component of the Unified Medical Staff and will have a Chief selected and entrusted with the authority, duties, and responsibilities as specified in Article 9.7.
- c. A Clinical division is a group of privileged providers who have common clinical training, practices, and interests and who are organized to conduct operational and quality activities specific to their specialties. Divisions are responsible to the department to which they belong. Each Clinical division shall have a Division Chair selected and entrusted with the authority, duties, and responsibilities specified in Article 9.8.
- d. The Medical Executive Committee will periodically reevaluate departmental structure and act to create or reorganize departments or divisions when deemed desirable for improved governance, efficiency, or patient care.

9.3 CURRENT DEPARTMENTS AND CLINICAL DIVISIONS

The Departments of the Medical Staff are the Department of Medicine and Department of Surgery.

The Department of Medicine includes, but is not limited to, the following Clinical divisions:

Emergency Medicine
Family Medicine
Internal Medicine
Pediatrics
Psychiatry

The Department of Surgery includes, but is not limited to, the following Clinical divisions:

Anesthesiology
Surgery and Surgical Subspecialties
OB-Gyn
Pathology
Radiology

9.4 ASSIGNMENT TO DEPARTMENTS

Each practitioner will be assigned to a division and department which most closely reflects his or her professional training and current practices and will have voting privileges only within that division and department.

If a practitioner has equal training in more than one area, the practitioner may request and be granted clinical privileges in more than one division. A practitioner's qualifications and exercise of clinical privileges within each division will be subject to the policies, rules, and regulations of that division. Practitioners granted privileges by more than one division will designate, at the time of appointment or reappointment, which division and department will be the practitioner's primary assignment. Each practitioner will have voting rights only in the division and department to which they are primarily assigned, unless otherwise specified.

A division may decide, at their discretion, to grant voting rights to a privileged practitioner who is primarily assigned to a different division. A provider's exercise of voting rights within that division will be subject to the policies, rules and regulations, and recommendations of that division.

9.5 FUNCTIONS OF DEPARTMENTS

The general functions of each department will include:

- a. conducting peer reviews for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients within the department. The department will routinely collect and assess information about important aspects of patient care provided in the department, develop objective criteria for use in evaluating patient care. Reviews will include all clinical work performed under the jurisdiction of the department, regardless of whether the member is a member of that department;
- b. recommending to the Credentials Committee guidelines for the granting of clinical privileges and the performance of specified services within the department;
- c. evaluating and making appropriate recommendations regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that department;
- d. conducting, participating, and making recommendations regarding continuing education programs pertinent to departmental clinical practice;
- e. reviewing and evaluating departmental adherence to Medical Staff policies and procedures and sound principles of clinical practice;
- f. coordinating patient care provided by the department's members with nursing and ancillary patient care services;
- g. submitting written or oral reports to the MEC concerning:

- (1) department's review and evaluation activities, actions taken thereon, and the results of such action; and
 - (2) recommendations for maintaining and improving the quality of care provided in the department, clinical divisions, and the hospitals;
- h. meeting quarterly, and as needed, for the purpose of considering peer review findings and the results of the department's or clinical divisions' other review and evaluation activities, as well as reports on other department, clinical divisions, administrative, and staff functions;
- i. establishing such committee or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocols;
- j. taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified;
- k. accounting to the MEC for all professional and Medical Staff administrative activities within the department; and
- l. formulating policies and procedures reasonably necessary for the proper discharge of its responsibilities.

9.6 FUNCTIONS OF CLINICAL DIVISIONS

Subject to approval of the Medical Executive Committee, each division shall perform the function assigned to it by the Department Chief. The division shall transmit regular reports to the Department Chief on the conduct of its assigned functions. Such functions may include, without limitation:

- (1) retrospective patient care reviews, evaluation of patient care practices,
- (2) credentials review and privileges delineation, and
- (3) continuing education programs.

Each division shall also be responsible for assessing and recommending to the Department Chief those resources outside the facilities of the Region needed for patient care services not provided by the facilities of the Region.

9.7 DEPARTMENT CHIEFS

9.7.1 QUALIFICATIONS

Each department will have a Chief and Vice-Chief who shall be members of the active Medical Staff and will be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the department.

9.7.2 SELECTION

The Department Chief and Vice-Chief will be elected by voting members of the department under the process defined in Section 9.3.

9.7.3 TERM OF OFFICE

Each Department Chief and Vice-Chief shall serve a two (2)-year term commencing on the first calendar day of the year following election. Department officers shall be eligible to succeed themselves.

9.7.4 REMOVAL

Any Department Chief may be removed from position for valid cause including, but not limited to, failure to perform the duties of office, health, or impairment of any extraordinary cause determined by the MEC. Recall of a Medical Staff Department Chief can be initiated by a petition signed by at least one-third (1/3) of the members of that department or by the Medical Executive Committee.

Any Department Chief vacancy shall be filled by the Vice-Chief of the department until the next regular election. The Chief of Staff shall appoint a Vice-Chief for the department to serve until the next regular elections.

9.7.5 DUTIES

Each Chief will have the following authority, duties, and responsibilities, and the Vice-Chief, in the absence of the Chief, will assume all of them and will otherwise perform such duties as may be assigned:

- a. act as presiding officer at departmental meetings;
- b. report to the MEC and to the Chief of Staff regarding all professional and administrative activities within the department;
- c. monitor the quality, safety, and appropriateness of patient care and professional performance rendered by practitioners with clinical privileges in the department through a planned and systematic process;
- d. recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department;
- e. develop and implement departmental programs for ongoing peer review;
- f. be a member of and attend meetings of the MEC;
- g. transmit to the MEC the department's recommendations concerning practitioner appointment and classification, reappointment, criteria for clinical privileges, monitoring

of specified services, and corrective action with respect to persons with clinical privileges in the department;

- h. endeavor to enforce the Medical Staff Bylaws, Rules and Regulations, and Medical Staff policies within the department;
- i. implement within the department actions taken by the MEC;
- j. participate in every phase of administration of the department;
- k. assist in the preparation of annual department reports, including budgetary planning, such as allocation to and acquisition of resources for the various divisions, as required or requested by the MEC;
- l. recommend delineated clinical privileges for each member of the department;
- m. transmit information from the MEC to department members;
- n. participate as needed to solve disputes and ensure the delivery of high-quality, safe, and appropriate patient care in accordance with Medical Staff policies; and
- o. perform other duties which commensurate with the office requested by the Chief of Staff or the MEC.

9.8 DIVISION CHAIRS

9.8.1 QUALIFICATIONS

Each division shall have a Chair and Vice Chair who shall be a member of the active Medical Staff and a member of the division and shall be qualified by training, experience, and demonstrated current ability in the clinical area covered by the division.

9.8.2 SELECTION

Each Division Chair and Vice Chair shall be elected by the voting members of his or her division. Any Division Chair vacancies shall be filled by the Vice Chair of the division for the remainder of the term. Any vacancy in the Vice Chair position will be filled by election at the next regular meeting of the division.

9.8.3 TERM OF OFFICE

Each Division Chair shall serve a two (2)-year term. Division Chairs shall be eligible to succeed themselves.

9.8.4 REMOVAL

Any Division Chair may be removed from position for valid cause including, but not limited to, failure to perform the duties of office, health, and impairment of any extraordinary cause

determined by the MEC. Recall of a Medical Staff Division Chair can be initiated by a petition signed by at least one-third (1/3) of the members of that department or by the Medical Executive Committee.

9.8.5 DUTIES

Each Division Chair shall:

- a. act as presiding officer at division meetings;
- b. assist in the development and implementation, in cooperation with the Department Chief, of programs to carry out the quality review and evaluation and monitoring functions assigned to the division;
- c. evaluate the clinical work performed in the division;
- d. conduct investigations and submit reports and recommendations to the Department Chief regarding the clinical privileges to be exercised with the division by members of or applicants to the Medical Staff;
- e. provide reports to the Department Chief on issues relating to administrative duties for supervision of hospital personnel, proper functioning of equipment, and efficient scheduling and staffing; and
- f. perform such other duties commensurate with the office as may from time to time be reasonably requested by the Department Chief, the Chief of Staff, or the Medical Executive Committee; and
- g. forward Items requiring action to the relevant department or MEC as appropriate.

ARTICLE 10: COMMITTEES

10.1 DESIGNATION

The committees described in this Article shall be the standing committees of the Unified Medical Staff. Other committees may be created by the MEC to perform specified tasks. The Chair and members of all committees will be appointed and removed by the Chief of Staff with approval by the MEC. Medical Staff committees report to the MEC.

10.2 GENERAL PROVISIONS

Terms, grounds for removal, and method of filling vacancies will be in accordance with Medical Staff policy.

10.3 MEDICAL EXECUTIVE COMMITTEE (MEC)

10.3.1 COMPOSITION

The MEC consists of:

A. Voting Members:

1. the officers of the Medical Staff;
2. immediate Past-Chief of Staff;
3. Ka'u Representative;
4. HHH Representative;
5. the Department Chiefs; and
6. three at-large members of the active Medical Staff who shall be nominated and elected for a two-year term in the same manner and at the same time as provided in Articles 8.3 through 8.4 for the nomination and election of officers.

B. Invited Participants Without Vote:

1. Regional CEO;
2. Chief Medical Officer;
3. Chair of Credentials Committee;
4. Chief Nurse Executive;
5. Medical Directors; and
6. Guests.

C. Medical Staff

Members of the Medical Staff not specified above may attend the general session of the MEC as specified in the Medical Staff Sunshine Policy and Procedure. They are not permitted to attend the executive session unless specifically invited by the Chief of Staff.

10.3.2 VOTING

Voting members of the Medical Executive Committee shall have one vote each.

10.3.3 DUTIES

The duties of the MEC will include:

- a. representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;
- b. establishing Medical Staff policy;
- c. receiving and acting upon reports and recommendations from Medical Staff departments, committees, and assigned activity groups;
- d. approving delineation of privileges for each department and/or specialty;

- e. making Medical Staff recommendations directly to the Governing Body for its approval, including:
 - 1. the organized Medical Staff structure,
 - 2. the process used to review credentials and to delineate privileges,
 - 3. delineation of privileges for each applicant privileged through the Medical Staff process, and
 - 4. Medical Staff membership;
- f. evaluating and recommending responses to the results of reviews;
- g. participating in the development policy for facilities of the Region;
- h. participating in planning for the East Hawaii Region;
- i. promoting ethical conduct and competent clinical performance for all Medical Staff members;
- j. developing continuing education activities and programs for the Medical Staff;
- k. designating committees and approving or rejecting appointments to those committees by the Chief of Staff;
- l. reporting to the Medical Staff at each regular staff meeting;
- m. assisting in the obtaining and maintaining of accreditation;
- n. participating in disaster planning;
- o. reviewing the quality and appropriateness of clinical services provided by contract physicians;
- p. establishing a mechanism for dispute resolution between Medical Staff members involving the care of a patient.

10.3.4 MEETINGS

The MEC shall meet no less than ten (10) times per year, and as often as necessary to conduct business in a timely manner. A record of the proceedings and actions of the MEC will be made and retained. These records are to be accessible as specified in the Medical Staff Sunshine policy.

10.4 CREDENTIALS COMMITTEE

The Credentials Committee shall be a standing committee which will meet and function in accordance with Medical Staff policy.

10.5 QUALITY COMMITTEE

The Quality Committee shall be a standing committee chaired by the Chief of Staff Elect. This committee will meet and function in accordance with Medical Staff policy.

ARTICLE 11: MEETINGS

11.1 MEETINGS

11.1.1 GENERAL STAFF AND ANNUAL MEETING

The Unified Medical Staff will hold general meetings quarterly in the months of March, June, September, and December. The general Medical Staff meeting in December of each year will be

designated as an annual meeting. Notice of this meeting will be given to the members at least thirty (30) days prior to the meeting date.

11.1.2 AGENDA

The Chief of Staff or designee shall determine the order of business at a meeting of the Medical Staff.

11.1.3 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Chief of Staff or the MEC or may be called upon the written request of ten percent (10%) of the members of the active Medical Staff. The person calling or requesting the special meeting will state the purpose of such meeting in writing. The Chief of Staff or presiding officer will convene the meeting within twenty-one (21) days after receipt of such request. The Chief of Staff or presiding officer will promptly disseminate the meeting dates to the members.

11.1.4 VOTING

Active and Affiliate Medical Staff members in good standing present, in person and electronically, and entitled to vote will constitute a quorum. An affirmative vote of the majority of Active and Affiliate Medical Staff members in good standing present and entitled to vote constitutes approval for action.

11.2 COMMITTEE AND DEPARTMENT/DIVISION MEETINGS

11.2.1 REGULAR MEETINGS

The chairs of committees, the chiefs of departments and chairs of divisions will establish quarterly meeting times. Attendance at meetings is encouraged and may be required at the discretion of the committee, department, or division. The Medical Staff Services Department will send meeting notices and schedule meeting rooms and arrange catering as needed.

Clinical divisions must hold a minimum of one (1) meeting per year but will not be required to hold all the regularly scheduled quarterly meetings if there is no business to be conducted. The Medical Staff Services Department will send meeting notices and schedule meeting rooms and arrange catering as needed.

11.2.2 SPECIAL MEETINGS

A special meeting of any Medical Staff committee, department or division, may be called by the Committee Chair, Department Chief, Division Chair, the MEC, or the Chief of Staff, or will be called by written request of one-third (1/3) of the current members, eligible to vote, but not less than two (2) members.

11.3 QUORUM/VOTING

Active and Affiliate Medical Staff members in good standing present, in person or electronically, and entitled to vote will constitute a quorum. An affirmative vote of the majority of Active and Affiliate Medical Staff members in good standing present and entitled to vote constitutes approval for action.

11.4 MINUTES

Minutes of meetings will be prepared by Medical Staff Services staff and presented to the relevant Chair or Chief for review. Minutes will be approved at the next scheduled meeting and, after approval, records will be retained in the Medical Staff office.

11.5 CONDUCT OF MEETINGS

Meetings will be conducted according to Rules of Order by Dr. James E. Davis.

11.6 EXECUTIVE SESSION

Executive session is a closed meeting for peer review and issues of quality improvement. Attendance in executive session is limited to voting members of that specific committee, division, and department. Additional individuals may attend if specifically invited by the relevant Chair or Chief. Only voting members of that committee may vote during executive session. Minutes of executive sessions will be kept but will be protected quality and peer review documents and be secured and kept separate from the minutes of the general meeting.

ARTICLE 12: CONFIDENTIALITY, IMMUNITY, AND RELEASES

12.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising clinical privileges within the Region, an applicant:

- (a) authorizes representatives of the Region and the Unified Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;
- (b) authorizes persons and organizations to provide information concerning such practitioner to the Unified Medical Staff;
- (c) agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Unified Medical Staff or the Region who acts in accordance with the provisions of this Article; and
- (d) acknowledges that the provisions of this Article are express conditions to an application for Unified Medical Staff appointment, the continuation of such appointment, and to the exercise of clinical privileges at hospitals, facilities and clinics of the Region.

12.2 CONFIDENTIALITY OF INFORMATION

12.2.1 GENERAL

The records and proceedings the MEC, all Unified Medical Staff committees, departments, divisions, and ad hoc committees including executive sessions that relate to evaluation of

provider credentialing, privileging and performance or improvement of quality of care rendered in the Region will, to the fullest extent permitted by law, be confidential.

12.2.2 BREACH OF CONFIDENTIALITY

Because effective peer review and deliberation of qualifications of medical staff and applicants requires free and candid discussions, any unauthorized release of the content of discussions or deliberations will be considered a violation of the Code of Conduct. Protected material may be released to other hospitals, licensing authorities, and professional societies in specific situations, but approval for release of this information should be obtained prior to release. If it is determined that a breach of confidentiality has occurred, the MEC shall undertake corrective action under the Code of Conduct policy as it deems appropriate.

12.3 IMMUNITY FROM LIABILITY

12.3.1 FOR ACTION TAKEN

Each representative of the Unified Medical Staff and the Region will be exempt, to the fullest extent permitted by law, from liability to an applicant, practitioner with clinical privileges, or members of the Medical Staff for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or facilities within the Region.

12.3.2 FOR PROVIDING INFORMATION

Each representative of the Unified Medical Staff and facilities of the Region, and all third parties will be exempt, to the fullest extent permitted by law, from liability to an applicant, practitioner with clinical privileges, or members of the Medical Staff for damages or other relief by reason of providing information to a representative of the Medical Staff or facilities of the Region concerning such person who is, or has been, an applicant to or member of the staff or who did, or does, exercise clinical privileges or provide services at this medical center.

12.4 ACTIVITIES AND INFORMATION COVERED

12.4.1 ACTIVITIES

The confidentiality and immunity provided by this Article will apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

- a. application for appointment, reappointment, or clinical privileges;
- b. corrective action;
- c. hearings and appellate reviews;
- d. utilization reviews;
- e. other department, or committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and
- f. National Practitioner Data Bank queries and reports, peer review organizations, Department of Commerce & Consumer Affairs, and similar reports.

12.5 RELEASES

Each applicant, practitioner with clinical privileges or member will, upon request of the Medical Staff, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases will not be deemed a prerequisite to the effectiveness of this Article.

12.6 CUMULATIVE EFFECT

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information, and immunities from liability will be in effect in addition to other protections provided by law. In the event of conflict, the applicable law will prevail.

12.7 SPECIAL LITIGATION COVENANT

The Region will provide liability coverage to any practitioner serving or assisting in any medical center or Medical Staff peer review or performance improvement activity. In the event a claim is made against the practitioner arising out of said membership of committee, a defense and indemnity will be provided for acts of liability in their capacity as a member of said committee only. The Medical Staff will initiate and adopt such Rules and Regulations as it may deem necessary for the proper conduct of its work and shall periodically review and revise its Rules and Regulations to comply with current Medical Staff practice. Applicants, practitioners with clinical privileges, and members of the Medical Staff will be governed by such Rules and Regulations.

12.8 SPECIAL ISSUES OF CONFIDENTIALITY

Other issues of confidentiality are to be handled according to applicable Medical Staff and Regional Compliance policies.

ARTICLE 13: GENERAL PROVISIONS

13.1 ADMISSION

Members of the Medical Staff will only admit patients if they have admitting privileges and for which they are capable, by training and experience, of providing care within accepted standards of care. All admissions will follow the process and documentation specified in Medical Staff policy.

13.2 HISTORY AND PHYSICAL

A medical history and physical exam will be completed on all patients admitted to an acute care facility, long-term care facility, or ambulatory surgical center in the Region. The timing, content, and validity of these histories and physical exams will comply with approved Medical Staff policy and will be compliant with all relevant laws and CMS regulations.

13.3 CONSENT FOR MEDICAL AND SURGICAL PROCEDURES

Informed consent for patients treated within all hospitals and facilities of the Region will conform to the relevant CMS regulations, Regional Compliance policies, and Medical Staff policies.

13.4 DUES OR ASSESSMENTS

The MEC shall have the power to set the amount of annual dues or assessments for each category of Medical Staff membership, to set and collect other assessments according to Medical Staff policy, and to determine the manner of expenditure of such funds received.

13.5 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. These Bylaws apply with equal force to both sexes wherever either term is used.

13.6 DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff offices, department chairmanships, or the MEC will, at least twenty (20) days prior to the date of election or appointment, disclose in writing to the MEC those personal, professional, or financial affiliations or relationships of which they are reasonably aware could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. A sample disclosure form is available upon request from the Medical Staff Services office.

13.7 CONFLICT MANAGEMENT

13.7.1 BETWEEN MEDICAL STAFF AND MEDICAL EXECUTIVE COMMITTEE

A conflict between the Medical Staff and the MEC is determined to exist when a written petition signed by 10% of the active and affiliate members in good standing and entitled to vote is submitted to the MEC. If the MEC is in agreement with the petitioned recommendation(s), as defined as a majority vote, then the procedures defined in Article 14 (Bylaws) or Article 16 (Policies) will be followed as applicable. If the MEC is in disagreement with the petitioned recommendations regarding a bylaw amendment, rule, regulation, or policy, the Medical Staff Conflict Management Policy should be followed. If the MEC is in disagreement with the petitioned recommendation regarding an issue other than a bylaw amendment, rule, regulation, or policy, the Conflict Management Policy should be followed.

13.7.2 BETWEEN LEADERSHIP GROUPS

Senior managers and leaders of the organized Medical Staff work with the Governing Body to develop an ongoing process for managing conflict between leadership groups to ensure the quality and safety of care (LD.02.04.01). Whenever a conflict arises that goes unresolved between the leadership groups, for example, the MEC and the Administration, the Conflict Management Between Leadership Groups policy will be implemented.

ARTICLE 14: ADOPTION AND AMENDMENT OF BYLAWS

Adoption, amendment, or repeal of these Bylaws will be considered on the request of the MEC or by written petition to the Board of Directors by 10% of the active and provisional staff in good standing. When bylaws revisions are proposed through a direct written petition submitted directly to the

Governing Body, the MEC will be notified. The MEC has thirty (30) days to provide their opinion to the Board but must proceed with the process of deliberation and voting as delineated below.

Acceptance or rejection of proposed adoption, amendment or repeal of Medical Staff Bylaws shall be taken only after:

- a. written notice of the proposed change was provided to all members before or during a regular or special meeting of the general Medical Staff during which the proposed changes to the Bylaws were presented and discussed, and
- b. notice is provided in advance of the day, time, and location of the subsequent meeting of the general Medical Staff at which the Bylaws changes will be discussed and receive a vote, and
- c. both notices shall include the exact wording of the existing bylaw language, if any, and the proposed change(s).

14.1 ACTION

Adoption, amendment, and repeal of Medical Staff Bylaws shall require an affirmative vote of the majority of Active and Affiliate Medical Staff members in good standing who are present and entitled to vote. Voting may be by a show of hands or by secret ballot. Failure to achieve a majority in the affirmative shall result in final rejection of the proposed adoption, amendment or repeal.

14.2 APPROVAL

- a. The Board shall review the proposed revision of the Bylaws at the next regularly scheduled meeting of the East Hawaii Regional Board. This review must be completed within sixty (60) days of the time the revisions are provided to the Board for consideration.
- b. The Board may approve the proposed Bylaws revisions without change. Upon this Board approval, the Bylaws revisions shall be in effect.
- c. The Board may approve the proposed Bylaws revisions with changes. The recommended changes must be submitted in writing to the MEC. The MEC must resolve these changes and submit the Bylaws to the Medical Staff for approval before resubmitting the amended Bylaws revisions to the Board.
- d. The Board may reject the proposed Bylaws revisions. This action will require resolution through the process defined in the Conflict Between Leadership Groups policy described in 13.6.2 above.
- e. If the East Hawaii Regional Board fails to approve or reject the Bylaws revisions within sixty (60) days of submission to the Board, the Bylaws revisions shall be approved by default and be in effect on the sixty-first (61st) day after submission.

14.3 EFFECT OF THESE BYLAWS.

Upon adoption and approval as provided in Article 14, in consideration of the mutual promises and agreements contained in these Bylaws, the hospitals and the Medical Staff, intending to be legally bound, agree that these Bylaws, including all duly executed amendments, shall constitute part of the contractual relationship existing between the hospitals and the Medical Staff members and Governing

Body, both individually and collectively. These Bylaws, and privileges of individual members of the Medical Staff accorded under these Bylaws, will be binding upon the Medical Staff and the Governing Body of any successor-in-interest in the hospitals of the Region.

14.4 DISUNIFICATION FROM THE UNIFIED MEDICAL STAFF

The Medical Staff of any hospital in the Region may disunify from the Unified Medical Staff. A petition to disunify must be presented to the Governing Body after a vote to disunify approved by no less than a majority vote of all Active and Affiliate Medical Staff assigned to the hospital seeking disunification. The vote on disunification must follow the procedural rules for bylaws amendments defined in Sections 14.1 and 14.2 above. Upon affirmative vote for disunification and approval of the Governing Body, the Medical Staff of the separating hospital shall become the unique Medical Staff of that hospital effective immediately, operating under the Medical Staff Bylaws in effect immediately prior to unification. Special Elections shall be called to elect officers, Department Chairs, and other Medical Staff leadership immediately consistent with the Medical Staff Bylaws in effect immediately prior to unification.

14.5 EFFECT OF DISUNIFICATION ON THESE BYLAWS

The withdrawal of one hospital from the Unified Medical Staff shall have no effect on the hospitals that remain. Application of these Unified Medical Staff Bylaws shall continue to govern the remaining Unified Medical Staff and be upheld by the Governing Body. Peer review and other activities of the Medical Staff and its members in the remaining Medical Staff shall continue unchanged.

14.6 AMENDMENTS IN URGENT OR EMERGENT CONDITIONS

Legislation, judicial rulings, or natural disasters may require amendment of the Bylaws on an urgent or emergent basis. In these conditions, the action and approval specified in Sections 14.1 and 14.2 cannot be completed in the necessary time span, and a process for expedited amendment must be followed. In all such cases, a quorum of the Medical Executive Committee shall convene on an urgent basis and draft the necessary amendment(s). On approval of the MEC members present, these amendments(s) will be forwarded to the Chair of the Governing Body for approval. Upon written approval of the Chair of the Governing Body, the urgent amendment(s) shall take full effect. The Medical Staff will be given notification of the urgent amendment(s) and reason for their adoption. Urgent amendment(s) to the Bylaws adopted under this section shall remain in effect only until the next regular or special meeting of the Active and Affiliate Medical Staff at which time the amendment(s) will be subject to the procedures for approval or rejection as specified in Sections 14.1 and 14.2 above.

ARTICLE 15: MEDICAL STAFF ROLE IN CLINICAL CONTRACTING

Prior to the granting of a clinical contract and upon renewal, the MEC will review and make recommendations for consideration of the CEO/CFO and the Governing Body regarding quality, safety, and appropriateness of care related to arrangements for physician and/or professional services.

ARTICLE 16: ADOPTION AND AMENDMENT OF POLICY AND PROCEDURES OR ORGANIZATIONAL PROTOCOLS AND ADDITIONAL ISSUES

The Unified Medical Staff shall have the authority to create and amend any policies, procedures, and protocols that are needed to conduct Medical Staff governance and to ensure safe, high-quality medical

care. These policies may apply specifically for any one of the hospitals in the Region or generally to the entire region, as appropriate.

16.1 PROCEDURE

Upon the communication to the MEC by a Medical Staff committee, division or department, a policy and procedure, or organizational protocol may be recommended to be adopted or amended by the MEC. All new policies or amended policies or organizational protocols are presented to the Medical Staff at the next regularly scheduled general Medical Staff meeting. All Medical Staff members are free to communicate with MEC if they disagree with any amendment to policies or protocols. Upon timely written petition signed by at least ten percent (10%) of the Active and Affiliate Medical Staff members in good standing and entitled to vote, consideration will be given to the amendment or repeal of Medical Staff policies or protocols that have been approved by the MEC at its next meeting. The MEC can adopt the proposal by majority vote. If the MEC rejects the proposal, then the Conflict Management process can be implemented per Medical Staff policy.

The organized Medical Staff has the ability to propose policies or organizational protocols directly to the Governing Body. Nothing in the foregoing is intended to prevent Medical Staff members from communicating with the Governing Body on a policy or organizational protocol adopted by the organized Medical Staff or the MEC or on any other issue. When a Medical Staff policy, organizational protocol, or any other issue is proposed through a written petition by ten percent (10%) of the Active and Affiliate Medical Staff members and submitted directly to the Governing Body, then MEC will be notified. The MEC has thirty (30) days to provide their opinion to the Board prior to Board action.

Policies and procedures approved by the MEC and/or adopted by the Medical Staff are sent to the Governing Body for consideration of acceptance or rejection of the recommendations.