No. 1

Writ of Summons (0.6, r.1)

IN THE GRAND COURT OF THE CAYMAN ISLANDS

CAUSE NO: OF 20

BETWEEN:

DR. SANJIB K. MOHANTY

PLAINTIFF

AND:

DOCTORS HOSPITAL CAYMAN

DEFENDANT

WRIT OF SUMMONS

DOCTORS HOSPITAL CAYMAN

16 Middle Road
PO Box 2000 KY1-1104
George Town, Grand Cayman
Cayman Islands

THIS WRIT OF SUMMONS has been issued against you by the above-named Plaintiff in respect of the claim set out on the next page.

Within [14 days] after the service of this Writ on you, counting the day of service, you must either satisfy the claim or return to the Court Office, P.O. Box 495G, George Town, Grand Cayman, the accompanying Acknowledgment of Service stating therein whether you intend to contest these proceedings.

If you fail to satisfy the claim or to return the Acknowledgment within the time stated, or if you return the Acknowledgment without stating therein an intention to contest the proceedings, the Plaintiff may proceed with the action and judgment may be entered against you forthwith without further notice.

Issued this day of 20 .

NOTE - This Writ may not be served later than 4 calendar months (or, if leave is required to effect service out of the jurisdiction, 6 months) beginning with the date of issue unless renewed by order of the Court.

IMPORTANT

Directions for Acknowledgment of Service are given with the accompanying form.

STATEMENT OF CLAIM

1. The Plaintiff was at all material times a registered Consultant General Surgeon/Urologist, with the Medical &Dental Council of the Health Practice Council of the Cayman Islands, with his primary offices situated at The Surgery, situated at No. 2 Smith Rd. Plaza, Grand Cayman, Cayman Islands

2. The Defendant was at all material times a provider of private-sector hospital and healthcare services within the Cayman Islands with its primary medical facility situated at, The Surgery,2 Smith Road Plaza, George Town, Grand Cayman, Cayman Islands.

3. By an agreement made between the Plaintiff and the Defendant on or around the year 2000 when the when DH first opened its doors and was known as Chrissie Tomlinson Hospital, the Plaintiff was at all material times a member of the medical staff of the Defendant, through the granting of 'privileges' by the Defendant to the Plaintiff.

4. The Plaintiff though not directly employed by the Defendant, was credentialed as a member of the Defendant's medical staff, who provides a medical level of care and/or performed surgical tasks consistent with the clinical privileges granted by the Defendant through its Board of Directors.

5. As between the Plaintiff and the Defendant "privileges" means the authorization granted by the Defendant, through its Board of Directors, to the Plaintiff to render specific patient care services, for which the Defendant's Medical Staff leaders and Board of Directors have developed eligibility and other credentialing criteria; ongoing professional practice evaluation review criteria; and focused professional practice evaluation review criteria. The privileges had been granted on the basis of training and qualifications that are typical of the defined specialty or subspecialty of each Practitioner.

6. There was no fixed term for the termination and or extension of privileges by the Defendant to the Plaintiff.

7. The said agreement was made partly orally, partly in writing and partly by conduct.

8. In so far as it was orally the said agreement as made at interviews on or about the year 2000 when the Plaintiff first became a member of the medical staff, between the plaintiff and the Defendant's authorized representatives.

9. In so far as the agreement was in writing, the said agreement was contained in or is to be inferred from the following documents [ANNEX 1 – STATEMENT OF CLAIM]:

   I. Chrissie Tomlinson Memorial Hospital Medical Staff Bylaws – Medical Staff ByLaws, Polices and Rules and Regulations – Effective date: January 1, 2014; and

   II. Doctors Hospital Medical Staff ByLaws.

10. In so far as the agreement was by conduct, the conduct consisted of or is to be inferred by the following conduct:

I. Continuation of the extension of privileges to the Plaintiff, once the Defendant is satisfied that:

   i. The Plaintiff's continued licensure, as a registered Consultant General Surgeon/Urologist, with the Medical & Dental Council of the Health Practice Commission of the Cayman Islands.
   ii. The Plaintiff is not compromised by disciplinary actions of licensing and certification agencies; and
   iii. The Plaintiff is physically and mentally able to provide patient care and treatment without supervision.

II. Further or in the alternative, by the course of dealings between the parties, it was agreed that privileges will only be suspended or revoked for good cause; and

III. Further or in the alternative, by the course of dealings between the parties, it was agreed either party to the agreement can choose to terminate the agreement, without good cause, subject to providing the other party with reasonable notice of that intention.

11. The agreement between the Plaintiff and the Defendant continued until on or about 29th January 2024.

12. On or around December 2023 the Defendant, having decided to seek accreditation from the Joint Commission International (JCI), which provides international accreditation standards for hospitals, informed the Plaintiff that as a result of their decision the Plaintiff would now be required to provide consent for Primary Source Verification (PSV) of his credentials.

13. JCI accreditation is not required or mandated by any Health Regulatory body in the Cayman Islands.

14. This was a unilateral decision by the Defendant. Nevertheless, this did not pose an issue for the Plaintiff as the PSV procedure had been carried out quite successfully in the past, in relation to his credentials by two (2) other JCI accredited Hospitals in the Cayman Islands, namely Health Services Authority of the Cayman Islands, and Health City Cayman Islands.

15. The Defendant confirmed that they were aware of the verification of the Plaintiff's credentials by these JCI accredited Hospitals.

16. There was no indication from the Defendant of any consequences that may follow from the verification process they had chosen to embark upon and how this may impact on the Plaintiff.

17. The Plaintiff complied with this added verification requirement from the Defendant, by personally signing the Consent form authorising for PSV, informing the Defendant that he has privileges extended to him at Health City and the Cayman Islands Health Services Authority (HSA), which are both JCI accredited Hospitals.

18. The Defendant then requested additional information from the Plaintiff stating that they are embarking on primary source verification as part of the JCI accreditation process. The information sought specifically was:

I. How to verify the Plaintiff's training in India – 1980; and also

II. General Surgery and Urology training in the UK - 1990.

19. This was a clear indication that the Defendant was either unable or unwilling to carry out the necessary due diligence required of it in order to properly conduct their own PSV/JCI accreditation.

20. The Defendant decided to use their own failures in properly conducting PSV to effectively deny privileges being extended to the Plaintiff. Despite there being available other acceptable means, through JCI, of verifying the Plaintiff's credentials, the defendant continued to deny privileges to the Plaintiff.

21. The Defendant even chose to disregard the steps recommended by the JCI that should and could have been taken in the event of their failure, despite best efforts, to complete PSV in relation to the Plaintiff's credentials.

22. The Plaintiff expressed his view to the Defendant that he was not in agreement with any suggestion that his continued privileges at the Defendant being linked to a JCI primary source verification of his credentials and agreed to meet with the Defendant to discuss the matter.

23. On January 29, 2024, following the meeting with the Defendant, the Plaintiff was told by the Defendant that his privileges had been granted for a maximum of 3 years and that it had now expired.

24. The defendant told the Plaintiff that he had to reapply for the privileges to be extended, even though the Defendant confirmed receipt of credentialling forms on 8th Jan 2024.

25. There was never a term limit placed on the privileges extended to the Plaintiff by the Defendant and as such those privileges were never subject to expiration.

26. The Defendant, without good cause, revoked the privileges extended to the Plaintiff forthwith, in breach of their agreement.

27. The Defendant failed to provide the Plaintiff with reasonable notice of its decision to revoke the privileges extended to the Plaintiff.

28. The Defendant failed to provide the Plaintiff any opportunity of Appeal against the decision to revoke his privileges.

29. As at the 29th January 2024 the Plaintiff was no longer able to provide a medical of care and/or perform surgical tasks for his patients at the Defendant's medical facility.

30. The Plaintiff thereafter was compelled to advise all the patients he would usually provide medical care to at the Defendant's medical facility that he can no longer do so, which inevitably resulted in many patients questioning his qualifications and competence.

31. The Plaintiff had to bear the added expense of re-scheduling all is intended appointments with patients at the Defendant's medical facility to other medical facilities. The patients that were not minded to use another facility never returned to the Plaintiff for medical care.

32. The Plaintiff lost the use of the Rezum equipment, which was available only at the Defendant's medical facility, and as such he can no longer provide that particular surgical care to any of his patients.

33. After the Defendant's decision, on the 22nd February 2024 Plaintiff wrote to the Defendant requesting that it reconsiders its decision to revoke his privileges, pointing out that his privileges were unreasonable revoked and highlighting the irreparable reputational damage caused to the Plaintiff as a result of the Defendant's decision. [ANNEX 2 – STATEMENT OF CLAIM]

34. In the Plaintiff's correspondence dated 22nd February 2024 it was highlighted to the Defendant that there were other acceptable means by which the Defendant can verify the Plaintiff's credentials and suggested that the Defendant use those means of verification.

35. On the 24th February 2024 the Defendant responded on the Plaintiff insisting that there was a term limit attached to the Plaintiff's privileges and that the Plaintiff had to undergo primary source verification. The Defendant further indicated that the Plaintiff was also required to undergo a Professional Practice Evaluation before being able to be granted privileges. [ANNEX 3 – STATEMENT OF CLAIM]

36. On the 22nd March 2024 the Plaintiff again wrote to the Defendant urging a reconsideration of it's decision. The Plaintiff again provided information that the Defendant stated it required to complete primary source verification and indicated that he was willing to undergo the further requirement of Professional Practice Evaluation. [ANNEX 4 – STATEMENT OF CLAIM]

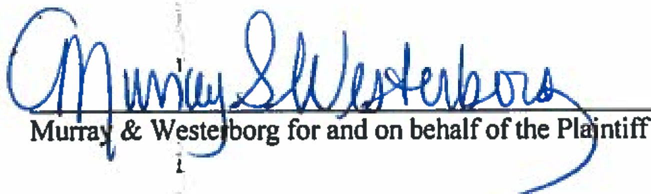
37. The Defendant failed to further respond to the Plaintiff, despite the Plaintiff writing again to the Defendant on the 17th April 2024. [ANNEX 5 – STATEMENT OF CLAIM]

38. As a result of the Defendant's actions the Plaintiff has suffered damage and loss.

AND THE PLAINTIFF claims:

1. Damages for reputational damage;
2. Loss of prospective earnings; and
3. Costs.

Dated 6th August 2024



Murray & Westerborg for and on behalf of the Plaintiff

THIS WRIT was issued by on behalf of the Plaintiff *c/o Murray & Westerborg, Attorneys-at-Law, whose address for service is PO Box 10067, No. 10 Shipping Lane, 2nd Floor, Cayman Shipping Centre Building, Grand Cayman, KY1-1001, Cayman Islands.*

IN THE GRAND COURT OF THE CAYMAN ISLANDS

CAUSE NO: OF 20

BETWEEN:

DR. SANJIB K. MOHANTY

PLAINTIFF

AND:

DOCTORS HOSPITAL CAYMAN

DEFENDANT

ANNEX 1

These are copies of the following documents, referred to as Annex 1 in the Plaintiff's Statement of Claim:

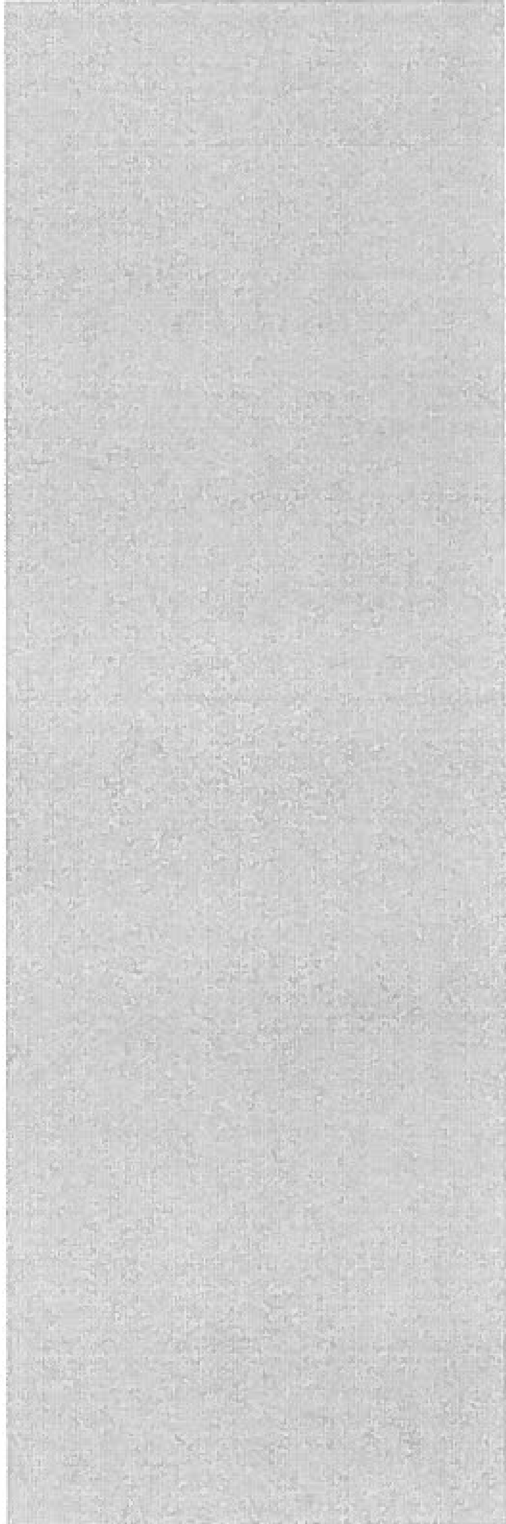
1. Chrissie Tomlinson Memorial Hospital Medical Staff Bylaws – Medical Staff ByLaws, Polices and Rules and Regulations – Effective date: January 1, 2014; and

2. Doctors Hospital Medical Staff ByLaws.

CHRISSIE TOMLINSON MEMORIAL HOSPITAL MEDICAL STAFF BYLAWS

MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS

Effective Date: January 1, 2014



CTMH MEDICAL STAFF
BYLAWS

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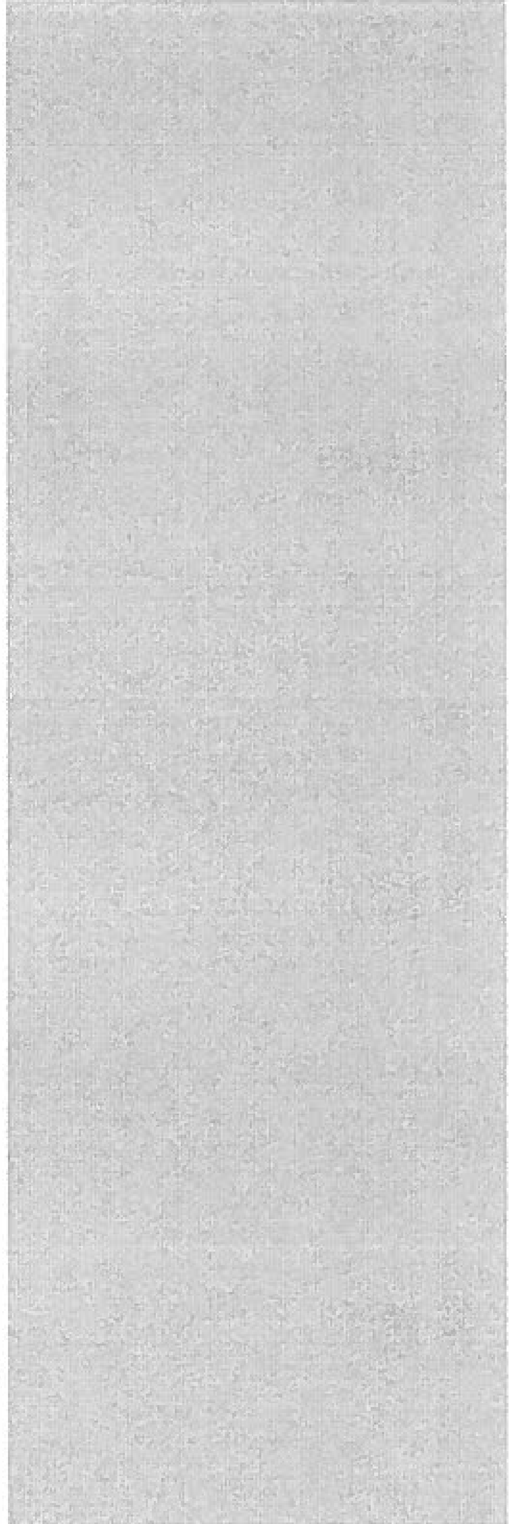

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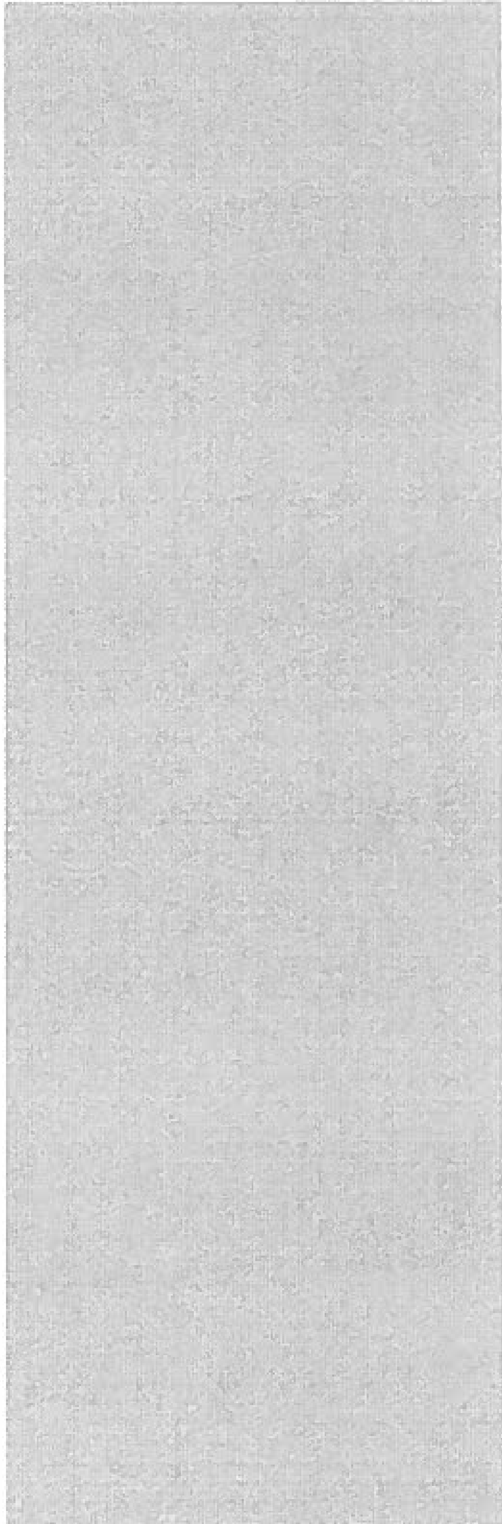

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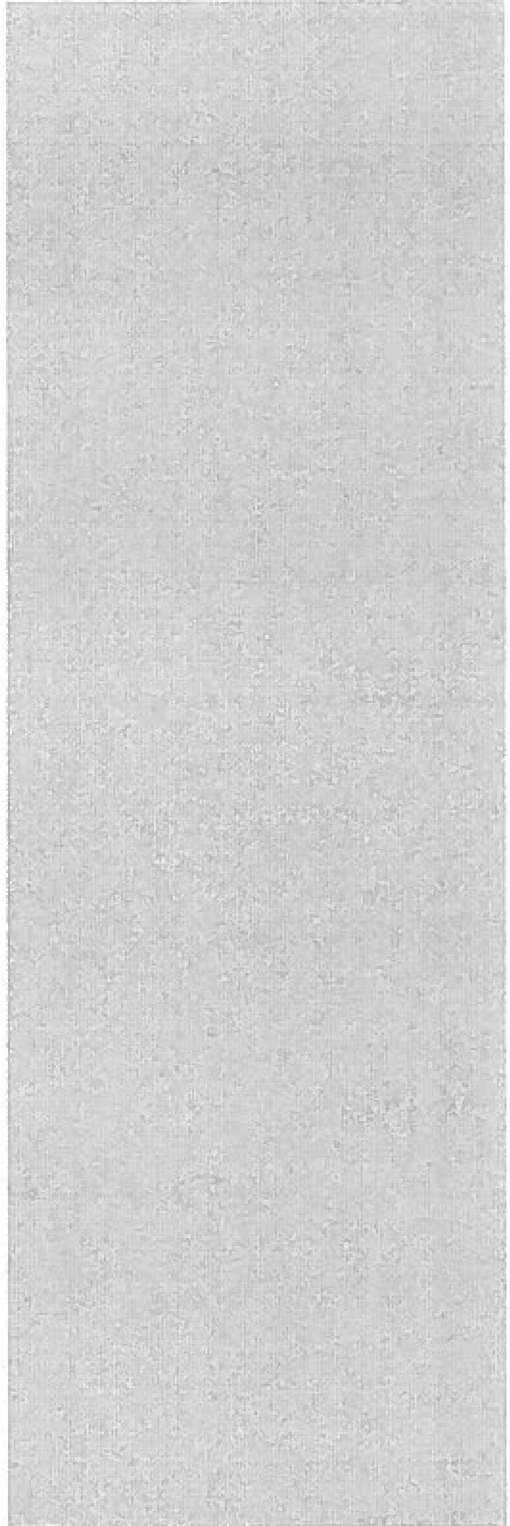

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The following definitions shall apply to terms used in these Bylaws and related policies and manuals:

(1) "ALLIED HEALTH PROFESSIONAL" means a health care practitioner other than a physician, dentist, podiatrist, or oral surgeon who is authorized to provide patient care services in the Hospital.

(2) "BOARD OF DIRECTORS" means the Board of Directors of the Hospital, which has the overall responsibility for the Hospital, or one of its designated committees.

(3) "CATEGORY I - EMPLOYED PRACTITIONER" means a Licensed Employed Practitioner, or an Employed Allied Health Professional who is permitted by law and by the Hospital to provide patient care services without direction or supervision, within the scope of his or her license and consistent with the clinical privileges granted.

(4) "CATEGORY II – INDEPENDENT PRACTITIONER" means an Independent Practitioner (not directly employed by CTMH) credentialed as a member of the CTMH Medical Staff , or an Independent Allied Health Professional (not directly employed by CTMH) who provides a medical level of care or performs surgical tasks consistent with the clinical privileges granted by the CTMH Board of Directors.

(5) "CATEGORY III – VISITING SPECIALIST PRACTITIONER" means a Dependent Practitioner, who resides and normally practices outside the Cayman Islands, who is Registered to practice within the Country and who does so as an employee of CTMH or another health care service provider in the Country. Said Practitioner can practice only within the limits of the privileges granted by the Credentials and Privileges Committee of the Medical Staff and ratified by the CTMH Board of Directors.

(6) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the CTMH Board of Directors to a practitioner to render

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specific patient care services, for which the Medical Staff leaders and Board of Directors have developed (i) eligibility and other credentialing criteria, (ii) ongoing professional practice evaluation review criteria, and (iii) focused professional practice evaluation review criteria. Said privileges shall be granted on the basis of training and qualifications that are typical of the defined specialty or subspecialty of each Practitioner.

(7) "CODE OF CONDUCT" means the Hospital's Medical Staff guidelines for actions and behaviors relating to ALL practitioners who are granted privileges for practicing any services offered by each Medical Staff of Hospital. The Code of Conduct is incorporated in its entirety into these Bylaws by reference, as amended by the Medical Staff Executive Committee from time to time. Every member of the Medical Staff shall sign a copy of the Code of Conduct as a condition for becoming, and remaining, a member of the CTMH Medical staff.

(8) "CORE PRIVILEGES" means a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in Medical residency and/or fellowship training for that specialty or subspecialty and which have been determined by the Medical Staff leaders and Board of Directors to require closely related skills and experience. The Credentials and Privileges Committee of the Medical Staff will establish, publish and annually review the Core Privileges for each defined specialty within the Hospital.

(9) "CREDENTIALS POLICY" means the Hospital's Medical Staff Policy on Appointment, Reappointment and Clinical Privileges.

(10) "DAYS" means calendar days.

(11) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").

(12) "EXECUTIVE SESSION" is a portion of a meeting of a Medical Staff committee or department which only the voting Medical Staff members may attend, along with senior Hospital management. Executive Sessions may be called by the presiding officer, and are intended to be utilized to discuss peer review issues, personnel issues, or any other issue requiring confidentiality.

(13) "HOSPITAL" means CTMH.

(14) "Hospitalist" refers to the physician who practices primarily in-house over the around the clock or at night to provide essential physician services to the inpatients, as might be required, in coordination with the Attending Physician of the patients admitted to the Hospital.

(15) "MEDICAL STAFF EXECUTIVE COMMITTEE" ("MSEC") means the Executive Committee of the Medical Staff.

(16) "MEDICAL STAFF" means all physicians, dentists, oral surgeons, and podiatrists who have been appointed and granted clinical privileges by the Medical Staff and by the Board of Directors.

(17) "MEDICAL STAFF LEADER" means any Medical Staff officer, Chief of Service (as might be designated), and committee chair.

(18) "MEMBER" means any physician, dentist, oral surgeon, and podiatrist who has been granted Medical Staff appointment and clinical privileges by the Board of Directors to practice at the Hospital.

(19) "NOTICE" means any written communication by regular mail, e-mail, facsimile, Hospital mail, or hand delivery.

(20) "ORAL OR MAXILLOFACIAL SURGEON" means an individual with a D.D.S. or a D.M.D. degree, who has successfully completed an accredited post-graduate training program in oral and maxillofacial surgery.

(21) "ORGANIZED HEALTH CARE ARRANGEMENT" describes a clinically-integrated care setting in which patients typically receive health care services and/or treatment from more than one provider (such as a Hospital and its Medical Staff members).

(22) "PATIENT CONTACT" includes any admission, assumption of care, consultation, procedure (inpatient or outpatient), or response to emergency call performed in the Hospital. It shall not include referrals for diagnostic or laboratory tests, or for non-diagnostic treatments or procedures.

(23) "PERMISSION TO PRACTICE" means the authorization granted to Physicians and Allied Health Professionals by the Hospital Administrator according to the oversight of the Board of Directors as applicable to a specific specialist or subspecialist, to exercise a scope of practice and/or clinical privileges.

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(24) "PHYSICIAN" includes all those with qualifications recognized by the Cayman Islands medical and Dental Council that legally allows them to practice medicine within the Cayman Islands.

(25) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").

(26) "ADMINISTRATOR" means the individual appointed by the Chief Executive Officer and/or Board of Directors to act on its behalf of the overall management of the Hospital.

(27) "SPECIAL NOTICE" means hand delivery, postal service certified mail (return receipt requested), or overnight delivery service providing receipt.

(28) "SPECIAL PRIVILEGES" means privileges that fall outside of the Core Privileges for a given specialty, which require additional and/or specialized Medical education, training, or experience beyond that required for core privileges in order to demonstrate competence.

(29) "UNASSIGNED PATIENT" means any individual who comes to the Hospital for care and treatment and who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him/her care while a patient at the Hospital. Unassigned patients should be assigned Active Medical Staff Members who are deemed in "Good Standing". This means Members who are meeting all Terms and Conditions of the Medical Staff By-Laws. This would include participation on Medical Staff committees.

1.B. TIME LIMITS

Time limits referred to in these Bylaws are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

(1) Unless otherwise provided in the Bylaws, when a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees. This may not apply to Committee assignments. Some delegation to address Committee responsibility might be inappropriate given the unique scope of the Committee. For example, the Medical Staff Executive Committee routinely addresses

matters that should not involve stand-ins.

(2) When a Medical Staff member is unavailable to perform a necessary function, one or more of the Medical Staff Leaders shall perform the function personally or delegate it to another appropriate individual, as appropriate.

1.D. MEDICAL STAFF DUES

At the time of writing, no medical staff dues are required. However, if they are implemented by MSEC the following rules will apply:

(1) Annual Medical Staff dues shall be collected, as recommended, by the full Medical Staff and may vary by category. Dues which are collected by the Medical Staff, shall be maintained by and applied by the Medical Staff at its discretion, as determined by the MSEC

(2) Dues shall be payable annually upon request by the Medical Staff Leader/Chief of Staff. Failure to pay dues shall result in ineligibility to apply for Medical Staff appointment or reappointment, as may be the case.

(3) Signatories to the Hospital's Medical Staff account shall be the Chief of Staff and the Chief of Staff-Elect.

1.E. GOVERNING LAWS

The Medical Staff Bylaws, Policies, Rules and Regulations and related documents have been drafted in accordance with pertinent and relevant Cayman Islands Bylaws and Regulations and shall be interpreted in accordance with those laws.

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in the Hospital's Credentials Policy are eligible to apply for appointment to one of the following categories:

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who: (a) are involved in at least one hundred (100) patient contacts per Calendar Year at CTMH, and who are physically present in the Hospital for at least two (2) working days in six (6) out of twelve (12) Calendar Months.

(b) Have demonstrated a commitment to the Medical Staff and Hospital through voluntary service on Hospital committees – where physician participation on said Committee is deemed necessary by the Medical Staff Executive Committee (MSEC) – or established Medical Staff Committees.

(c) An Active Medical Staff member can be a CTMH Employed Physician or an Independent Practice Physician (IPP) who has been credentialed and granted specific privileges to practice at CTMH.

Guidelines

Unless an Active Staff member can definitively demonstrate to the satisfaction of the Credentials and Privileges Committee at the time of reappointment that his/her practice patterns have changed and that he/she satisfies the activity requirements of this category:

1. Any member who has less than 100 patient-contacts in a Calendar Year or who has not been in the hospital attending to patients for at least two (2) days in each of six (6) months within the same Calendar Year may not be eligible to request Active Staff status at the time of his/her reappointment; and

2. The member must request another staff category that best reflects his/her relationship to the Medical Staff and the Hospital.

2. A.2. Prerogatives:

Active Staff Members:

(a) May admit patients without limitation, in accordance with the Core Privileges and Special Privileges that have been granted by the Credentials and Privileges Committee and ratified by the Board of Directors, except as otherwise provided for in the Bylaws or Bylaws-related documents, or as limited by the Credentials and Privileges Committee and/or the Board of Directors.

Commented [e1]: An example of this would be where the physician has been Privileged to perform a procedure in the past but is now under remedial action or is being proctored to perform a Special Privilege beyond the scope of Core Privileges.

(b) May vote in all general and special meetings of the Medical Staff

and applicable Committee meetings;

c) May hold office, serve as Chief of Service (for any Service that may be defined by the MSEC), and serve on Medical Staff Committees and sit as the chairs of such Committees; and

(d) May exercise such Core Privileges and Special Privileges as are granted to them by the Credentials and Privileges Committee.

Commented [a2]: Core Privileges for an Orthopedic Surgeon might not include the use of Stem Cells in a procedure. The "authorization to conduct a procedure which includes the injection of Stem Cells could be a Special Privilege. This becomes a significant distinction as CTMH looks to doing avant-garde Medical Tourism

2.A.3. Responsibilities:

(a) Active Staff members must:

(1) Assume all the responsibilities of membership on the Active Staff, including committee service, providing specialty or other coverage for the Hospital as required, negotiated and mutually agreed, providing care for unassigned Hospital patients, and participating in evaluation of fellow Medical Staff members during any designated provisional period(s). Such "provisional period(s)" may include, but may not be limited to, a period of required Proctorship during which the scope of Special Privileges are being established, or a period during which remedial oversight of another qualified Medical Staff member is prescribed for any reason. "Other" coverage may include staffing of the Urgent Care Department and/or the Hospitalist function, as might be required in an emergency situation. Only members of the Active Medical Staff may participate in a Peer Review activity;

(2) Actively participate in routine professional practice evaluation and performance improvement processes of members of Medical Staff and the Medical Staff-at-Large;

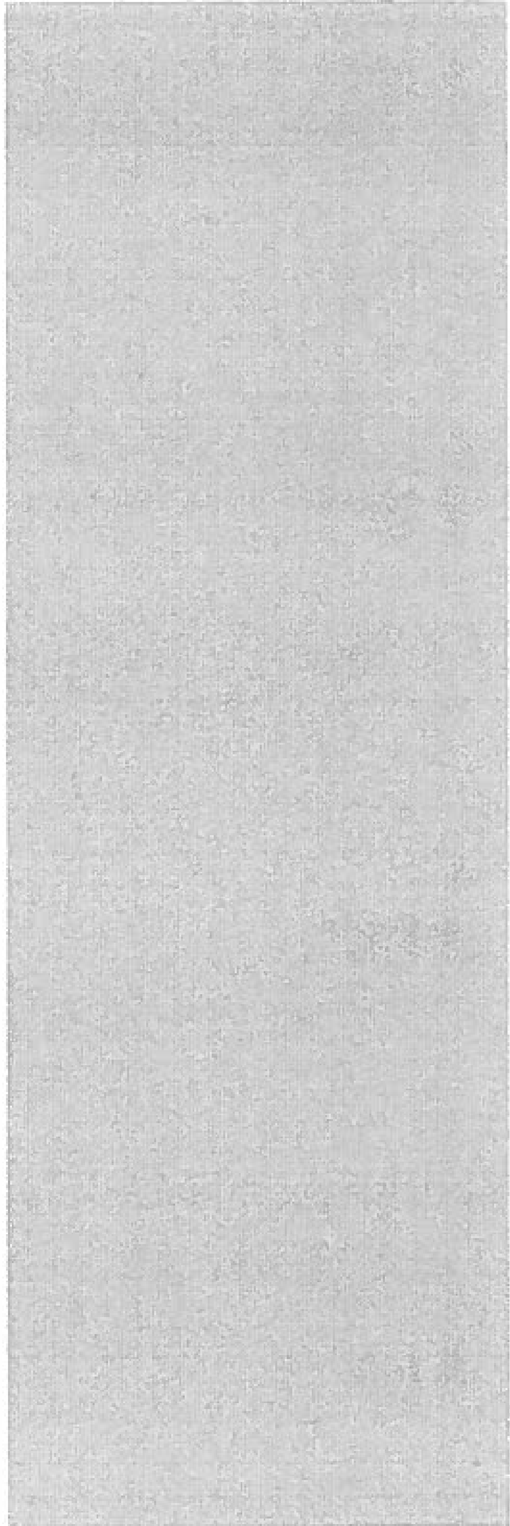
(3) Accept appropriate consultation requests, if able and willing to do so.

(4) Attend applicable meetings;

(5) Pay applicable fees, dues, and assessments;

(6) Perform other duties assigned by the Medical Staff Leaders; and

(7) In the event that the Hospital's Disaster Plan is activated, the Medical Staff Member shall come to the Hospital promptly, if called, and perform duties assigned by the



Medical Staff Leaders.

2.B. COURTESY STAFF

2.B.1. Qualifications:

The Courtesy Staff shall consist of those physicians, dentists, oral surgeons, and podiatrists who:

(a) Are involved in the care of fewer than one hundred (100) patient contacts per Calendar Year, and who are not in the hospital providing patient care for a minimum of two (2) working days in at least six (6) of twelve (12) Calendar Months;

(b) Are members in good standing of the Active Staff at another hospital, whether in the Cayman Islands or in an international venue (provided said physician is Registered to practice medicine in the Cayman Islands). The Work Permits of Courtesy Staff, if required, need not be held by CTMH; and;

(c) At the time of each re-appointment, provide such quality data and other pertinent information, as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges. Examples include but not limited to, information from another hospital, information from the individual's office practice, information from appropriate physician review organizations, local or international (as the physicians nationality and training history might dictate), and/or receipt of confidential evaluation forms completed by referring/referred to physicians.

Guidelines

Unless a Courtesy Staff member can definitively demonstrate to the satisfaction of the Credentials and Privileges Committee at the time of reappointment that his/her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

1. Any member who has less than the required patient contacts in the Calendar Year or has been in the Hospital fewer than two (2) days in each of six separate months of the same Calendar Year, must request another staff category that best reflects his/her relationship to the Medical Staff and the Hospital;.

2. Any member who exceeds the upper threshold criteria of the

Courtesy Medical Staff and meets the criteria of Active Medical Staff, must request another staff category that best reflects his/her relationship to the Medical Staff and the Hospital (options – Active or Coverage).

2. B.2. Prerogatives/Responsibilities:

Courtesy Staff members:

(a) May attend and participate in Medical Staff and Hospital meetings (without vote);

(b) May not hold office or serve as Chief of Service or Committee chair;

(c) Shall generally have no staff Committee responsibilities, but may be assigned to Committees (to share expertise);

(d) Are excused from providing specialty coverage for the Urgent Care and Hospitalist role and providing care for unassigned patients, unless the MSEC finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

(e) Shall cooperate in the professional practice evaluation and performance improvement processes of the Hospital; and

(f) Shall pay applicable fees, dues, and assessments.

2.C. CONSULTING STAFF

2.C.1. Qualifications:

The Consulting Staff shall consist of those physicians who:

(a) Are of recognized professional ability and expertise who provide a service that is not available on the Active Staff (should the service become available on the Active Staff, the Consulting Staff members would not be eligible to request continued Consulting Staff status at the time of their next reappointments);

(b) Have been specifically invited by the MSEC and the Board of Directors to apply for Consulting Staff status;

(c) Provide services at the Hospital only at the request of members of the Medical Staff;

(d) Are members in good standing of the Active Staff at another hospital

(unless this requirement is waived by the Board of Directors after considering the recommendations of the Credentials and Privileges Committee and the MSEC); and

(e) At each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

2.C.2. Prerogatives/Responsibilities:

Consulting Staff Members:

(a) May evaluate and treat (but not admit) patients in conjunction with members of the Medical Staff;

(b) May not hold office or serve as service line chairs or committee chairs;

(c) May attend meetings of the Medical Staff and applicable service line meetings (without vote);

(d) Shall generally have no staff Committee responsibilities, but may be assigned to Committees (with vote);

(e) Are excused from providing call coverage and from providing care for unassigned patients unless the MSEC determines otherwise after reviewing the facts and circumstances and the needs of the hospital; and

(f) Shall pay applicable fees, dues, and assessments.

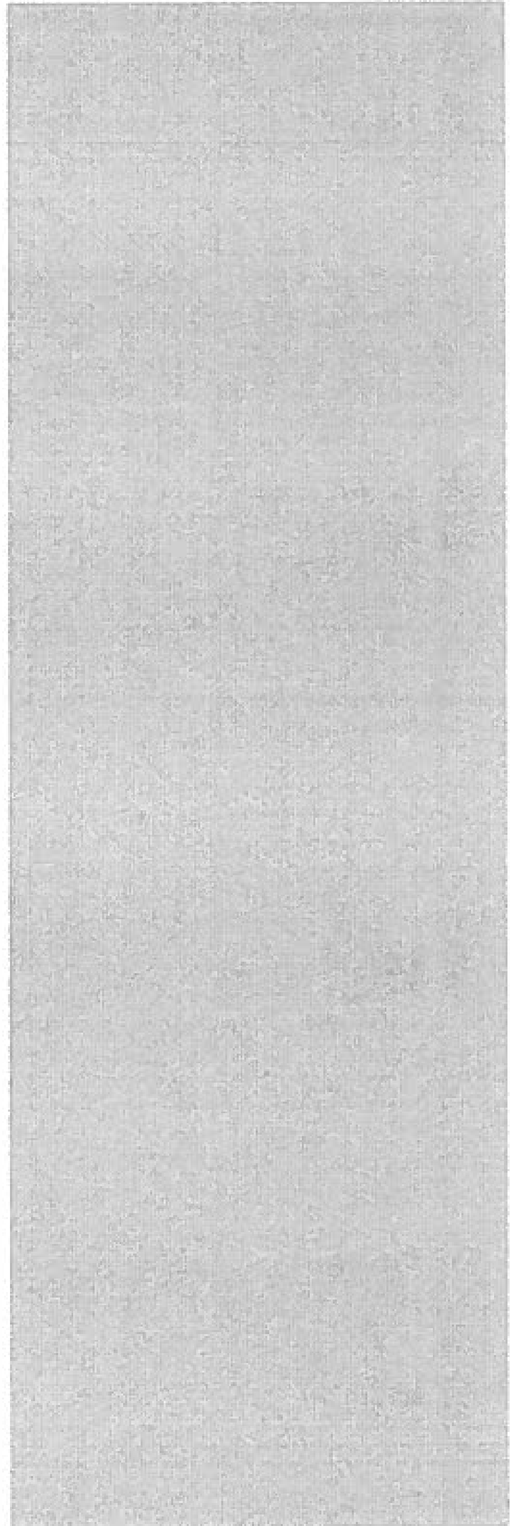
2.D. COVERAGE STAFF

2.D.1. Qualifications:

The Coverage Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) Desire appointment to the Medical Staff solely for the purpose of being able to provide coverage assistance to Active Staff members;

(b) Are members in good standing of the Active Staff at another hospital or



have established private practices within the Cayman Islands community and do not ordinarily admit patients to a hospital. This requirement may be waived by the Board of Directors after considering the recommendations of the Credentials and Privileges Committee and the MSEC);

(c) At each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians);

(e) Agree that their Medical Staff appointment and clinical privileges will be automatically relinquished, with no right to a hearing or appeal, if their coverage arrangement with the Active Staff member(s) terminates for any reason.

<u>2. D.2. Prerogatives/Responsibilities</u>:

Coverage Staff members:

(a) When providing coverage assistance for an Active Staff member, shall be willing to admit and/or treat patients who are the responsibility of the Active Staff member that is being covered (i.e., the Active Staff member's own patients or unassigned patients);

(b) Shall be entitled to attend Medical Staff and hospital committee meetings (without vote);

(c) Shall assume all Medical Staff functions and responsibilities as may be assigned, including, where appropriate, care for unassigned patients, consultation and teaching assignments when covering for members of their group practice;

(d) Shall generally have no staff committee responsibilities, but may be assigned to Committees (with vote);

(e) May not serve as an officer, a service chair, or a

Committee chair;

(f) Shall pay applicable fees, dues, and assessments; and

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(g) In the event that the Hospital's Disaster Plan is activated, shall come to the Hospital promptly, if called, and perform duties assigned by the Medical Staff Leaders (this applies only when the Coverage Staff member is covering for an Active Staff member).

2.E. AMBULATORY CARE STAFF

2.E.1. Qualifications:

(a) The Ambulatory Care Staff consists of those physicians, dentists, oral surgeons, and podiatrists who desire to be associated with the Hospital but who do not wish to exercise clinical privileges on an inpatient basis.

(b) The primary purpose of the Ambulatory Care Staff is to permit these members to access inpatient Hospital services for their patients by referral to members of the Active Staff, while at the same time providing follow-up care, on an outpatient basis, and those discharged by the hospitalist service and providing additional physician alternatives for patients with outpatient needs.

(c) Individuals requesting appointment to the Ambulatory Care Staff must submit an application as prescribed in the Credentials and Privileges Policy.

2. E.2. Prerogatives & Responsibilities

Ambulatory Care Staff members:

(a) May attend meetings of the Medical Staff and applicable service lines (all without vote);

(b) Shall generally have no staff Committee responsibilities, but may be assigned to Committees (with vote);

(c) May attend educational activities sponsored by the Medical Staff and the Hospital;

(d) May refer patients to members of the Active Staff for admission and/or care;

(e) Are required to submit their relevant outpatient records for inclusion in the Hospital's medical records for any patients who are referred;

(f) Are also required to communicate directly with the Active Staff members about the care of any patients referred, as well as to visit

any such patients and record a courtesy visit note in the medical record containing relevant information from the patients' outpatient care;

(g) May review the medical records and test results (via paper or electronic access) for any patients who are referred;

(h) May perform preoperative history and physical examinations in the office and enter those reports into the Hospital's medical records;

(i) May not admit patients, attend patients, exercise inpatient clinical privileges, write inpatient orders or progress notes, perform consultations, assist in surgery, or otherwise participate in the provision or management of clinical care to inpatients at the Hospital, but may apply for and be granted appropriate clinical privileges for ambulatory care only;

(j) Establish and provide the Hospital with evidence of a formal arrangement with a member of the Active Staff to provide inpatient care for their patients;

(k) Actively participate in the professional practice evaluation and performance improvement processes, as pertinent to their scope of practice;

(l) May refer patients to the Hospital's diagnostic facilities;

(m) Must accept referrals from the Urgent Care Department and from hospitalists for follow-up care of patients treated in the Emergency Department and/or discharged by the hospitalist service; and

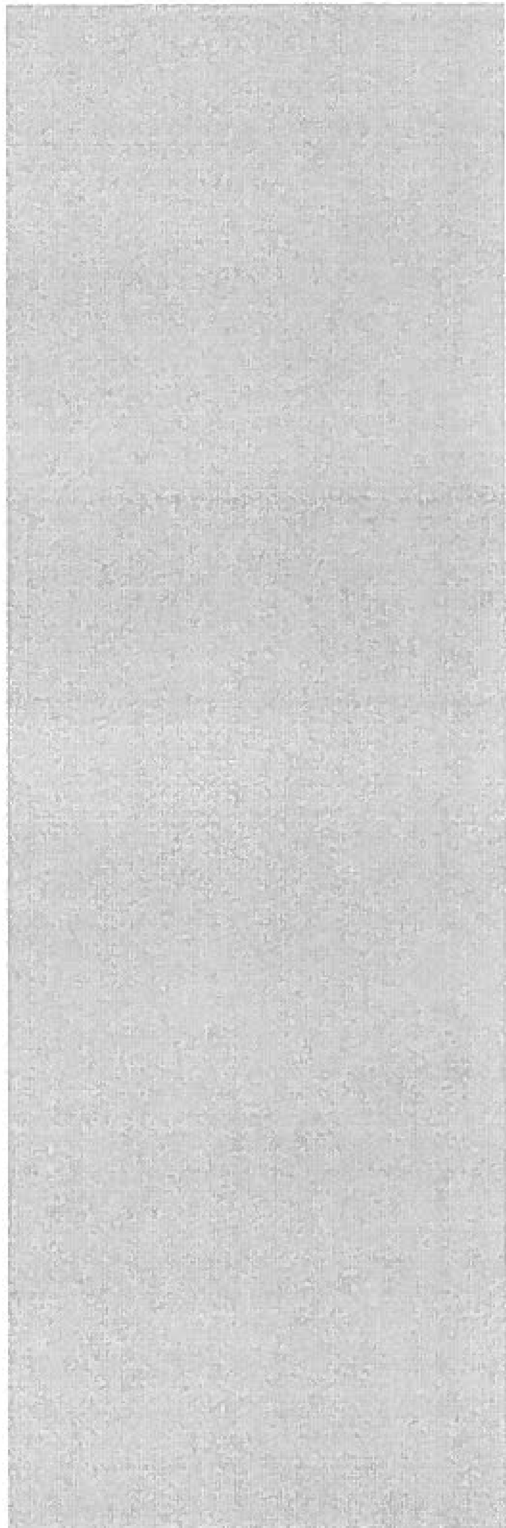
(n) Pay applicable fees, dues, and assessments.

2.F. HONORARY STAFF

2.F.1. Qualifications:

(a) The Honorary Staff shall consist of practitioners who are recognized for outstanding and/or noteworthy contributions to the medical profession or have a record of previous long-standing service to the Hospital and have retired from the active practice of medicine.

(b) Once an individual is appointed to the Honorary Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application/reappointment processing.



2.F.2. Prerogatives and Responsibilities:

Honorary Staff members may:

(a) Not consult, admit, or attend to patients;

(b) Attend Medical Staff and service line meetings when invited to do so (without vote);

(c) Be appointed to Committees (with vote);

(d) Not vote, hold office, or serve as a service line chair; and

(e) Not pay any fees, dues, or assessments.

ARTICLE 3

OFFICERS

3. A. DESIGNATION

The officers of the Medical Staff shall be the Chief of Staff, Immediate Past-Chief of Staff and the Chief of Staff-Elect.

3. B. ELIGIBILITY CRITERIA

Only those members of the Active Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff. They must:

(1) Be appointed in good standing to the Active Staff and have served on the Active Staff for at least five years;

(2) Have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;

(3) Not presently be serving as Medical Staff officers, Board of Directors members or department/service line chairs at any other hospital and shall not so serve during their terms of office;

(4) Be willing to faithfully discharge the duties and responsibilities of the position;

(5) Have experience in a leadership position, or other involvement in performance improvement functions, for at least two years;

(6) Attend continuing education relating to Medical Staff leadership and/or credentialing functions prior to or during the term of the office;

(7) Have demonstrated an ability to function collegially and cooperatively in the performance of Medical Staff responsibilities; and

(8) Provide full disclosure of any financial relationship (i.e., an ownership or investment interest in or compensation arrangement) with an entity that competes with the Hospital or any affiliate or any financial relationship with the Hospital itself. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner.

These eligibility criteria are also used in the selection process for service line and committee chairs unless indicated otherwise in those sections of the Bylaws.

3. C. DUTIES

3. C.1. Chief of Staff:

The Chief of Staff shall:

(a) Act in coordination and cooperation with Hospital Administration in matters of mutual concern involving the care of patients in the Hospital and affiliated entities;

(b) Be accountable to the Board of Directors in conjunction with the MSEC for the quality and efficiency of clinical services and performance within the Hospital and affiliated entities;

(c) Receive, develop, and interpret the policies of the Board of Directors and Hospital Administration to the Medical Staff;

(d) Represent and communicate the views, policies, and needs of, and report on the activities of, the Medical Staff to the Administrator and the Board of Directors;

(e) Direct the development of, and adherence to, policies and procedures which organize and govern Medical Staff affairs and professional practice within the Hospital;

(f) Participate in ensuring compliance with standards of ethical conduct and professional demeanor among the members of the

Medical Staff in their relations with each other, the Board of Directors, Hospital management, other professional and support staff, and the community the Hospital serves;

(g) Provide leadership in accomplishing process measurement, assessment, and improvement initiatives related to organization performance improvement activities, and encourage physicians to assume a leadership role when a clinical process is the primary responsibility of physicians;

(h) Call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the MSEC;

(i) Unless otherwise specified, appoint all Medical Staff Committee chairs and Committee members;

(j) Chair the MSEC (with vote, if necessary to resolve a tie vote by the other members) and may attend any other Medical Staff and Hospital Committees, ex officio, without vote;

(k) Review and authenticate the MSEC and Medical Staff meeting minutes;

(l) Attend Board of Directors meetings unless otherwise requested by the Board of Directors;

(m) Promote adherence to the Bylaws, Policies, and Rules and Regulations of the Medical Staff and to the Policies and Procedures of the Hospital;

(n) Be the spokesperson for the Medical Staff in its external professional and public relations;

(o) Recommend Medical Staff representatives to Hospital Committees and work with the Administrator to assure that service line chairs and other physicians have input in the Hospital planning and budgetary process;

(p) Perform all functions authorized in all applicable policies, including collegial intervention steps outlined in the Credentials Policy; and

(q) Complete the conflict of interest disclosure form on an annual basis, and also disclose, at the time it occurs, any other conflict of interest that may arise during the term of office.

3.C.2. Chief of Staff-Elect:

The Chief of Staff-Elect shall:

(a) Assume all duties of the Chief of Staff with the full authority of the Chief of Staff in his or her absence (when functioning on behalf of the Chief of Staff, the Chief of Staff-Elect may vote on the MSEC if necessary to resolve a tie vote by the other members;

(b) Serve on the MSEC and attend meetings of the Board of Directors unless otherwise requested by the Board of Directors;

(c) Assume all such additional duties as are assigned to him or her by the Chief of Staff or the MSEC or by the Board of Directors; and

(d) Complete a conflict of interest disclosure form on an annual basis; and also disclose, at the time it occurs, any other conflict of interest that may arise during the term of office.

3.C.3. Immediate Past Chief of Staff:

The immediate Past Chief of Staff will support the Chief of Staff as necessary to ensure continuity in leadership and process.

3.D. NOMINATIONS

(1) The Chief of Staff shall appoint a Nominating Committee consisting of three to five members of the Active Staff for all general and special elections. The most immediate Past Chief of Staff shall serve as chair of the Nominating Committee. The Nominating Committee shall prepare at least one nominee for the office of Chief of Staff-Elect who satisfies the qualifications set forth in Section 3.B. The nominee shall be contacted by the Nominating Committee and advised of the obligations of the office for which he/she has been nominated and an inquiry shall be made about his/her willingness to serve. The Medical Staff Office, through the Medical Staff Coordinator shall provide notification to the Medical Staff of the nominee(s) at least four weeks prior to the election.

(2) No later than two weeks prior to the election, any five members of the Active Staff may submit to the Nominating Committee the name of a qualified member of the Medical Staff for inclusion as a candidate on the ballot. The Nominating Committee shall review the qualifications of the proposed candidate and if the candidate satisfies the qualifications for office, as set forth in Section 3.B of these

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Bylaws, the Medical Staff Office shall provide notice to all Active Staff members of the additional nominee(s). Nominations from the floor shall not be accepted.

3.E. ELECTION

(1) The Chief of Staff attains office by automatic succession from the office of Chief of Staff-Elect.

(2) The candidate receiving a majority of votes cast (written or voice) at the Medical Staff meeting for the office of Chief of Staff-Elect shall be elected. Only members of the Active Staff present at the meeting shall be eligible to vote, with the exception of permitted proxy voting as defined in Article 6 of these Bylaws. If no candidate receives a simple majority vote (51%) on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

(3) In the alternative, at the discretion of the MSEC, the election shall be held solely by written ballot returned to the Medical Staff Office. Ballots may be returned in person, by mail, by facsimile, or by e-mail ballot. All ballots must be received in the Medical Staff Office by the day of the election. The candidate who receives a majority of the votes cast shall be elected. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

3.F. TERM OF OFFICE

Officers shall serve for a term of two (2) years or until a successor is elected. The officer shall assume office on May 1st of the year elected. Each officer serves until the end of his or her term or until a successor is elected. Officers may be reelected to serve additional terms, but not consecutively.

3. G. REMOVAL

(1) Removal of an elected officer or a member of the MSEC may be effectuated by a two-thirds (2/3) vote of the Active Staff; by a two-thirds (2/3) vote of the MSEC; or by the Board of Directors. Grounds for removal shall be:

(a) Failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) Failure to remain in good standing on the Medical Staff, including being the subject of an adverse recommendation pursuant to the Credentials Policy, or having automatically relinquished privileges pursuant to that Policy;

(c) Failure to perform the duties of the position held;

(d) Conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(e) An infirmity that renders the individual incapable of fulfilling the duties of that office.

(2) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered by the body initiating the removal action. The individual shall be afforded an opportunity to speak to the Active Staff, the MSEC, or the Board of Director as applicable and appropriate, prior to a decision for removal.

3.H. VACANCIES

A vacancy in the office of Chief of Staff shall be filled by the Chief of Staff-Elect. If the Chief of Staff-Elect has to fill the office of Chief of Staff, a special election will be held within 90 days for the position of Chief of Staff-Elect. The term of office for the newly elected Chief of Staff-Elect shall begin at the time of election. In the event there is a vacancy in the office of Chief of Staff-Elect, the MSEC shall appoint an individual to fill the office until a special election can be held.

ARTICLE 4

CLINICAL SERVICE LINES

4. A. ORGANIZATION

The Medical Staff may be organized into the service lines as listed in the Organization Manual.

4.B. CREATION AND DISSOLUTION OF SERVICE LINES

(1) The MSEC will periodically assess the Medical Staff's service line structure and recommend to the Hospital Board of Directors any changes to improve organizational efficiency and patient care (i.e., creating new or combining service lines and eliminating service lines).

In addition, any group of staff members who satisfy the criterion for service line designation set forth below may petition the MSEC in writing and with appropriate supporting documentation for such a designation. The MSEC will consider the request and forward its recommendation to the Hospital Board of Directors for final action. Action taken by the Hospital Board of Directors pursuant to this section shall be effective on the date of Hospital Board of Directors action and shall not require formal amendment of these Bylaws.

(2) The following factors shall be considered by the MSEC and the Hospital Board of Directors in determining whether the creation of a new service line is warranted:

(a) The existence of a sufficiently large number of Medical Staff members who are available for appointment to and are reasonably expected to actively participate in the proposed new service line. This number must be sufficiently large to enable the service line to accomplish its functions as set forth in these Bylaws; and

(b) A substantial level of clinical activity by the new service line to warrant imposing the responsibility to accomplish service line functions on a routine basis.

(3) The following factors shall be considered by the MSEC and the Hospital Board of Directors in determining whether the elimination of a service line is warranted:

(a) An adequate number of Medical Staff members in the service line are no longer available to accomplish the functions set forth in these Bylaws;

(b) The number of patients or the amount of clinical activity is insufficient to warrant the imposition of the designated duties on the members in the service line;

(c) The service line fails to meet often enough to accomplish the functions set forth in these Bylaws;

(d) The service line fails to fulfill all service line responsibilities and functions; or

(e) No qualified individual is willing to serve as service line chair.

4.C. ASSIGNMENT TO SERVICE LINE

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(1) Upon initial appointment to the Medical Staff, each member shall be assigned to a clinical service line. Assignment to a particular service line does not preclude an individual from seeking and being granted clinical privileges typically associated with another service line.

(2) An individual may request a change in service line assignment to reflect a change in the individual's clinical practice. Any such request shall be reviewed by the Credentials and Privileges Committee and the MSEC, which shall forward their recommendations to the Board of Directors for action.

4.D. FUNCTIONS OF SERVICE LINES

The service lines shall be organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the service line; (ii) to monitor the practice of all those with clinical privileges in a given service line; (iii) to provide appropriate specialty coverage , consistent with the provisions in these Bylaws and related documents; and (iv) to monitor care delivery processes used by Medical Staff members and Hospital staff, research opportunities for improvement, and recommend improvements when appropriate.

4.E. QUALIFICATIONS OF SERVICE LINE CHAIRS AND MSEC REPRESENTATIVES

Each service line chair and MSEC representative shall:

(1) Be an Active Staff member;

(2) Be certified by an appropriate specialty Board of Directors or possess comparable competence, as determined through the credentialing and privileging process; and

(3) Satisfy all of the eligibility criteria in Section 3.B, except that he/she is only required to have been appointed to the Active Staff for a period of three years.

4.F. APPOINTMENT AND REMOVAL OF SERVICE LINE CHAIRS

(1) Except as otherwise provided by contract, service line chairs shall be elected by the members of the service line.

(2) Any service line chair may be removed by a two-thirds vote of the service line members; or by a two-thirds vote of the MSEC; or by the Board of Directors.

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Grounds for removal shall be:

(a) Failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) Failure to remain in good standing on the Medical Staff, including being the subject of an adverse recommendation pursuant to the Credentials Policy, or having automatically relinquished privileges pursuant to that Policy;

(c) Failure to perform the duties of the position held;

(d) Conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(e) An infirmity that renders the individual incapable of fulfilling the duties of that office.

(3) Prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action shall be taken, at least 10 days prior to the date of the meeting. The individual shall be afforded an opportunity to speak to the service line, MSEC, or the Board of Directors, as applicable, prior to a vote on such removal.

(4) Service line chairs shall serve two-year (2) terms, commencing on the first day of the Medical Staff year, or until a successor is elected. Service line chairs and cross representatives may be reelected to serve additional terms; however, there must be a two-year break between terms.

4.G. DUTIES OF SERVICE LINE CHAIRS

Each service line chair is responsible for the following functions, either personally or in collaboration with Hospital personnel:

(1) All clinically related activities of the service line;

(2) All administratively related activities of the service line, unless otherwise provided for by the Hospital;

(3) Continuing surveillance of the professional performance of all individuals in the service line who have delineated clinical privileges;

(4) Recommending criteria for clinical privileges that are relevant to the

care provided in the service line;

(5) Evaluating requests for clinical privileges for each member of the service line;

(6) Assessing and recommending off-site sources for needed patient care services not provided by the service line or the Hospital;

(7) The integration of the service line into the primary functions of the Hospital;

(8) The coordination and integration of interdepartmental and intra-departmental services;

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

(10) Recommendations for appropriate numbers, qualifications, and competencies for Hospital staff who provide care or service in the service line;

(11) Continuous assessment and improvement of the quality of care and services provided;

(12) Maintenance of quality monitoring programs, as appropriate;

(13) The orientation and continuing education of all persons in the service line; (14) recommendations for space and other resources needed by the service line;

(15) Performing all functions authorized in the Credentials Policy, including collegial intervention;

(16) Appointing one or more vice chairs as deemed necessary, subject to approval of the MSEC, who shall perform such duties as may be requested by the service line chair or the MSEC; and

(17) Completing a conflict of interest disclosure form on an annual basis and also disclosing, at the time it occurs, any other conflict of interest that may arise during his/her term of office.

4. H. APPOINTMENT AND REMOVAL OF SERVICE LINE CROSS-REPRESENTATIVES

(1) Individuals shall be elected as cross-representatives of their

respective clinical service lines by their home service line members.

(2) Any cross-representative may be removed by the service line chair. Grounds for removal shall be:

(a) Failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) Failure to remain in good standing on the Medical Staff, including being the subject of an adverse recommendation pursuant to the Credentials Policy, or having automatically relinquished privileges pursuant to that Policy;

(c) Failure to perform the duties of the position held;

(d) Conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(e) An infirmity that renders the individual incapable of fulfilling the duties of that office.

(3) Prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action shall be taken, at least 10 days prior to the date of the meeting. The individual shall be afforded an opportunity to speak to the service line, MSEC, or the Board of Directors, as applicable, prior to a vote on such removal.

(4) Service line cross-representatives shall serve two-year (2) terms, commencing on the first day of the Medical Staff year, or until a successor is elected. Service line cross-representatives may be reelected to serve additional terms; however, there must be a two-year break between terms.

4.I. DUTIES OF SERVICE LINE CROSS-REPRESENTATIVES

Service line cross-representatives shall:

(1) Serve as advocates for their service lines;

(2) Attend meetings as assigned;

(3) Be responsible for communication and feedback between home service lines and the service line to which they are assigned as cross-representatives; and

(4) Represent their home services line by voting at the assigned service line meetings.

ARTICLE 5

MEDICAL STAFF COMMITTEES AND PERFORMANCE IMPROVEMENT FUNCTIONS

5. A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

This Article and the Medical Staff Organization Manual outline the Medical Staff committees that carry out peer review and other performance improvement functions that are delegated to the Medical Staff by the Board of Directors.

5.B. APPOINTMENT OF COMMITTEE CHAIRPERSONS AND MEMBERS

(1) Unless otherwise provided by specific policies, all Medical Staff and Hospital committee chairs and members shall be appointed by the Chief of Staff. Committee chairs shall be selected based on the criteria set forth in Section 3.B of these Bylaws, except that they are only required to have been appointed to the Active Staff for a period of three (3) years. Consideration in appointments will be given to the practical availability of each Physician, time commitment required and such practical considerations that are deemed relevant.

(2) Committee chairs and members shall be appointed for initial terms of two (2) years, but may be reappointed for additional terms. All appointed chairs and members may be removed and vacancies filled by the Chief of Staff at his/her discretion.

(3) Unless otherwise provided, all Hospital and administrative representatives on the committees shall be appointed by the Administrator. All such representatives shall serve on the committees without vote, unless these are hospital committees and not, specifically, committees of the Medical Staff. All duly assigned members of hospital committees, including physicians, shall have voting rights. .

(4) Unless otherwise specified, the Chief of Staff and the Administrator shall be ex-officio members on all committees. This includes committees of the Medical Staff and broader hospital committees. The Administrator shall have voting rights of the Hospital Management Committee.

5.C. MEETINGS, REPORTS AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in these Bylaws shall meet as necessary to accomplish its functions and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely written report after each meeting to the MSEC and to other committees and individuals as may be indicated.

5.D. MEDICAL STAFF EXECUTIVE COMMITTEE

5.D.1. Composition:

(a) The MSEC shall include the officers of the Medical Staff and four (4) Active Staff members. The methodology for determining the allocation of additional Medical Staff representatives shall be as set forth in the Medical Staff Rules and Regulations.

(b) The Administrator shall be an ex officio member of the MSEC.

5.D.2. Duties:

The MSEC has the primary oversight authority related to professional activities and functions of the Medical Staff and performance improvement activities regarding the professional services provided by individuals with clinical privileges. The MSEC is responsible for the following:

(a) Acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, the officers are empowered to act in urgent situations between MSEC meetings subject to ratification by the MSEC at the next regularly scheduled meeting;

(b) Recommending directly to the Board of Directors on at least the following:

(1) The Medical Staff's structure;

(2) The MSEC mechanism used to review credentials and to delineate individual clinical privileges;

(3) Applicants for Medical Staff appointment;

(4) Delineation of clinical privileges for each eligible applicant;

(5) Participation of the Medical Staff in Hospital performance improvement activities;

(6) The mechanism by which Medical Staff appointment may be terminated; and

(7) Hearing procedures;

(c) Consulting with the Administrator on quality-related aspects of contracts for patient care services as well as privileging inclusion/exclusion issues related to such contracts;

(d) Receiving and acting on reports and recommendations from Medical Staff committees, service lines, and other groups as appropriate, and making appropriate recommendations for improvement of the clinical practices of individual Medical Staff members and of Hospital processes generally;

(e) Reviewing (or delegating the review of) quality indicators to ensure uniformity regarding patient care services;

(f) Providing leadership in activities related to patient safety;

(g) Providing oversight in the process of analyzing and improving patient satisfaction;

(h) Prioritizing continuing medical education activities;

(i) Reviewing, at least every three years, the Bylaws, Policies, Rules and Regulations, and associated documents of the Medical Staff and recommending such changes as may be necessary or desirable; and

(j) Performing such other functions as are assigned to it by these Bylaws, the Credentials Policy, the Board of Directors or other applicable policies.

5.D.3. Meetings:

(a) The MSEC shall meet as often as necessary to fulfill its responsibilities and shall maintain a permanent record of its proceedings and actions.

(b) MSEC meetings shall be open to members of the Medical Staff. Non-MSEC members may participate in discussions (without a vote) unless the Chief of Staff calls an executive session.

5.E. PERFORMANCE IMPROVEMENT FUNCTIONS

(1) The Medical Staff is actively involved in performance improvement functions, including reviewing data and recommending and implementing processes to address the following:

(a) Patient safety, including processes to respond to patient safety alerts, meet patient safety goals and reduce patient safety risks;

(b) The Hospital's and individual practitioners' performance on Joint Commission International core measures;

(c) Medication usage/administration, including review of significant adverse drug reactions, medication errors and the use of experimental drugs and procedures;

(d) Utilization of blood and blood components, including review of significant transfusion reactions;

(e) Operative and other procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(f) Education of patients and families;

(g) Coordination of care, treatment and services with other practitioners and Hospital personnel;

(h) Accurate, timely and legible completion of medical records;

(i) The quality and timeliness of history and physical examinations on all patients;

(j) The use of developed criteria for autopsies;

(k) Sentinel events (major incidents involving the care and treatment of patients), including root cause analyses and responses to adverse events;

(l) Noscomial infections and the potential for infection;

(m) Unnecessary procedures or treatment;

(n) Appropriateness of resources utilization; and

(o) Compliance with all relevant laws, regulations, and Hospital policies.

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(2) A description of the Committees that carry out systematic monitoring and performance improvement functions, including their composition, duties, and reporting requirements, is contained in the Medical Staff Organization Manual.

5.F. CREATION OF STANDING COMMITTEES

In accordance with the amendment provisions in the Medical Staff Organization Manual, the MSEC may, by resolution and upon approval of the Board of Directors and without amendment of these Bylaws, establish additional Committees to perform one or more staff functions. In the same manner, the MSEC may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws that is not assigned to an individual Medical Staff member, a standing Committee, or a special task force shall be performed by the MSEC.

5.G. SPECIAL COMMITTEES

Special Committees shall be created and their members and chairs shall be appointed by the Chief of Staff. Such Committees shall confine their activities to the defined purpose for which they were appointed and shall report to the MSEC.

ARTICLE 6

MEETINGS

6.A. MEDICAL STAFF YEAR

The Medical Staff year is defined from May 1 to April 30.

6.B. MEDICAL STAFF MEETINGS

6.B.1. Regular Meetings:

The Medical Staff shall meet at least bi-annually.

6. B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the Chief of Staff, the MSEC, the Board of Directors, or by a petition signed by not less than one fourth of the Active Staff.

6.C. SERVICE LINE AND COMMITTEE MEETINGS

6.C.1. Regular Meetings:

Except as otherwise provided in these Bylaws or in the Medical Staff Rules and Regulations, each service line and committee should meet bi-annually, or more often as necessary, at times set by the presiding officer.

6.C.2. Special Meetings:

A special meeting of any service line or committee may be called by or at the request of the presiding officer, the Chief of Staff, the MSEC, or by a petition signed by not less than one-fourth of the Active Staff members of the service line or committee, but not by fewer than two members.

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.D.1. Notice of Meetings:

(a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff, service lines and committees at least two weeks in advance of the meetings. Notice may also be provided by posting in a designated location at least two weeks prior to the meetings. All notices shall state the date, time, and place of the meetings.

(b) When a special meeting of the Medical Staff, a service line, and/or a committee is called, all of the provisions in paragraph (a) shall apply except that the notice period shall be reduced to 48 hours (i.e., must be given at least 48 hours prior to the special meeting). All relevant members shall be notified of special meetings and posting may not be the sole mechanism used for providing notice.

(c) The attendance of any individual at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

6.D.2. Quorum and Voting:

(a) For any regular or special meeting of the Medical Staff, service line, or committee, one-third of the voting members (but in no event fewer than two members) shall constitute a quorum. Exceptions to this general rule are as follows:

(1) For meetings of the MSEC, the Credentials and Privileges Committee, and other such Medical staff committees, the presence of at least 50% of the voting members of the

Committee shall constitute a quorum; and

(2) For amendments to the Medical Staff Bylaws, at least 50% of the voting staff shall constitute a quorum.

(b) Recommendations and actions of the Medical Staff, service lines, and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a simple majority vote of the eligible Medical Staff members of the Hospital;

(c) The voting members of the Medical Staff, a service line, or a Committee may also be presented with a question or concern by mail, facsimile, e-mail, website, hand delivery, or telephone, and their votes returned to the presiding officer by the method designated in the notice. Except for amendments to these Bylaws and actions by the MSEC, Credentials and Privileges Committee, and other such Medical Staff Committees, a quorum for purposes of these votes shall be the number of responses returned to the presiding officer by the date indicated. The question or concern raised shall be determined in the affirmative if a simple majority of the responses returned has so indicated.

(d) Meetings may also be conducted electronically.

(e) Voting by proxy.

(1) Physicians required to provide onsite Hospital coverage at the time of the Medical Staff meeting in which voting is taking place may delegate their vote to another member of the Active Medical Staff. The Physician will notify the Medical Staff Office, in writing, of the proxy vote within 24 hours of the full Medical Staff meeting.

(2) The MSEC has the discretion to permit other voting members of the Medical Staff to vote by proxy in exceptional circumstances. Voting members must specifically request permission to vote by proxy at least 10 days in advance of the Medical Staff meeting.

6. D.3. Agenda:

The presiding officer for the meeting shall cause the agenda to be set for any regular or special meeting of the Medical Staff, service line, or Committee.

6.D.4. Rules of Order:

The latest edition of Robert's Rules of Order may be used for reference at

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all meetings and elections, but shall not be binding. Specific provisions of these Bylaws, and Medical Staff, service line, or Committee custom, shall prevail at all meetings. The presiding officer shall have the authority to rule definitively on all matters of procedure.

6.D.5. Minutes, Reports, and Recommendations:

(a) Minutes of all meetings of the Medical Staff, service lines, and Committees shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the presiding officer.

(b) A summary of all recommendations and actions of the Medical Staff, service lines, and Committees shall be transmitted to the MSEC. The Board of Directors shall be kept apprised of the recommendations of the Medical Staff and its service lines and committees.

(c) A permanent file of the minutes of all meetings shall be maintained by the Hospital in the Medical Staff Services Office.

6.D.6. Confidentiality:

Members of the Medical Staff who have access to, or are the subjects of Credentialing and/or Peer Review information agree unconditionally to maintain the confidentiality of all such confidential information. Credentialing and Peer Review documents, records, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes. Confidential information pertaining to Credentialing and/or Peer Review shall be protect by the laws and regulations of the Cayman Islands and shall not be discoverable. A breach of confidentiality by any member of the Medical Staff or Hospital support personnel shall result in the imposition of disciplinary action.

6.D.7. Attendance Requirements:

(a) Attendance at meetings of the MSEC, the Credentials and Privileges Committee and other such Medical staff committee meetings is required by all appointed members. All members are required to attend 75% of all regular and special meetings of these committees. Failure to attend the required number of meetings may result in replacement of the member.

(b) For all other meetings including Medical Staff, service lines, and Committees, each Active Staff member is expected to attend and participate in at least 50% of regular and special meetings. Failure to attend the required number of meetings may result in disciplinary action.

ARTICLE 7

INDEMNIFICATION

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff officers, service line chairs, Committee chairs, Committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by the Hospital's Corporate Bylaws and the laws and regulations of the Cayman Islands.

ARTICLE 8

AMENDMENTS

8. A. MEDICAL STAFF BYLAWS

(1) All proposed amendments to the Medical Staff Bylaws must be reviewed by the MSEC prior to a vote by the Medical Staff. The MSEC shall provide notice by reporting on the proposed amendments either favorably or unfavorably at the next regular meeting of the Medical Staff or at a special meeting called for such purpose. The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, (i) a quorum of at least 50% of the voting staff must be present, and (ii) the amendment must receive a simple majority of the votes cast by the voting staff at the meeting.

(2) The MSEC may present proposed amendments to the voting staff by mail ballot, e-mail, or website, to be returned to the Medical Staff Office (or recorded on the Medical Staff website) by the date indicated by the MSEC. Along with the proposed amendments, the MSEC may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, an amendment must receive a simple majority of the votes cast, so long as the amendment is voted on by at least 50% of the Medical Staff eligible to vote.

(3) The MSEC shall have the power to adopt such amendments to these

Bylaws which are needed because of reorganization, renumbering, or punctuation, spelling or other errors of grammar or expression.

(4) All amendments shall be effective only after approval by the Board of Directors.

(5) If the Board of Directors has determined not to accept a recommendation submitted to it by the MSEC or the Medical Staff, the MSEC may request a conference between the officers of the Board of Directors and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board of Directors' rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the Administrator within two weeks after receipt of a request for same submitted by the Chief of Staff.

8.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there shall be policies, procedures and rules and regulations that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. All Medical Staff policies, procedures and rules and regulations shall be considered an integral part of the Medical Staff Bylaws.

(2) All Medical staff are expected to read and abide by the Code of Conduct and professional ethics issued by the Medical and Dental Council of the Cayman Islands and in particular the section referencing disparagement of professional colleagues

"It is improper for a practitioner to disparage, whether directly or by implication, the professional skill, knowledge, or qualifications of any other practitioner, irrespective of whether this may result in his own professional advantage, and such disparagement may raise a question of serious professional misconduct. It is however, entirely proper for a practitioner, having carefully considered the advise and treatment offered to a patient by a colleague, in good faith to express a different opinion and to advise and assist the patient to seek an alternative source of medical care. The practitioner must however, always be able to justify such action as being in the patient's best medical interests."

(3) The Credentials Policy addresses the following matters: qualifications for appointment, the process for granting initial appointment, clinical privileges, reappointment, collegial intervention, the investigation process, automatic relinquishments, precautionary suspensions, and the process for hearings and appeals.

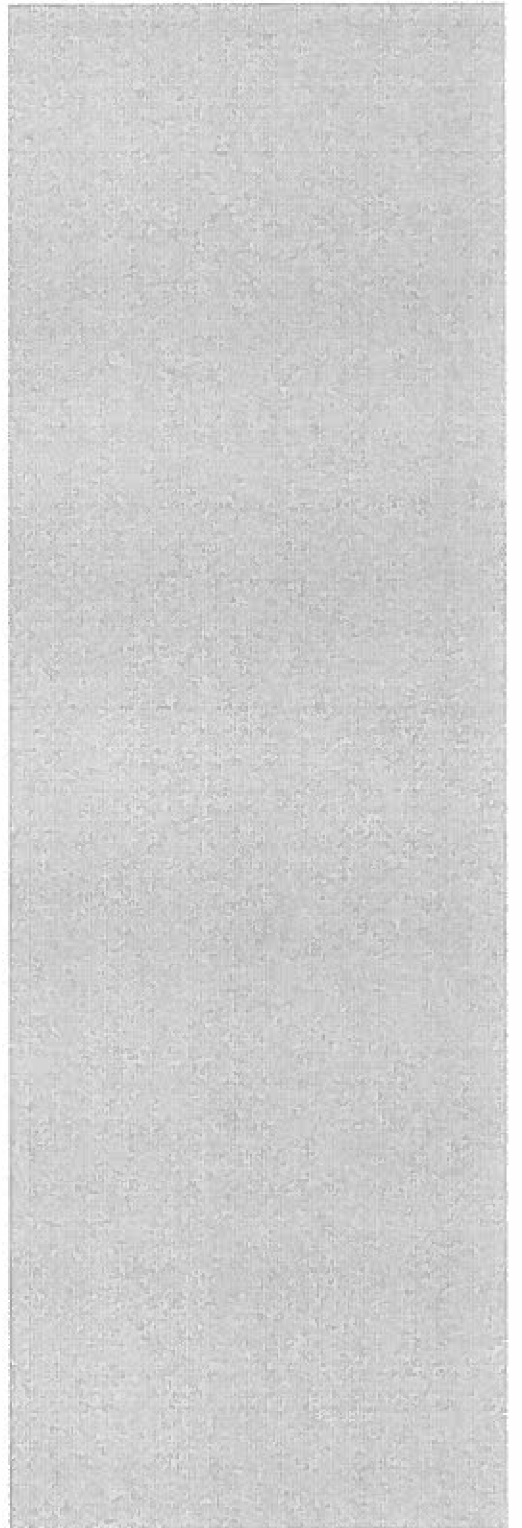
(4) The Medical Staff Development Plan lists the service lines of the Medical Staff. The Medical Staff Development Plan lists the number of any specialty physicians deemed appropriate at any time. In the interest of the Medical Staff members and the stability of the Hospital, the Medical Staff will monitor itself to ensure its quotas are not exceeded or left unmet. The Medical Staff Organization Manual also contains a description of the committees of the Medical Staff.

(5) The Policy on Allied Health Professionals addresses the following matters as they relate to allied health professionals: the process for determining need for new allied health professionals, qualifications for appointment, the process for granting clinical privileges or a scope of practice initially and on an ongoing basis, collegial intervention, investigations, suspensions, and procedural rights.

(6) An amendment to the Credentials Policy or the Policy on Allied Health Professionals may be made by a majority vote of the members of the MSEC present and voting at any meeting of that committee where a quorum exists, provided that the written recommendations of the Credentials and Privileges Committee concerning the proposed amendments shall have first been received and reviewed by the MSEC. Notice of all proposed amendments to these two documents shall also be provided to each member of the Medical Staff at least 14 days prior to the MSEC meeting when the vote is to take place. Any member of the Medical Staff may submit written comments on the amendments to the MSEC.

(7) An amendment to the Medical Staff Development Plan or the Medical Staff Rules and Regulations may be made by a majority vote of the members of the MSEC present and voting at any meeting of that committee where a quorum exists. Notice of all proposed amendments to these two documents shall be provided to each member of the Medical Staff at least 14 days prior to the MSEC meeting when the vote is to take place. Any member of the Medical Staff may submit written comments on the amendments to the MSEC.

(8) Unless specified differently in a specific policy, all other policies of the Medical Staff may be adopted and amended by a majority vote of



the MSEC. No prior notice is required.

(9) Adoption of and changes to the Credentials Policy, Medical Staff Organization Manual, Policy on Allied Health Professionals, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board of Directors.

(10) The currently approved Medical Staff Rules and Regulations of the Hospital are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any present Rule or Regulation is inconsistent with these Bylaws, it is of no force or effect.

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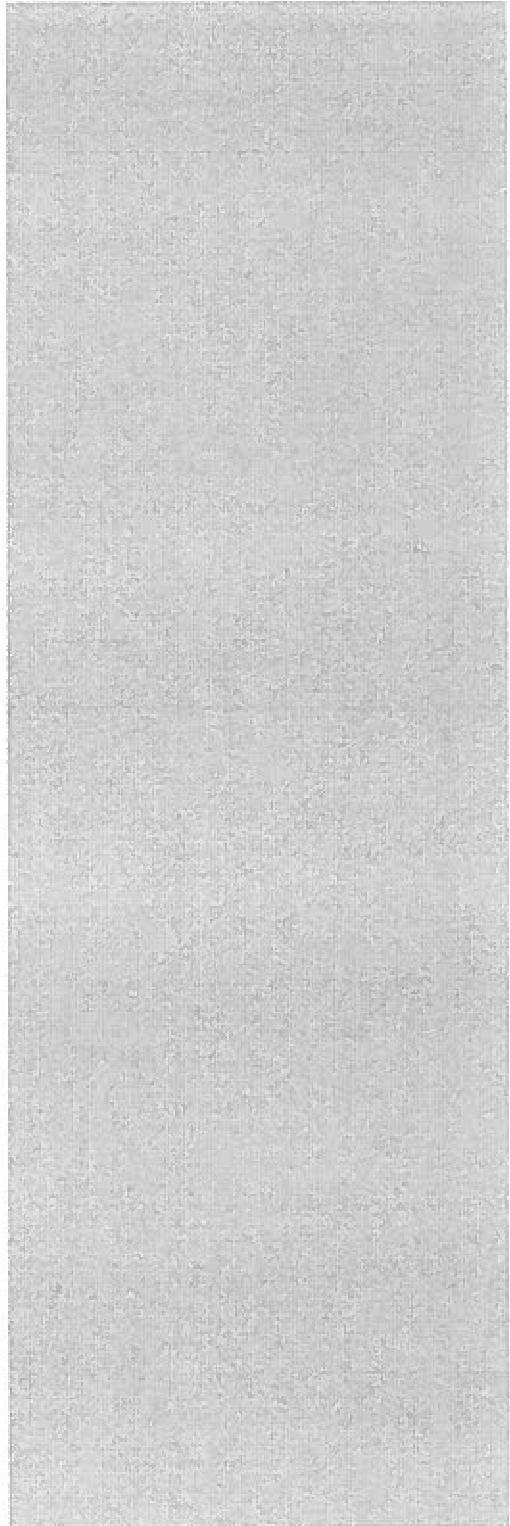

ARTICLE 9

ADOPTION

These Bylaws are adopted, and made effective as of January 1, 2014, upon approval of the Board of Directors, superseding and replacing any and all previous Medical Staff Bylaws, Rules and Regulations, policies, manuals or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff on January 1, 2014:

____
Chief of Staff

Approved by the Board of Directors:

____
Chair, Board of Directors

Date: __________

Future Revision Dates:

1.

2.

3.

4.

5.

Doctors Hospital

Unwavering commitment to your changing health

Medical Staff Bylaws

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Medical Staff Bylaws

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Medical Staff Bylaws

1. ARTICLE 1: DEFINITION OF TERMS

Unless otherwise provided, the following definitions apply to the provisions of these Medical Staff Bylaws:

Active Staff shall mean a privileged member appointed to the Active Medical Staff as described in Article III of these Bylaws.

Allied Health Staff shall mean a privileged Allied Health Professional appointed to the Allied Health Staff as described in Article III of these Bylaws.

Applicant shall mean any practitioner who has submitted any application to become a Member of the Medical Staff through clinical privileging.

Associate Staff shall mean a privileged member appointed to the Associate Medical Staff as described in Article III of these Bylaws.

Board shall mean the hospital's Board of Directors.

Bylaws shall mean the Medical Staff Bylaws.

Chief of Staff (COS) shall mean the elected leader of MSEC or Chief of the Medical Staff.

Chief of Surgery shall mean a practicing surgeon and member of the Medical Staff whom the Medical Staff Executive Committee appoints.

Clinical Director shall mean the appointed leader of the Clinical Service created by the MSEC by these Bylaws. Clinical Directors are appointed by and report to the Chief of Staff regarding the quality of clinical practice and assist the Medical Director (MD) regarding operational issues e.g., budgetary, hiring or firing of physicians, and strategic planning decisions.

Clinical Privileges shall mean the authorization granted by the Medical Staff Executive Committee to a Member, Practitioner, or AHP to provide specific care, treatment, and services in the Hospital or its facilities per the process set forth in the Credentials Manual.

Clinical Services Manual the document outlines all defined scope of clinical services of the hospital and may include functional component description: demographics targeted; personnel; operational hours; and goals or plans to improve quality of service.

Confidential Information means patient information, peer review information, and the Hospital's business information designated as confidential by the Hospital or its representatives before disclosure

Affiliate Staff shall mean a privileged member appointed to the Affiliate Medical Staff as described in Article III of these Bylaws.

Medical Staff Bylaws

Credentials Manual shall document outlining the process of credentialing, privileging, and appointment to the Medical Staff and the Allied Health Staff.

Deputy Chief of Staff shall mean a Member appointed by the Chief of Staff to assist the COS and discharge the duties of the COS when required by the absence of the COS.

Hospital shall mean "Doctors Hospital."

Hospital Administrator shall mean the appointed Administrative lead of the Hospital and is accountable to the Board of Directors.

Hospital Administrator Designee shall mean the designated Administrative lead from the Hospital Administration Committee that supports the mandate from the Board of Directors.

Hospital Administration Committee (HAC) shall mean the committee tasked to support the operational duties and oversight of the organization that supports the Board of Directors. For the sake of these Bylaws, the designee is the representative from this committee conferred with administrative and operational oversight.

Investigation and Fair Hearing Manual shall mean the document that guides the appropriate actions that must be taken while conducting any investigation or evaluation of any member of the Medical Staff.

Joint Conference Committee (JCC) shall mean a committee consisting of the Medical Director (chairperson), and other members: Chief Financial Office, Director of Operations, and the Chief of Nursing.

Medical Director (MD) shall mean a privileged member appointed by, and accountable to, the Hospital Administrator (or designee) such as the HAC, and will complement the functions of the Hospital Administrator (or designee) in the clinical, administrative, and operational affairs of the Medical Staff and the organization.

Medical Staff shall mean the body of all practitioners: physicians, dentists, or podiatrists who are clinically privileged at the hospital to provide patient care.

Member shall mean a privileged member appointed to the Medical Staff of the Hospital.

Member-at-Large shall be an elected Officer of the Medical Staff and member of the Medical Staff Executive Committee (MSEC).

Medical Staff Executive Committee (MSEC) shall be an elected and appointed group of Medical Staff Members as described in Article IV of these Bylaws.

Nominating Committee shall mean the Nominating Committee described in Article IV of these Bylaws.

Officers shall mean officers of the Medical Staff.

Medical Staff Bylaws

Medical Staff Organizational Manual shall mean the document that outlines the Medical Staff structure, it's committees and their functions and involvement to inter-department activities and standards.

Physician shall mean a doctor of medicine, dentist or podiatry who is licensed to practice medicine in the Cayman Islands.

Practitioners shall mean any licensed practitioner who is permitted by law to provide care, treatment, and services to patients within the scope of their respective practices.

Privileged Member shall mean any clinically privileged member of the Medical Staff or Allied Health Staff.

Rules and Regulations Manual shall mean document containing the Rules and Regulations of the Medical Staff.

Senior Leadership Team (SLT) means the management and administrative team for the organization

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Medical Staff Bylaws

2. ARTICLE II: HOSPITAL LEADERSHIP AND GOVERNANCE

2.1.1. ORGANIZATIONAL OVERVIEW Doctors Hospital Mission Statement:

The Mission of Doctors Hospital is to promote the health and well-being of all we serve through the provision of First World, International Standard Healthcare Services in collaboration with all physicians and other providers who share the same vision and values.

2.1.2. Doctors Hospital Vision Statement:

Doctors Hospital is the Cayman Island's leading provider of private-sector hospital and healthcare services as a true Doctors Hospital. A "Doctors Hospital" is owned and operated to afford physicians and other healthcare professional providers a place to work where the mandate is to meet their needs and expectations as Customers. It is viewed as the Preferred Provider and Preferred Employer in the hospital and healthcare services sector of the Country.

2.1.3. Doctors Hospital Values:

Doctors Hospital is committed to Quality Clinical Outcomes, Patient Safety, and Complete Customer Satisfaction while demonstrating "... an unwavering commitment to your changing health."

2.1.4. Structure and Governance

a. The hospital is led by the Board of Directors and has all responsibilities relating to the hospital's fulfillment of its mission and vision and agreed strategic plans, thereby meeting the needs of its shareholders.

b. The Board is supported and advised by the HAC, which is responsible for carrying out the mission, vision and operational duties of the organization, including the day-to-day management.

c. The HAC guides the Senior Leadership Team (SLT). The SLT oversees the hospital managers in the daily administrative and operational requirements outlined by the Board through the HAC. The seven (7) areas of responsibilities of the HAC are:

   i. Regulatory Compliance
   ii. Culture including mission development
   iii. Patient Care
   iv. Quality and Safety

d. Financial oversight

e. Staffing including Medical Staff Credentialing and Privileging

f. Strategic Decision Making

g. The Senior Leadership Team (SLT) is the management arm of the organization and monitors and reacts to the hospital's daily operational and administrative demands. Its membership is led by the Hospital Administrator (or designee) and includes the Medical Director. The SLT appoints relevant hospital managers in their leadership roles in collaboration with other staff members on various hospital committees.

h. The HAC appoints the Medical Director to lead the Medical Staff Operational and Clinical Services of the organization, is accountable to the Hospital Administrator (or designee), and works in congruence with the SLT to consistently outline clinical directives that are supported by the Medical Staff, as well as managing the daily operational and administrative duties. Thereby meeting the expectations of the Board and HAC to the outlined plan and strategy of the organization.

i. The duties of the Medical Director (MD duties also listed in the MD Job Description) and other Officers of the Medical Staff are mentioned therein below.

3. ARTICLE III: MEDICAL STAFF MEMBERSHIP

3.1. OVERVIEW

a. Qualifications and conditions for appointment to the Medical Staff and the Allied Health Staff are outlined in the Credentials Manual. The qualifications for appointment to the specific categories are outlined below.

b. The Medical Director will make appointments and reappointments on behalf of the HAC after the Medical Staff Executive Committee's (MSEC) careful recommendation for consideration to an of the Medical Staff categories.

c. The Board reserves the authority to determine appropriate staff categories for all members, including but not limited to individuals employed by group practices and seeking appointment and privileges primarily to benefit their group by providing coverage. Except as otherwise provided, only those individuals who satisfy the qualifications and conditions contained in the Credentials Manual are eligible to apply for appointment or reappointment.

d. A member of the Medical Staff may request a change in staff category during the appointment

term.

3.2. GENERAL RESPONSIBILITIES OF THE MEDICAL STAFF MEMBERS

Unless otherwise advised, each member must:

a. Provide appropriate, timely, and continuous care of his/her patients, ultimately to ensure patient safety and quality of service.

b. Participate in quality/performance improvement activities and in discharging other staff functions as may be required.

c. Participate in on-call coverage of the emergency service and other coverage programs as determined by the MSEC to ensure that patient care needs of the community are continuously met. Members (active) employed by the hospital are required to provide on-call coverage for the emergency service and other coverage programs as deemed necessary by the Clinical Director in addition to those determined by the MSEC.

d. Provide an appropriate health evaluation at the time of appointment and if requested by the COS as part of a post-treatment monitoring plan consistent with the provisions of the Hospital or Medical Staff policies when dealing with physician impairment. The health evaluation will be paid for by the Hospital.

e. Participate in any type of competency evaluation as is determined necessary by the MSEC to properly delineate the Member's Clinical Privileges.

f. Abide by these Bylaws, any Manuals, Rules and Regulations, and other hospital policies, procedures, and plans.

g. Agree to release from any liability to the fullest extent permitted by law, all persons for their conduct in connection with investigating and evaluating the quality of care provided by such Member and their credentials.

h. According to organizational policies, adhere to standards of appropriate medical documentation in a timely manner for all patients to whom the practitioner provides care in the hospital or any other clinical space.

i. Use Confidential Information only as necessary for treatment, payment, or healthcare operations per the current Health Practice Act and Data Protection Act, conduct authorized research activities, or perform Medical Staff responsibilities. For these Bylaws, "Confidential Information" means patient

information, peer review information, and the Hospital's business information designated as confidential by the Hospital or its representatives before disclosure.

j. Disclose to the Medical Staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or Hospital.

3.3. MEDICAL STAFF MEMBERS RIGHTS

Unless otherwise advised, any member has the right to:

a. Initiate a re-call election of an Officer by following the procedure outlined in these Bylaws, regarding removal and resignation from office (Article IV).

b. Call a general meeting of the Medical Staff:
   - i. upon presentation of a petition signed by at least fifty percent plus one (50% plus 1) of the Members,
   - ii. the MSEC shall schedule a general meeting for the specific purposes addressed by the petitioners;
   - iii. no business other than that detailed in the petition may be transacted.

c. May raise a challenge to any rule or policy established by the MSEC:
   - i. in the event a rule, regulation or policy is thought to be inappropriate, any Member may submit a petition signed by at least fifty percent plus one (50% plus 1) of the Members;
   - ii. when the MSEC has received such petition, it will either
     - provide the petitioners with information clarifying the intent of such rule, regulation, or policy, and/or
     - schedule a meeting with the petitioners to discuss the issues.

d. A hearing/appeal in the event that sanctions are taken or recommended.

The members of the Medical Staff are divided into the following categories:

a. Active
b. Associate
c. Affiliate

3.4. ACTIVE STAFF

3.4.1. Qualifications

The Active Staff consists of physicians, dentists and podiatrists who:

a. are privileged members of the Medical Staff

b. are employed by the hospital to have a consistent inpatient/outpatient practice
c. meet all eligibility for appointment and reappointment to the Medical Staff outlined in the Credentials Manual;
d. seek appointment to the Medical Staff solely for the purpose of fulfilling medical coverage to all patients of the organization;

3.4.2. Prerogatives

Active Staff members:

a. may exercise the privileges granted;
b. may attend any general, special or emergency Medical Staff meeting or Clinical Service and Committee meetings (with a vote);
c. may serve as an Officer of the Medical Staff, Clinical Director or a Chairperson of a Medical Staff Committee or Hospital Committee.

3.4.3. Responsibilities

Active Staff members must:

a. assume the responsibilities of membership on the Medical Staff, as assigned, including but not limited to evaluation of members as requested;
b. actively involved in any performance or quality improvement process or peer review, if requested;
c. accept consultations at the Hospital, when requested.

The grant of appointment as an Active Staff member is a courtesy that the Board may terminate without rights to the hearing or appeal procedures outlined in the Investigation and Fair Hearing Manual.

3.5. ASSOCIATE STAFF

3.5.1. Qualifications

The Associate Staff consists of physicians, dentists and podiatrists who:

a. are privileged members of the Medical Staff;
b. have contractual arrangements with the hospital;
c. meet all eligibility for appointment and reappointment to the Medical Staff outlined in the Credentials Manual.

3.5.2. Prerogatives

Associate Staff members:

a. may exercise the privileges granted;

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b. may attend any general, special or emergency Medical Staff meeting or Medical Staff Committee meetings (with a vote);
c. may serve as an Officer of the Medical Staff, Clinical Director or a Chairperson of a Medical Staff Committee or Hospital Committee.

3.5.3. Responsibilities

Associate Staff members must:

a. assume the responsibilities of membership on the Medical Staff, as assigned, including but not limited to evaluation of members as requested;
b. actively involved in any performance or quality improvement process or peer review, if requested;
c. accept consultations at the Hospital, when requested;

The grant of appointment as an Associate Staff member is a courtesy which may be terminated by the Board without rights to the hearing or appeal procedures set forth in the Investigation and Fair Hearing Manual.

3.6. AFFILIATE STAFF

3.6.1. Qualifications

The Affiliate Staff consists of physicians, dentists and podiatrists who:

a. are privileged members from the medical community with their private practices off-site;
b. meet all eligibility for appointment and reappointment to the Medical Staff outlined in the Credentials Manual;
c. desire to have an inpatient practice and are willing to provide consultation to any inpatient/outpatient practice of Active or Associate Medical Staff, as required.

3.6.2. Prerogatives

Affiliate Staff member:

a. may exercise the privileges granted;
b. may attend any general, special or emergency Medical Staff meeting or Clinical Service meeting (with a vote);
c. may serve as a Clinical Director, member or chairperson of eligible Medical Staff Committee, if requested (with a vote);
d. may not serve as an Officer of the Medical Staff other than a Clinical Director.

3.6.3. Responsibilities

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The Affiliate Staff members:

a. assume the responsibilities of membership on the Medical Staff, as assigned, including but not limited to evaluation of members as requested;

b. actively involved in any performance or quality improvement process or peer review, if requested;

c. accept consultations at the Hospital, when requested.

The grant of appointment as an Affiliate Staff member is a courtesy which may be terminated by the Board without rights to the hearing or appeal procedures set forth in the Investigation and Fair Hearing Manual.

3.7. ALLIED HEALTH STAFF

3.7.1. Qualifications

The Allied Health Professionals are licensed members of the Council for Professions Allied with Medicine (CPAM) and satisfy the qualifications and conditions for appointment to the Allied Health Staff in the Credentials Manual. For these Bylaws, the Allied Health Staff is not regarded as a category of the Medical Staff but is included in this Article for convenient reference.

3.7.2. Prerogatives and Responsibilities

Allied Health Staff members:

a. must cooperate in the peer review and performance improvement process in their respective disciplines, when required.

b. may attend applicable clinical service meetings, if requested (with a vote);

c. may serve on a Medical Staff Committee, if requested (with a vote);

d. may not attend general and special meetings of the Medical Staff;

e. may not serve as an Officer of the Medical Staff, Clinical Director of a clinical service.

4. ARTICLE IV: MEDICAL STAFF OFFICERS

4.1. DESIGNATION

a. The Medical Staff will have the following Officers:

i. Medical Director

ii. Chief of Staff

iii. Deputy - Chief of Staff

iv. Chief of Surgery

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v. Clinical Director(s)

vi. Member-At-Large

b. These Officers of the Medical Staff together form the Medical Staff Executive Committee (MSEC).

c. The Medical Staff Executive Committee will also have one (1) elected Member-at-large member that does not simultaneously serve as a Clinical Director of any clinical service.

4.2. ELIGIBILITY CRITERIA OF OFFICERS

Any member of either the Active or Associate Medical Staff categories who have been a member of the Medical Staff for at least twelve (12) months is eligible to serve as an Officer of the Medical Staff (excluding the Medical Director position). Affiliate Members who have been a member of the Medical Staff for at least twelve (12) months are eligible to serve only as an Officer of the Medical Staff in the role of Clinical Directors. The eligibility criteria are as follows:

a. be elected or appointed in good standing and continue to be in good standing during their term of office;

b. have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges at any hospital;

c. be actively and constructively participating in Medical Staff affairs;

d. not presently be serving as a Medical Staff Officer at any other hospital and will not so serve during their term of office;

e. not presently be serving as a or Department Chairperson (or Clinical Director) at any other hospital and will not so serve during their term of office;

f. not presently be serving as a Board member at any other hospital and will not so serve during their term of office

g. be willing to faithfully discharge the duties and responsibilities of the position;

h. have experience in any previous leadership or quality improvement roles;

i. attend continuing education relating to Medical Staff leadership or credentialing functions prior to or during the term of the office; and

j. have demonstrated an ability to work well with others.

These eligibility criteria are also used in the selection process for Clinical Directors and committee chairpersons unless otherwise specified in these sections of the Bylaws.

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4.3. DUTIES OF OFFICERS

4.3.1. Medical Director

a. DESIGNATION

The Medical Director is a member of the Medical Staff with administrative and managerial experience appointed by the Hospital Administrator or Hospital Administration Committee.

b. RESPONSIBILITIES OF MEDICAL DIRECTOR

The Medical Director shall:

i. Ensure best clinical practice by implementing international guidelines of care and availing reputable electronic educational reference tools.

ii. Ensures effective care in the various Clinical Services through compliance to policies and protocols.

iii. Encourage and supports quality improvement initiatives being shared by the Quality and Patient Safety department.

iv. Directs the thorough investigation and resolution of patient complaints, incidents and adverse events by the effective utilization of the various Medical Staff Committees referred by the DH Quality Patient Safety Process.

v. Ensure the following Medical Staff processes are efficient:

   i. Clinical privileging and appointment/re-appointment

   ii. Recruitment and Onboarding

   iii. Clinical Governance

   iv. Continuing medical education programs as well as training and leadership activities of the Medical Staff.

vi. Develop and implement continuous improvement process which evaluates and monitors Medical Staff performance and all clinical care activities.

vii. Ensure the appropriate clinical support, be it personnel, clinical space or software is available to the Medical Staff.

viii. Encourage and facilitate effective communications and collaboration among Clinical Services and providers.

ix. Overseeing and managing the Medical Staff Officers to ensure effective support is given to the Medical Staff.

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x. Develops and recommends the annual operating and capital budget for the Clinical Services, in collaboration with hospital management and Clinical Directors.

xi. Ensure clinical fiscal accountability through the Joint Conference Committee and apply the appropriate actions to achieve agreed deliverables.

xii. Responsible for the delivery of services within approved budget.

xiii. Accountable for the overall allocation and efficient utilization of clinical resources.

xiv. Works with other internal and external care providers to improve hospital performance and patient satisfaction.

xv. Leads the development of, monitors and manages clinical and workload metrics, program risk indicators and outcome measures.

xvi. Perform administrative functions required to ensure Hospital's compliance with licensure and/or certifications and accreditation.

xvii. Ensure the development of a strong network of strong clinical providers and facilities for DH

xviii. Optimize strong relationships among our clinical network that will lead to best referral for our patients.

xix. Work with DH providers in promoting public policies or initiatives of health and wellness being recommended by government institutions or services.

xx. Ensure application and implementation of all corporate policies and procedures within each clinical service.

xxi. Work with clinical directors to market and promote all clinical services.

xxii. Create and foster a culture that enhances excellent patient-physician relationship and high morale throughout all departments.

xxiii. Perform other duties listed in the Medical Director Job Description.

c. TERM OF OFFICE

The Medical Director shall serve for the tenure agreed upon by the Hospital Administrator (or designee), as per contract.

4.3.2. Chief of Staff

a. DESIGNATION

The Chief of Staff is the elected clinical leader of the Medical Staff.

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b. DUTIES OF CHIEF OF STAFF

The Chief of Staff shall:

i. Call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the MSEC.

ii. Be accountable to the Hospital Administrator (or designee) and Medical Director for the assessment of quality and efficiency of clinical services and performance within the Hospital and partnering entities.

iii. Work in collaboration with the Medical Director and hospital management teams to coordinate care activities throughout the hospital and partnering entities.

iv. Be required to attend Board and other Hospital meetings whenever requested for reporting on and discussing clinical matters.

v. Represent and communicate the views, policies, and needs of, and report on the activities of the Medical Staff to the Medical Director, Hospital Administrator (or designee) and the Board of Directors as requested.

vi. Be accountable to the Medical Director in the evaluation and discipline of the various Medical Staff Officers and their functions.

vii. Help to develop and implement clinical policies, processes and protocols being promoted by Hospital Administrator (or designee) and the Medical Director.

viii. Direct the development of, and adherence to policies and procedures which organize and govern Medical Staff affairs and professional practice within the Hospital.

ix. Work with Clinical Directors and Medical Director to appoint or re-appoint practitioners to the Medical Staff.

x. Collaborate with Clinical Directors, Medical Director and Hospital Administrator (or designee) regarding appropriate budget allocation to ensure fiscal accountability.

xi. Be involved in the clinical appraisal and evaluation of Medical Staff.

xii. Unless otherwise specified, appoint all Medical Staff Committee membership and chairpersons.

xiii. Chair the MSEC (with vote, if necessary, to resolve a tie vote by the other members) and may attend any other Medical Staff and Hospital Committees, ex officio, without vote.

xiv. Appoint Clinical Directors and the Chief of Surgery to the MSEC.

xv. Review and authenticate the MSEC and Medical Staff meeting minutes.

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xvi. Promote adherence to the Bylaws, Policies, and Rules and Regulations of the Medical Staff and to the Policies and Procedures of the Hospital.

xvii. Be the spokesperson for the Medical Staff in its external professional and public relations.

xviii. Perform all functions authorized in all applicable policies, including collegial intervention steps outlined in the Credentials Manual.

xix. Collaborate with the Chief Nurse in matters relating to nursing support and patient care.

xx. Not be entitled to any stipend/honorarium for such duties.

c. TERM OF OFFICE

The Chief of Staff shall serve for a term of two (2) years or until a successor is elected. The officer shall assume office on May 1st of the elected year.

4.3.3. Deputy Chief of Staff

a. DESIGNATION

The Deputy Chief of Staff is appointed by the Chief of Staff and supported by MSEC.

b. DUTIES OF DUPUTY CHIEF OF STAFF

The Deputy Chief of Staff shall:

i. Act as the Chief of Staff, in their absence and shall assume all authority and discharge the responsibilities of the Chief of Staff.

ii. Perform such further duties in the absence of the Chief of Staff, when required.

iii. Assist the Chief of Staff as requested in support of MSEC functions.

4.3.4. Chief of Surgery

a. DESIGNATION

i. The Chief of Surgery is appointed by the Chief of Staff after consultation with the Medical Director and the Hospital Administrator (or designee).

ii. He or she must be a surgeon and an Active member of the Medical Staff of at least 12 months.

b. DUTIES

The Chief of Surgery is responsible, but not limited to the following:

i. Overseeing the surgeons that rely on our Operating Theatre Services.

ii. Chairperson of the Operating Theatre User Committee (OTUC), thereby ensuring that the OTUC fulfills its duties and responsibilities.

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iii. Provide continuous improvement process and methods of performance evaluation for appointment and reappointment for surgical privileging.

iv. Communicating with MSEC any challenges and changes that arise and that must be collectively addressed.

v. Partnering with other Medical Staff committees and organizations associated with Doctors Hospital to bring about excellent surgical services and foster evidence-based surgical expectations by all surgical specialists given clinical privileges.

vi. Collaborate with Operating Theatre Manager and surgical services team to ensure efficient operating theatre utilization and fair surgical practice governance as determined by the OTUC.

vii. Act as the General Surgery Clinical Director if a General Surgeon, if not a separate General Surgeon Clinical Director will be appointed.

viii. Not be entitled to any stipend/honorarium for such duties.

c. TERM OF OFFICE

The Chief of Surgery shall serve for a term of two (2) years or until a successor is appointed. The officer shall assume office on May 1st of the elected year.

4.3.5. Clinical Directors

a. DESIGNATION

i. There is a designated Clinical Director of each Clinical Service. That individual must be a voting member (Active, Associated or Affiliate) of the Medical Staff and a designated member of that clinical service.

ii. This position of Clinical Director is appointed by the Chief of Staff.

b. RESPONSIBILITIES OF CLINICAL DIRECTOR

Each Clinical Director shall:

i. Be responsible for clinically and administratively related activities of the clinical service.

ii. Oversee continuing surveillance of the professional performance of individuals in the clinical service who have delineated clinical privileges.

iii. Recommend criteria for clinical privileges that are relevant to the care provided in the clinical service.

iv. Review and report on applications to the Medical Director for initial appointment, reappointment, including interviewing applicants.

v. Assess and recommend to the Hospital off-site sources for needed patient care services not provided within the clinical service or the Hospital.

vi. Integrate the clinical service into the primary functions of the Hospital.

vii. Coordinate and integrate new and existing clinical services.

viii. Develop and implement programs, policies and procedures that guide and support the provision of services, including clinical practice guidelines, utilization review and research.

ix. Recommend a sufficient number of qualified and competent persons to provide patient care service.

x. Determine the qualifications and competence of clinical service personnel who provide patient care services.

xi. Oversee continuous assessment of clinical service staff and improvement of the quality of care and services provided, including review at reappointment.

xii. Maintain quality monitoring programs, as appropriate.

xiii. Oversee orientation and continuing education of persons in the clinical service.

xiv. Assist in developing an on-call schedule to reflect the services that are available, if requested.

xv. Conduct clinical service meetings and report minutes to the Medical Director and MSEC.

xvi. Perform functions authorized in the Credentials Manual and Investigation & Fair Hearing Manual, including collegial intervention.

c. TERM OF OFFICE

The Chief of Surgery shall serve for a term of two (2) years or until a successor is appointed. The officer shall assume office on May 1st of the elected year.

4.3.6. Member-at-Large (of Medical Staff)

a. Designation

This is member of the Active or Associate Medical Staff, elected by the Medical Staff and who is not a Clinical Director to serve as a clinical advisor to the Chief of Staff in alignment with the MSEC.

b. Term of Office

The Member-at-Large shall serve for a term of two (2) years or until a successor is appointed. The officer shall assume office on May 1st of the elected year.

4.3.7. Hospital Administrator (or Designee)

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This individual serves the administrative functions of the Hospital and may sit on the Hospital Administration Committee (HAC). He/she is an ex-officio member of the MSEC.

4.4. Nominating Committee: Elections of Officers

a. COMPOSITION OF THE NOMINATING COMMITTEE

Every two (2) years, the MSEC shall appoint a Nominating Committee consisting of:

i. Chief of Staff (Chairperson)

ii. Medical Director

iii. Clinical Directors (3)

The Chairperson has the deciding vote when necessary. The following are nominated Officers of the Medical Staff:

i. Chief of Staff

ii. Member-At-Large

b. NOMINATIING PROCESS:

i. The Nominating Committee will meet prior to the annual meeting (1st Monday of March) to consider nominee(s) for office.

ii. The Nominating Committee will contact the potential nominee(s), advise them of the obligations of the position for which they are being considered, and inquire about their willingness to serve.

iii. The Nominating Committee will also consider whether potential nominee(s) satisfy the eligibility criteria set forth in Article III of these Bylaws.

iv. Only individuals who satisfy these eligibility criteria will be included on the ballot.

v. At least two weeks prior to the day of the first day of the election (1st Monday of April), the Medical Staff will be provided with a list of the nominee(s) and the positions (Chief of Staff & Member at Large Only) for which they have been nominated.

vi. At that same date or no later than two weeks prior to the first day of the election, at least 50% of the voting members of the Medical Staff may submit any signed petition to the nominating committee naming any other eligible member(s) of the Medical Staff for inclusion on the ballot.

vii. Once all nominated members are confirmed eligible by the Nominating Committee,

contact will be made by the Nominating Committee to ensure their commitment to serve in the positions being nominated.

viii. One week prior to the first day of the election, the Nominating Committee will prepare a final ballot, a copy of which will be provided via email to:

- All voting members of the Medical Staff
- Human Resources Manager
- Hospital Administrator (designee).

ix. A ballot will not be required if a position is uncontested.

c. ELECTION:

i. Through the auspices of the Medical Staff Office and the Human Resources Department, the Medical Staff Executive Committee will establish a specific, continuous two (2) week period (from the 1st Monday of April) during which the election of the nominated Officers of the Medical Staff will be held.

ii. Only the Active, Associate and Affiliate Staff members of the Medical Staff can vote in the election of the Chief of Staff and Member at Large.

iii. Votes must be received by the Medical Staff Office within the established two (2) week election period in order to be counted.

iv. The election will be by written or electronic ballot.

v. Nominated members who received the most votes cast will be acknowledged as elected, subject to Board confirmation. Uncontested nominated members will be acknowledged as elected, subject to Board confirmation.

d. VACANCIES:

i. A vacancy in the office of Chief of Staff will be filled by the Deputy Chief of Staff, who will serve until the end of the Chief of Staff's unexpired term. In the event there is a vacancy in either the office of the Chief of Staff or the Deputy Chief of Staff, the Medical Staff Executive Committee will nominate and vote from an eligible member of the MSEC to be appointed for the remainder of the unexpired term. If there is no consensus of the majority vote from the MSEC, a special election must be held.

ii. For any vacancy in the Office of Chief of Surgery, the Chief of Staff will appoint an

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eligible member from the MSEC for the remainder of the unexpired term.

iii. For any vacancy in the Office of Clinical Director, the Chief of Staff will appoint an eligible member from the Medical Staff for the remainder of the unexpired term.

iv. For any vacancy in the Office of the Member-At-Large, the Medical Staff Executive Committee will nominate and vote for an eligible member from the Medical Staff to be appointed for the remainder of the unexpired term.

4.5. TERM AND REMOVAL PROCEEDINGS

4.5.1. Term

Unless otherwise stated in these Bylaws, Officers of the Medical Staff (except the Medical Director) will take office on the first day of the Medical Staff year (by no later than May 1st) and will serve a two-year term.

4.5.2. Removal of Officers

a. Justifications for removal include:

i. Non-compliance to applicable policies, bylaws, manuals, or rules and regulations of the Medical Staff;

ii. Non-fulfilment of duties of the position;

iii. Any behaviour or decorum contrary to those expected from members of the Medical Staff; or

iv. Failure to remain in good standing to the eligibility criteria set forth in these Bylaws.

b. Removal of an Officer of the Medical Staff (except the Medical Director) may be effectuated by the following proceedings:

i. A petition of 25% of the voting members (Active/Associate/Affiliate) of the Medical Staff in favor of removing a Medical Staff Officer;

ii. followed by a subsequent 2/3 affirmative vote of Active, Associate and Affiliate Staff members of the Medical Staff approving the removal;

iii. followed by approval of the removal by the Administrator (or designate).

c. Whenever the Medical Staff Executive Committee seeks to consider a removal, prior to scheduling a Medical Staff Executive Committee meeting to consider such action, the Chief of

Staff and the Medical Director will meet with the Officer in question and inform him/her of the reasons for the proposed removal proceedings. Said Officer must be given at least thirty days special notice of the date of the Medical Staff Executive Committee meeting at which removal is to be considered. The Officer will be afforded an opportunity to speak to the Medical Staff Executive Committee prior to a vote on removal. Until such time of audience with the Medical Staff Executive Committee, that Officer is exempt from all meetings of the MSEC and obligations unless otherwise requested by the Chief of Staff.

d. Removal of the Medical Director is not governed by the above process as the Medical Director reports to the Hospital Administrator or designate or Hospital Administration Committee.

e. If any of the above justifications become apparent and are valid in the option of the majority of members of MSEC about the Medical Director – the Chief of Staff and two other MSEC members should arrange a meeting forthwith with the Hospital Administration Committee, Hospital Administrator or designate to communicate these justifications. The Hospital Administration Committee, Hospital Administrator or designate with decide the next course of action.

5. ARTICLE V: CLINICAL SERVICES

5.1. ORGANIZATION

5.1.1. Organization of Clinical Services

Each clinical service will be organized as a clinical unit and will have a Clinical Director who has the authority, duties, and responsibilities as set forth in these Bylaws. The Medical Staff will be organized into those clinical services set forth in the Clinical Services Manual.

5.1.2. Creation and Dissolution of Clinical Services

The clinical service structure should support the needs of the Hospital. The Board may create new clinical services, eliminate clinical services, or otherwise reorganize the clinical service structure, upon the recommendation of the Medical Director and the Medical Staff Executive Committee. Approval by the Medical Staff is not required for changes in the clinical service structure.

5.1.3. Assignment to Clinical Service

a. Upon initial appointment, each member will be assigned to a clinical service. Assignment to

a clinical service does not preclude an individual from seeking and being granted clinical privileges typically associated with another clinical service.

b. An individual may request a change in clinical service assignment to reflect a change in clinical practice.

5.1.4. Functions of Clinical Services

a. The clinical services will be organized for the purpose of implementing processes to monitor and evaluate the quality and appropriateness of the care of patients and to monitor the practice of those with clinical privileges in a given clinical service.

b. Each clinical service will oversee emergency roster coverage for patients who present to the Outpatient department and elsewhere in the Hospital, as may be needed.

c. Members of the clinical service are required to participate in emergency call coverage, as required by the Medical Director, Administrator, HAC or designate.

6. ARTICLE VI: MEDICAL STAFF COMMITTEES, PERFORMANCE AND QUALITY IMPROVEMENT FUNCTIONS

6.1. APPOINTMENT

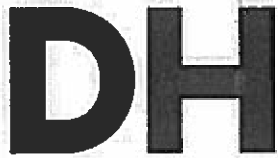
a. Except as otherwise specifically designated in these Bylaws, chairpersons and members of standing Medical Staff committees will be appointed by the Chief of Staff in collaboration with the Medical Director.

b. Committee chairpersons will be selected based on the criteria set forth in these Bylaws for officers or already outlined by the Terms of Reference of each committee.

c. Chairpersons and members of standing committees will be appointed for an initial term of up to two years, but may be reappointed for additional terms.

6.2. MEDICAL STAFF FUNCTIONS AND SUPPORT

a. Provision will be made for the effective performance of Medical Staff functions through committees as may be established by the Medical Staff Executive Committee. The composition, duties and meeting requirements of additional committees will be set forth in the Organization Manual.



b. The Medical Staff Office (MSO) has the privilege to support the MSEC and all other Medical Staff Committees in their fulfilment of duties and actions.

c. The MSO requires all committees to provide records of their meeting minutes to effect changes or recommendations among clinical services, departments or the organization as a whole.

6.3. MEDICAL STAFF EXECUTIVE COMMITTEE

6.3.1. Composition of Medical Staff Executive Committee

a. The Medical Staff Executive Committee will consist of the following:

   i. Medical Director
   ii. Chief of Staff
   iii. Deputy-Chief of Staff
   iv. Chief of Surgery
   v. Clinical Director(s)
   vi. Member-At-Large
   vii. Hospital Administrator (or designee)

b. The Chief of Staff of the Medical Staff will serve as Chairperson of the Medical Staff Executive Committee, with a vote.

c. The Hospital Administrator or the representative (or designee) of the Hospital Administration Committee is an individual who offers administrative perspective and feedback to the MSEC and is an ex-officio member without a vote.

6.3.2. Duties

a. The Medical Staff Executive Committee is delegated the primary responsibility to oversee the medical care rendered to the patients of the Hospital and for activities related to the functions of the Medical Staff with respect to the Hospital, including but not limited to credentialing, peer review, and performance improvement activities. Except as otherwise provided in these Bylaws, the Medical Staff Executive Committee may act on behalf of the Medical Staff.

b. The Medical Staff Executive Committee will perform the duties outlined below and where appropriate report to the Board through the Medical Director, Hospital Administrator (or designate) or Hospital Administration Committee on the following:

i. Act on behalf of the Medical Staff in the intervals between Medical Staff meetings.

ii. Recommend:
   - the Medical Staff's structure;
   - the mechanism used to review credentials and to delineate individual clinical privileges;
   - the delineation of clinical privileges for eligible individuals;
   - participation of the Medical Staff in performance improvement activities;
   - the mechanism by which appointment may be terminated; and
   - the hearing procedures;

iii. Make recommendations to Hospital Administrator (or designee) on quality-related aspects of contracts for patient care services with entities outside the Hospital.

iv. Receive and act on reports and recommendations from committees, clinical services, and other groups, and make recommendations for improvement when there are significant departures from established or expected clinical practice patterns.

v. Assist in the identification of community health needs in keeping with the strategic plan of the Hospital.

vi. Provide leadership in activities related to patient safety.

vii. Provide oversight in the process of analyzing and improving patient satisfaction.

viii. Review quality indicators to promote uniformity regarding patient care services.

ix. Review the depth, scope, and quality of clinical services, and educational and research programs.

x. Input in continuing medical education activities.

xi. Keep the Medical Staff abreast of accreditation requirements and inform the Medical Staff of the accreditation status of the Hospital.

xii. Advise the Board with respect to issues of policy which are inter-clinical service.

xiii. Implement and enforce Hospital and Medical Staff bylaws, policies, manuals,

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procedures and rules and regulations.

xiv. Take reasonable steps to ensure ethical and professional conduct on the part of all members, and initiate such collegial intervention or other action as may be indicated.

xv. Perform such other functions as are assigned to it by the Credentials Manual and the Investigation & Fair Hearing Manual or other applicable policies.

6.3.3. Meetings

a. The Medical Staff Executive Committee will meet as often as necessary to transact pending agenda to discussing clinical service business or strategy.

b. The Medical Staff Executive Committee will maintain a permanent record of its proceedings and actions. Copies of minutes will be transmitted to the Medical Staff Office for communication to the Hospital Management.

6.4. PERFORMANCE IMPROVEMENT FUNCTIONS

The Medical Staff is actively involved in performance improvement functions, including reviewing quality and patient safety data and recommending and implementing processes to address performance issues. A description of the committees that carry out systematic monitoring and performance improvement functions, including their composition, duties, and reporting requirements, is contained in the Organization Manual.

6.5. CREATION OF STANDING COMMITTEES

a. The Medical Staff Executive Committee may, by resolution, and without amendment of these Bylaws, establish additional Medical Staff committees to perform one or more staff functions, including peer review activities.

b. The Medical Staff Executive Committee may dissolve or rearrange the structure, duties, or composition of Medical Staff committees except the Medical Staff Executive Committee.

c. Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special task force will be performed by the Medical Staff Executive Committee.

d. Special task forces will be created and their members and chairpersons will be appointed by the Chief of Staff in conjunction with the Medical Director. Such task forces

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will confine their activities to the purpose for which they were appointed and will report to the Medical Staff Executive Committee and Hospital Management.

7. ARTICLE VII: MEDICAL STAFF MEETINGS

7.1. GENERAL

7.1.1. Medical Staff Year

For the purpose of these Bylaws, the Medical Staff year commences on the first day of May and ends on the 30th of April.

7.1.2. Meetings

a. The Medical Staff will meet at least twice a year. The date of any Medical Staff meeting can be changed with 14 days advance notification. Communication with the Medical Staff on this date change will be coordinated by the Medical Staff Office.

b. Clinical services will meet as often as necessary, but at least quarterly per calendar year. Each clinical service will maintain a permanent record of its findings, proceedings, and actions and submit the same to the Medical Staff Office to be circulated to the MSEC.

c. Standing committees will meet as set forth in these Bylaws and the Staff Organization Manual. Each standing committee will maintain a permanent record of its findings, proceedings and actions and submit the same to the Medical Staff Executive Committee.

d. Meetings may be conducted by video-conferencing or any other electronic means.

7.1.3. Regular Meetings

a. At the beginning of each Medical Staff year, the Clinical Director of each clinical service, and each standing committee, will schedule regular meetings. Members of the clinical service and committee will be notified of these dates for these meetings.

b. The attendance of any individual at any meeting will constitute a waiver of that individual's notice of the meeting.

7.1.4. Special Meetings

A special meeting of the Medical Staff may be called by or at the request of the Chief of Staff, the

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Medical Director, the Medical Staff Executive Committee, the Chairperson of the Board, or by a petition signed by at least 25% of the voting members of the Medical Staff.

a. A special meeting of any clinical service or committee may be called by or at the request of the relevant Clinical Director, the Chief of Staff, the Medical Director, or by a petition signed by at least 25% of the members of the clinical service or committee.

b. No agenda will be transacted at any special meeting except that stated in the meeting notice.

7.1.5. Notice

a. The notice of regular and special meetings will state the date, time, and place of the meeting.

b. Notice of special meetings of any clinical service or any committee will be provided to each voting member of the relevant clinical service or committee at least three (3) business days in advance of the meeting.

c. Notice of special meetings of the Medical Staff will be provided to each voting member of the Medical Staff at least thee (3) business days in advance of the meeting.

7.1.6. Quorum

a. Except as otherwise provided in these Bylaws or the Medical Staff Organization Manual, for any regular or special meeting of the Medical Staff, clinical service or committee, those voting members present will constitute a quorum. When voting occurs by mail or electronic ballot, those voting members who return a ballot will constitute a quorum. This quorum standard applies to votes on amendments to these Bylaws.

b. For meetings of the Medical Staff Executive Committee and all other Medical Staff Committees, the presence of at least 50% of the voting committee members will constitute a quorum.

c. Once a quorum is established, the agenda of the meeting may commence and actions taken will be binding.

7.1.7. Voting

a. Any individual, regardless of position or staff category, will only be eligible to vote once on any issue.

b. Recommendations and actions of the Medical Staff, clinical services and committees will be by consensus. Except as otherwise provided in these Bylaws, in the event it is necessary to vote on an issue, the issue will be determined by a majority vote of those individuals present and eligible to vote.

c. Any matter may be presented by notice and votes returned to the relevant chairperson or chief by the method designated in the notice.

7.1.8. Agenda

a. The Chief of Staff in conjunction with the Medical Director will set the agenda for regular and special meetings of the Medical Staff.

b. The Clinical Director of each clinical service and chair of each committee will set the agenda for general and special meetings of the respective clinical service and committees.

c. The Medical Staff Office will support the dissemination of agenda prior to meetings, with a minimum of three (3) business days prior to scheduled meeting.

7.1.9. Rules of Order

The latest edition of Robert's Rules of Order Revised may be used for reference at meetings and elections, but will not be binding. Specific provisions of these Bylaws and Medical Staff, clinical service and committee custom will prevail at meetings, and the Medical Director, the Chief of Staff of the Medical Staff, Clinical Directors or committee chairperson will have the authority to rule definitively on matters of procedure.

7.1.10. Minutes

a. Minutes of Medical Staff, clinical service, and committee meetings will be prepared and will include the recommendations made.

b. The Hospital Administrator (or designee) and the Medical Staff Executive Committee will receive a copy of minutes and reports of the meetings of Medical Staff, clinical services and committees. The Board will be kept aware of relevant recommendations of the Medical Staff through the Hospital Administrator or designate.

c. A permanent file of the minutes of meetings will be maintained by the Medical Staff Office.

7.2. ATTENDANCE REQUIREMENTS

Medical Staff Bylaws

a. Members of the Medical Staff Executive Committee and the Credentialing, Privileging and Clinical Review Committee are expected to attend at least one-half of the meetings held.

b. Whenever there is an apparent or suspected deviation from standard clinical practice, or professional conduct, involving any individual, the clinical director or the Chief of Staff may require the individual to attend a special conference with Medical Staff Leaders and/or with a standing or ad hoc committee of the Medical Staff. The procedures for, and consequences of failing to abide by, these special attendance requirements are addressed in the Investigation & Fair Hearing Manual.

8. ARTICLE VIII: BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentials Manual and the Investigation & Fair Hearing Manual.

8.1. QUALIFICATIONS FOR APPOINTMENT

An applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct and ability to safely and competently perform the clinical privileges requested as set forth in the Credentials Manual.

To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the grant of clinical privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct and ability to safely and competently perform the clinical privileges requested as set forth in the Credentials Manual.

8.2. PROCESS FOR CREDENTIALING – APPOINTMENT & PRIVILEGES

Completed applications are sent to the applicable Clinical Director, who prepares a written report to the Credentialing, Privileging and Clinical Review Committee (CPCR). The CPCR committee then prepares a recommendation and forwards it along with the Clinical Director's report to the Medical Staff Executive Committee for review and recommendation and to the Medical Director for final action.

As part of DH Disaster Planning, the Hospital Administrator (or designee) and the Medical Director may advise the Chief of Staff to modify the privileging process to confer emergency clinical privileges to urgently needed Medical Staff for immediate critical medical relief. Emergency clinical privileges

are acknowledged as only temporary, unless otherwise extended by the Credentialing, Privileging and Clinical Review (CPCR) committee.

8.3. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT

a. Appointment and clinical privileges will be automatically relinquished if an individual:

i. Fails to:
- update medical records as per Doctors Hospital policies;
- satisfy eligibility criteria, including licensure, use of controlled substance authorization, insurance coverage and/or financial responsibility.
- participate in required assessments and provide requested information;

ii. is involved or alleged to be involved in defined criminal activity; or

iii. makes a misstatement or omission on an application form.

b. Automatic relinquishment shall take effect immediately and shall continue until the matter is resolved, if applicable.

8.4. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

Whenever failure to take appropriate action results in imminent danger to the health and/or safety of any individual, any officer of the Medical Staff or clinical director, in concurrence with the Hospital Administrator (or designee); or the Board Chairperson is authorized to suspend or restrict all or any portion of an individual's clinical privileges pending an investigation.

A precautionary suspension is effective immediately and will remain in effect until it is modified by the Hospital Administrator or designate in consultation with the Medical Director and Chief of Staff, or the Board.

The individual shall be provided a brief written description of the reason(s) for the precautionary suspension.

a. The Credentialing, Privileging and Clinical Review (CPCR) Committee will review the reasons for the suspension as per Investigation and Fair hearing manual.

b. Prior to, or as part of this review, the individual will be given an opportunity to meet with the CPCR Committee.

8.4.1. Termination of Suspension of Appointment and Privileges or Reduction of Privileges

a. Following an investigation, the Medical Staff Executive Committee may recommend suspension or revocation of appointment or clinical privileges based on concerns about

  i. clinical competence or practice;
  ii. violation of ethical standards or the bylaws, policies, manuals, rules and regulations of the Hospital or the Medical Staff; or
  iii. conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff.

b. The Medical Staff Executive Committee may, with the approval of the Hospital Administrator (or designee), institute one or more disciplinary suspensions of a member.

8.5. HEARING AND APPEAL PROCESS

This process is outlined in detail in the Fair Hearing and Investigation Manual.

9. ARTICLE IX: CONFLICT MANAGEMENT

9.1. CONFLICT MANAGEMENT PROCESS

a. A special meeting of the voting members of the Medical Staff will be called when there is a conflict between the Medical Staff and the Medical Staff Executive Committee with regard to:

  i. proposed amendments to the Medical Staff Rules and Regulations,
  ii. a new policy proposed by the Medical Staff Executive Committee, or
  iii. proposed amendments to an existing policy that is under the authority of the Medical Staff Executive Committee

b. The agenda for that meeting will be limited to attempting to resolve the conflict.

c. If the conflict cannot be resolved, the Medical Staff Executive Committee will forward its recommendations, along with the proposed recommendations

pertaining to the conflict to the Board for final action.

d. This conflict management section is limited to the matters noted above. It is not to be used to address any other issue including, but not limited to, professional review actions concerning individual members of the Medical Staff.

10. ARTICLE X: AMENDMENTS TO MEDICAL STAFF BYLAWS

a. Amendments to these Bylaws may be proposed by a petition signed by 25% of the Active Staff members of the Medical Staff, the Board of Directors or by the Medical Staff Executive Committee.

b. The Medical Staff Executive Committee (MSEC) must review all amendments being proposed prior to a vote by the Medical Staff prior to a vote. These amendments must also be circulated to the Medical Staff at the next regular meeting of the Medical Staff or at any special meeting called for such a purpose.

c. The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, the amendment must receive a majority of the votes cast.

d. The Chief of Staff, in collaboration with the Medical Director and the Hospital Administrator (or designee), may decide to present any proposed amendments to the voting members of the Medical Staff by written or electronic ballot, which must be returned to the Medical Staff Office within five days. In addition to any proposed amendments, a written report in support of said amendment from the Medical Staff Executive Committee is acceptable.

e. An amendment must receive a majority of the votes cast for it to be approved.

f. The Medical Director will provide approved amendments to the Board of Directors through the Hospital Administration Committee.

g. Amendments will be effective only after being adopted by the Board.

h. If the Board has agreed not to accept the recommendation submitted to it by the Medical Staff Executive Committee or the Medical Staff, the Medical Staff Executive Committee may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference will be for the purpose of further

communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. The conference must be conveniently scheduled by the Medical Staff Office within two weeks after receipt of a request.

11. ARTICLE XI: ASSOCIATED DOCUMENTS

11.1. OTHER MEDICAL STAFF DOCUMENTS

a. In addition to the Medical Staff Bylaws, there shall be policies, manuals, procedures, and rules and regulations. These documents include, but are not limited to:

   i. Credentials Manual
   ii. Investigation & Fair Hearing Manual
   iii. Medical Staff Organization Manual
   iv. Medical Staff Rules and Regulations
   v. Clinical Services Manual

b. An amendment to the Credentials Manual may be made by a majority vote of the members of the Medical Staff Executive Committee, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Medical Staff Executive Committee.

c. An amendment to the Investigation & Fair Hearing Manual or the Organization Manual, which outlines the Medical Staff committee structure, may be made by a majority vote of the members of the Medical Staff Executive Committee.

d. An amendment to the Medical Staff Rules and Regulations may be made by a majority vote of the members of the Medical Staff Executive Committee. Notice of proposed amendments to the Rules and Regulations will be provided to voting members of the Medical Staff at least 14 days prior to the vote by the Medical Staff Executive Committee. Any voting member of the Medical Staff may submit written comments on the amendments to the Medical Staff Executive Committee.

e. The Medical Staff Executive Committee and the Board have the power to provisionally adopt urgent amendments to the Rules and Regulations that are

needed in order to comply with a law or regulation, without prior notification of the proposed amendments to the Medical Staff. Notice of all provisionally adopted amendments will be provided to each member of the Medical Staff as soon as possible. The Medical Staff will have 14 days to review and provide comments on the provisional amendments to the Medical Staff Executive Committee. If there is no conflict between the Medical Staff and the Medical Staff Executive Committee, the provisional amendments will stand. If there is conflict over the provisional amendments, then the process for managing conflicts set forth below shall be implemented.

f. All other policies of the Medical Staff may be adopted and amended by a majority vote of the Medical Staff Executive Committee. No prior notice is required. Members of the Medical Staff will be provided with notice of the adoption or amendment of policies after final action by the Board.

g. Amendments to Medical Staff policies and Rules and Regulations may also be proposed by a petition signed by 25% of the voting members of the Medical Staff. Any such proposed amendments will be reviewed by the Medical Staff Executive Committee.

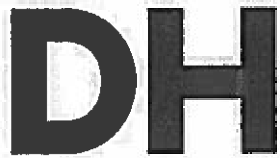
h. Adoption of and changes to the Credentials Manual, Investigation & Fair Hearing Manual, Organization Manual, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.

12. ARTICLE XII: DOCUMENT APPROVAL

These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any previous Medical Staff Bylaws.

Originally adopted on February 10th 2021.

Adoption and Approval Acknowledged by:



Medical Staff Bylaws

Approved By	Chief of Staff	Date	2022-
Approved By	Medical Director	Date	2022-
Approved By	Chairman of the Board	Date	2022-

IN THE GRAND COURT OF THE CAYMAN ISLANDS

CAUSE NO: OF 20

BETWEEN:

DR. SANJIB K. MOHANTY

PLAINTIFF

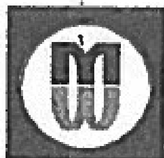
AND:

DOCTORS HOSPITAL CAYMAN

DEFENDANT

<u>ANNEX 2</u>

This is a copy of the Plaintiff's letter to the Defendant dated 22nd February 2024, referred to as Annex 2 in the Plaintiff's Statement of Claim.



MURRAY & WESTERBORG
ATTORNEYS-AT-LAW & NOTARY PUBLIC

February 22, 2024

Doctors Hospital Cayman
16 Middle Road
PO Box 2000 KY1-1104
George Town
Grand Cayman
Cayman Islands

Attention: Dr. Med Yaron Rado - The Chairman of the Board

Re: Dr. Sanjib K. Mohanty, FRCS, Consultant General Surgeon/Urologist – Renewal of Privileges at Doctors Hospital Cayman

Dear Sir,

Good day to you.

We represent Dr. Sanjib K. Mohanty, FRCS, a registered Consultant General Surgeon/Urologist, with the Health Practitioners Board of the Cayman Islands since 2001.

We write regarding the renewal of his privileges at Doctors Hospital Cayman, which we understand has been unreasonably deferred by your Medical Director, Dr. Richard Preece, and thus likely to cause our client irreparable reputational damage.

Dr. Mohanty has, for an uninterrupted period of 23 years since 2000, had privileges extended to him by your medical facility, and has accordingly attended innumerable patients at Doctors Hospital in his role as a Consultant General Surgeon/Urologist. The unreasonable deferral of his privileges has caused undue hardship to him in, among other things, having to re-schedule several appointments for patients who would have usually been attended to by him at Doctors Hospital.

We are also instructed that Dr. Preece has determined and advised our client that privileges at Doctors Hospital can only be renewed for a period of 3 years, after which our client is required to re-apply for the extension of privileges. This has never been the case with respect to our client for the past 23 years or, to the best of his knowledge, with any other medical practitioner who has had privileges at your medical facility.

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We are further instructed that Doctors Hospital is currently seeking Joint Commission International (JCI) Accreditation pursuant to which the hospital has been seeking to verify the credentials of medical practitioners employed to the facility as well as those to whom privileges have been extended, including Dr. Mohanty.

Whilst we understand that determining medical staff membership through staff qualifications and education (SQE) verification is integral to obtaining JCI accreditation, we take the view that though the expected standard is to be applied uniformly, this does not mean that it is to be applied in the same manner with respect to each and every medical staff. Allowances for differing approaches, based on the circumstances of each medical staff, is clearly outlined in the JCI Standard SQE.9.

Despite this it appears that Dr. Preece has taken the view that primary source verification is the JCI mandated approach to SQE verification. This, in our view, is entirely erroneous.

Pursuant to the JCI SQE.9 "*verification is the process of checking the validity and completeness of a credential from the source that issued the credential. This process can be accomplished by an inquiry to a secure online database of, for example, those individuals licensed in the hospital's city or country. This process can also be accomplished by documenting a telephone conversation with the issuing source, or by corresponding via email or conventional postal letter with the source. Verification of credentials from outside the country may be more complex and, in some cases, not possible. There should, however, be evidence of a credible effort to verify the credential. A credible effort is characterized by multiple (at least two within 60 days) attempts by various methods (for example, phone, e-mail, and letter) with documentation of the attempts and results(s).*

Dr. Preece appears to have unreasonably rejected this clear guidance on the required process of verification. Dr. Preece has, despite the availability of records showing that Dr. Mohanty is registered as a Consultant General Surgeon/Urologist with the Health Practitioners Board of the Cayman Islands since 2001, unreasonably determined not to rely on these records to verify Dr. Mohanty's credentials.

The guidance to verification of credentials provided by the JCI clearly accepts the difficulty that at times occasions attempts to verify credentials obtained outside the country where the hospital operates and suggests that what is required in these instances is the documentation of all credible attempts at verification.

Dr. Mohanty has provided Dr. Preece with all his credentials and it appears, from communications between them, that Dr. Preece has made several credible efforts to verify our client's credentials which were obtained from overseas without success. However, rather than adhering to the JCI's guidance on verification of credentials, by documenting these efforts and relying on the records from the Health Practitioners Board of the Cayman Islands, Dr. Preece has unreasonably decided that nothing short of primary source verification will suffice.

The JCI SQE.9 clearly provides acceptable substitutes for primary source verification of credentials, namely:

1. *"Applicable to hospitals overseen directly by government bodies, the government's verification process, supported by availability of published government regulations about primary source verification; plus government licensure, or equivalent such as registration; and granting of specific status (for example, consultant, specialist, and others) are acceptable. As with all third-party verification processes, it is important to verify that the third party (for example, a government agency) implements the verification process as described in policy or regulations and that the process meets the expectations described in these standards.*

2. *Applicable all hospitals, an affiliated hospital that has already conducted primary source verification of the medical staff applicant is acceptable as long as the affiliated hospital has current JCI accreditation with "full compliance" on its verification process found in SQE.9.1, ME's 1 and 2. Full compliance means that the hospital's Official Survey Findings Report indicates that all measurable elements are fully met, or any not met or partially met measurable element required to be addressed by Strategic Improvement Plan (SIP) actions have been addressed and are now in full compliance.*

3. *Applicable to all hospitals, the credentials have been verified by an independent third party, such as a designated, official, governmental, or nongovernmental agency, as long as the following conditions apply: Any hospital that bases its decision in part on information from a designated, official, governmental, or nongovernmental agency should have confidence in the completeness, accuracy, and timeliness of that information. To achieve this level of confidence in the information, the hospital should evaluate the agency providing the information initially and then periodically thereafter ensure that JCI standards continue to be met."*

We are instructed that despite these available and accepted JCI substitutes Dr. Preece has unreasonably determined that with respect to Dr. Mohanty primary source verification is the only means by which his qualifications and experience can be verified.
Dr. Preece has taken this position despite being acutely aware that the difficulties that will likely occasion attempts at primary source verification of Dr. Mohanty's credentials.

We say Dr. Preece is acutely aware of this as it was he who provided our client with a copy the Grand Court Decision, by the then Chief Justice, Sir Anthony Smellie, in Mohanty v. Health Practitioners Board [2001 CILR 459]. In that case, which was brought by our client challenging the then Health Practitioners Board's (HPB) refusal to register our client as a specialist urologist in the Cayman Islands, the then Chief Justice determined that the HPB's refusal was unfair and unreasonable. The then Chief Justice in his decision carefully reviewed Dr. Mohanty's qualifications and the post-1997 UK criteria for consultancy status being applied by the HPB and determined that the HPB's strict adherence to those criteria, which is akin to primary source verification of credentials, to be unreasonable, unfair and oppressive to our client. Following the decision the then Chief Justice the HPB reviewed its decision and properly registered our client as a Consultant General Surgeon/Urologist.

It is rather astonishing that, despite being so acutely aware of the difficulties occasioning primary source verification of overseas credentials with respect to our client, Dr. Preece is adamant that such verification is required for a re-appointment of Dr. Mohanty's privileges with Doctors Hospital. We, though we do not hasten to do so, are bound to cast suspicion on Dr. Preece's motives for taking this stance.

Further, the JCI SQE.9 asserts that in circumstances of Renewal, which we assert clearly applies to Dr. Mohanty's privileges at Doctors Hospital, the medical facility need only review the medical staff member's file to verify:

- *Continued licensure;*
- *That the medical staff member is not compromised by disciplinary actions of licensing and certification agencies;*
- *That the file contains sufficient documentation for seeking new or expanded privileges or duties in the hospital; and*
- *That the medical staff member is physically and mentally able to provide patient case and treatment without supervision.*

It appears from this further guidance that the re-appointment of Dr. Mohanty's privileges at Doctors Hospital, which is licensed to operate within these islands by the government of the Cayman Islands, can be accomplished by verification of his continued licensure with the Health Practitioners Board of the Cayman Islands as a Consultant General Surgeon/Urologist.
Further, Dr. Mohanty's credentials can easily be verified, pursuant to the JCI SQE.9 guidance to verification, by relying on the verification completed by the Health Services Authority (HSA), which is JCI Accredited.

In all the circumstances we take the view that Dr. Preece's insistence that primary source verification according to JCI, as it relates to Dr. Mohanty's credentials as a Consultant General Surgeon/Urologist, is the only means by which to determine staff membership and thereby continue to extend privileges to our client, is unreasonable, unfair and oppressive to him.

We would invite Doctors Hospital, in fairness to our client, to review its position in this regard bearing in mind the Grand Court decisions in Mohanty v. Health Practitioners Board [2001 CILR 459].

We suggest that in all the circumstances it would only be fair to our client that Doctors Hospital employs one of the acceptable substitutes to primary source verification of his qualifications and education as outlined in the JCI SQE.9 Determining Medical Staff Membership, in determining his qualifications and experience as a general practitioner and specialist urologist.

We ask that Doctors Hospital, bearing in mind the many years for which our client has been registered as such in these islands and his decades of experience and practice as a Consultant General Surgeon/Urologist, consider his position favourably.

We await your response to the issues raised by our client.

Regards,

Murray & Westerborg
Attorneys-At-Law & Notary Public

IN THE GRAND COURT OF THE CAYMAN ISLANDS

CAUSE NO: OF 20

BETWEEN:

DR. SANJIB K. MOHANTY

PLAINTIFF

AND:

DOCTORS HOSPITAL CAYMAN

DEFENDANT

ANNEX 3

This is a copy of the Defendant's letter to the Plaintiff dated 24th February 2024, referred to as Annex 3 in the Plaintiff's Statement of Claim.

DH

16 Middle Road, George Town
P.O. Box 2000
Grand Cayman KY1-1104
Cayman Islands

February 24th, 2024

Greg G. Walcolm
Murray & Westerborg
PO Box 10067, #10 Shipping Lane, 2nd Floor, Cayman Shipping Centre Building
Grand Cayman, KY1-1001, CAYMAN ISLANDS.

Re: Dr. Sanjib Mohanty – Renewal of Privileges at Doctors Hospital

Dear Sir,

The maximum duration of privileges at DH is three years (JCI Standard SQE12) as stated in our by-laws. On 29 January the Medical Director made an extra effort to collaborate closely with Dr. Mohanty to obtain information that would enable Primary Source Verification to facilitate his renewal. Dr Mohanty did not provide this information. He was then informed that his privileges had become time-expired.

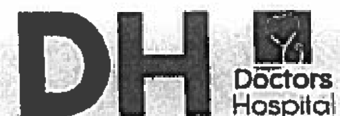
In you letter from 22nd of February you share the understanding Dr. Mohanty's privilege renewal has been unreasonably deferred. This is not the case. He is invited to complete the renewal / reapplication process.

As a hospital, we ensure that privileging decisions are made in accordance with established procedural regularities, free from bias or discrimination, with transparent communication, and grounded in evidence-based decision-making. All physicians whose privileges were granted over three years ago are being asked to go through the reapplication procedure. This process is beginning with those physicians who have been the most active and have held the longest tenure.

Primary Source Verification (PSV) is a crucial process in credentialing and privileging in healthcare. It involves verifying a practitioner's credentials directly from the original source, such as medical schools, licensing boards, and other relevant institutions. This process helps ensure that the information provided by the practitioner is accurate and reliable. The Cayman Islands Medical and Dental Council (MDC) does not do Primary Source Verification (PSV). Doctors Hospital is not able to rely on MDC registration and as such every privileged physicians is going through PSV from another awarding organization.

Dr Mohanty is registered with MDC as a 'General Surgeon with a specialist interest in Urology'. He was invited to provide specific information to enable PSV as part of a re-application:

1. *Provide full details of appointments held in the period March 1988 – 1991 (before moving to the Cayman Islands)*



DH

16 Middle Road, George Town
P.O. Box 2000
Grand Cayman KY1-1104
Cayman Islands

2. *Provide an explanation why your surgical residency in India was not recognized in the UK so you held training appointments in the UK*

At the meeting on 29 January Dr Mohanty was adamant DH could not keep his credentials information on file. This is obviously essential not just for the period of privileges but some time afterwards in case an issue arises. He was informed that if he proceeded with a reapplication all his data supporting this would be retained throughout the period he held those privileges (and any ensuing reapplication periods).

He will also need to participate in a first **Professional Practice Evaluation** (PPE) with the Medical Director prior to being able to exercise privileges. PPE is critical component of the credentialing and privileging process in healthcare and has been approved by DH's MSEC (Medical Staff Executive Committee). It involves the ongoing assessment of a practitioner's clinical competence, professional conduct, and adherence to standards of care. By incorporating PPE into their credentialing and privileging practices, healthcare organizations can uphold high standards of quality, safety, and professionalism in patient care delivery, it is required by JCI.

All the above is required of all privileged doctors at Doctors Hospital and as such Dr. Mohanty's pathway for privilege renewal was not "unreasonably deferred". In addressing the evolving nature of healthcare, it's imperative to ensure that privileging procedures remain aligned with the latest standards and practices.

With respect to Dr. Mohanty's extensive experience, the hospital administration kindly encourages all practitioners, including seasoned professionals, to remain adaptable to changes in the medical field. Embracing updates in privileging procedures not only enhances patient care but also reflects the commitment to excellence that defines our institution.

The hospital values Dr. Mohanty's insight and cooperation as we collectively navigate these necessary adjustments for the betterment of our patients and the practice.

Regards,

Dr. Y[illegible] Rado
Chairman of the Board of Directors

IN THE GRAND COURT OF THE CAYMAN ISLANDS

CAUSE NO: OF 20

BETWEEN:

DR. SANJIB K. MOHANTY

PLAINTIFF

AND:

DOCTORS HOSPITAL CAYMAN

DEFENDANT

<u>ANNEX 4</u>

This is a copy of the Plaintiff's letter to the Defendant dated 22nd March 2024, referred to as Annex 4 in the Plaintiff's Statement of Claim.

MURRAY & WESTERBORG
ATTORNEYS-AT-LAW & NOTARY PUBLIC

March 22, 2024

Doctors Hospital Cayman
16 Middle Road
PO Box 2000 KY1-1104
George Town
Grand Cayman
Cayman Islands

Attention: Dr. Med Yaron Rado - The Chairman of the Board

Re: Dr. Sanjib K. Mohanty, FRCS, Consultant General Surgeon/Urologist – Privileges at Doctors Hospital Cayman

Dear Sir,

Reference is made to yours of February 24, 2024.

We remain of the view that you have unreasonably revoked our client's privileges. To revoke his privileges until you have completed Primary Source Verification (PSV) does not accord with the JCI recommended verification process and is therefore unreasonable. That process contemplates the completion of an 'initial survey', employing JCI SQE9, where the hospital completes the verification of qualifications of new medical staff members employed within the 12 months preceding the initial survey. Thereafter, the hospital is allowed 12 months to complete the verification of credentials of all other medical staff. JCI SQE12, as adopted in your recently implemented by-laws, cannot be used as a basis for revoking our client's privileges where SQE9 has not yet been completed by the hospital, as the former is the periodic (3 year minimum) confirmation of the latter. Further SQE9 refers to the *'appointment'* of a medical practitioner's privileges, whilst SQE12 refers to the *'re-appointment'* of those privileges.

As we understand that Doctors Hospital is still within the stage of verifying the qualifications of medical staff. As such, until that is completed Doctors Hospital should have allowed our client's privileges to continue whilst this process is being undertaken. Rather than purporting to use a newly implemented term limit under the guise of SQE12 to revoke our client's privileges whilst at the same time seeking to verify our client's credentials.

Our client has at all times been cooperative with Dr. Preece and has provided him with all information he has requested in order to facilitate (PSV). He has provided the requested documents on two occasions to Dr. Preece. On 29 January 2024 our client did not fail to provide his qualifications to Dr. Preece, rather our client insisted, as is his right, that the documents provided to Dr. Preece should only be retained for the purpose for which they were provided, that is, to facilitate PSV. Once the PSV

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process was completed we are of the view that our clients documents should be returned to him rather than be retained by Doctors Hospital. Three (3) months should be sufficient to complete the PSV.

In the spirit of full cooperation, our client provides the below response to the information requested in order to complete PSV, those inquiries being:

1. *Provide full details of appointments held in the period March 1988 – 1991 (before moving to the Cayman Islands.*
2. *Provide an explanation why your surgical residency in India was not recognized in the UK so you held training appointments in the UK.*

The UK, more appropriately the General Medical Council of the UK has a consensus that if a Physician's Primary Medical Qualifications (PMQ's) are from outside the UK and not a relevant European qualification, then to obtain GMC registration the physician must be eligible to take the Professional and Linguistics Assessment Board (PLAB) test. Our client qualified for and successfully passed the PLAB test on 22 July 1988.

After passing the PLAB test our client was employed/trained in the NHS in Senior House Officer posts which were supervised posts for surgical training in the UK, namely:

1. Royal Gwent Hospital, Newport, Wales;
2. Walsall Manor Hospital, West Midlands;
3. Middlesbrough General Hospital, South Tees;
4. Stonehouse Hospital, Lanarkshire; and
5. Hexham General Hospital, Northumbria.

Our client was thereafter employed to the Cayman Islands Health Services between September 1991 to April 2000.

Our client has no issue with participating in Professional Practice Evaluation (PPE), however, we cannot accept that this should be performed by Dr. Preece. We take this view because our client strongly believes that an assessment conducted by Dr. Preece would not be fair and unbiased and that Dr. Preece is not qualified to conduct the PPE.

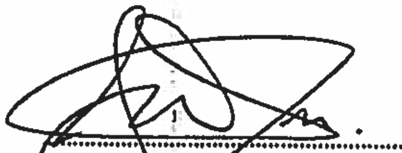
Our client has already, in a mediation meeting held on 13 December 2023 which was called to address the suspension of Dr. Glatz's privileges, complained bitterly that Dr. Preece had repeatedly accused him of failing to comply with Doctors Hospital's EMR system to document operation notes. All these allegations have been proven to be baseless. We can only surmise that the repeated allegations were an attempt to undermine our client's professionalism. Our client therefore believes that Dr. Preece would not be fair and unbiased should he conduct his PPE.

Further, the PPE should be conducted by one of our client's peers, namely a surgeon of similar qualifications and experience. Dr. Preece would not qualify as such as we understand that Dr. Preece is only licensed by the MDC in the field of Occupational Health and therefore not similarly qualified to our client. Neither does Dr. Preece similar years of experience to our client.

We take not issue with Doctors Hospital appointing a physician other than Dr. Preece, who is of similar qualifications and experience to our client to conduct the PPE.

We look forward to hearing from you as we work to resolve the issues raised by our client.

Regards,



Greg G Walcolm
Attorney-at-Law
Murray & Westerborg
Attorneys-At-Law & Notary Public

IN THE GRAND COURT OF THE CAYMAN ISLANDS

CAUSE NO: OF 20

BETWEEN:

DR. SANJIB K. MOHANTY

PLAINTIFF

AND:

DOCTORS HOSPITAL CAYMAN

DEFENDANT

ANNEX 5

This is a copy of the Plaintiff's letter to the Defendant dated 17th April 2024, referred to as Annex 5 in the Plaintiff's Statement of Claim.

MURRAY & WESTERBORG
ATTORNEYS-AT-LAW & NOTARY PUBLIC

April 17, 2024

Doctors Hospital Cayman
16 Middle Road
PO Box 2000 KY1-1104
George Town
Grand Cayman
Cayman Islands

Attention: Dr. Med Yaron Rado - The Chairman of the Board

Re: Dr. Sanjib K. Mohanty, FRCS, Consultant General Surgeon/Urologist – Privileges at Doctors Hospital Cayman

Dear Sir,

Reference is made to yours of February 24, 2024 and ours correspondence of March 21, 2024, which we are yet to receive a response from you.

Given the passage to time we request a response by close of business on Friday April 26, 2024.

Should your position regarding the subject matter remain the same, and in anticipation of litigation, we would request the following by way of discovery:

1. Doctors Hospital's records with respect to the privileges extended/granted to Dr. Mohanty for entire period for which privileges have been extended/granted to him by Doctors Hospital; and
2. Doctors Hospital's records regarding the medical qualifications held by Dr. Preece.

Regards,

Murray & Westerborg
Attorneys-At-Law & Notary Public

P.O. Box 10067 | 10 Shipping Lane | Grand Cayman KY1-1001 | CAYMAN ISLANDS | Tel.: 345-943-3838 | Fax: 345-943-3839 | Email: info.mw@candw.ky

Acknowledgement of service of writ of summons (0.12, r.3)

DIRECTIONS FOR ACKNOWLEDGMENT OF SERVICE
OF WRIT OF SUMMONS

1. The accompanying form of Acknowledgment of Service should be completed by an Attorney acting on behalf of the Defendant or by the Defendant if acting in person.

   After completion it must be delivered or sent by post to the Law Courts, P.O. Box 495G, George Town, Grand Cayman.

2. A Defendant who states in his Acknowledgment of Service that he intends to contest the proceedings must also serve a defence on the Attorney for the Plaintiff (or on the Plaintiff if acting in person).

   If a Statement of Claim is indorsed on the Writ (i.e. the words "Statement of Claim" appear on the top of page 2), the Defence must be served within 14 days after the time for acknowledging service of the Writ, unless in the meantime a summons for judgment is served on the Defendant.

   If the Statement of Claim is not indorsed on the Writ, the Defence need not be served until 14 days after a Statement of Claim has been served on the Defendant.

   If the Defendant fails to serve his defence within the appropriate time, the Plaintiff may enter judgment against him without further notice.

3. A Stay of Execution against the Defendant's goods may be applied for where the Defendant is unable to pay the money for which any judgment is entered. If a Defendant to an action for a debt or liquidated demand (i.e. a fixed sum) who does not intend to contest the proceedings states, in answer to Question 3 in the Acknowledgment of Service, that he intends to apply for a stay, execution will be stayed for 14 days after his Acknowledgment, but he must, within that time, issue a Summons for a stay of execution, supported by an affidavit of his means. The affidavit should state any offer which the Defendant desires to make for payment of the money by instalments or otherwise.

See over for notes for guidance

Please complete overleaf

Notes for Guidance

1. Each Defendant (if there are more than one) is required to complete an Acknowledgment of Service and return it to the Courts Office.

2. For the purpose of calculating the period of 14 days for acknowledging service, a writ served on the Defendant personally is treated as having been served on the day it was delivered to him.

3. Where the Defendant is sued in a name different from his own, the form must be completed by him with the addition in paragraph 1 of the words "sued as (the name stated on the Writ of Summons)".

4. Where the Defendant is a FIRM and an attorney is not instructed, the form must be completed by a PARTNER by name, with the addition in paragraph 1 of the description "Partner in the firm of (......................................)" after his name.

5. Where the Defendant is sued as an individual TRADING IN A NAME OTHER THAN HIS OWN, the form must be completed by him with the addition in paragraph 1 of the description "trading as (...........................)" after his name.

6. Where the Defendant is a LIMITED COMPANY the form must be completed by an Attorney or by someone authorised to act on behalf of the Company, but the Company can take no further step in the proceedings without an Attorney acting on its behalf.

7. Where the Defendant is a MINOR or a MENTAL PATIENT, the form must be completed by an Attorney acting for a guardian ad litem.

8. A Defendant acting in person may obtain help in completing the form at the Courts Office.

IN THE GRAND COURT OF THE CAYMAN ISLANDS

CAUSE NO: OF 20

BETWEEN:

DR. SANJIB K. MOHANTY

PLAINTIFF

AND:

DOCTORS HOSPITAL CAYMAN

DEFENDANT

ACKNOWLEDGMENT OF SERVICE OF WRIT OF SUMMONS

If you intend to instruct an Attorney to act for you, give him this form IMMEDIATELY.

Important. Read the accompanying directions and notes for guidance carefully before completing this form. If any information required is omitted or given wrongly, THIS FORM MAY HAVE TO BE RETURNED.

Delay may result in judgment being entered against a Defendant whereby he may have to pay the costs of applying to set it aside.

1. State the full name of the Defendant by whom or on whose behalf the service of the Writ is being acknowledged.

2. State whether the Defendant intends to contest the proceedings (tick appropriate box)
   ☐ yes ☐ no

3. If the claim against the Defendant is for a debt or liquidated demand, AND he does not intend to contest the proceedings, state if the Defendant intends to apply for a stay of execution against any judgment entered by the Plaintiff (tick box)
   ☐ yes ☐ no

Service of the Writ is acknowledged accordingly

(Signed)..

Attorney for

Please complete overleaf

Notes on address for service

Attorney: where the Defendant is represented by an attorney, state the attorney's place of business in the Cayman Islands. A Defendant may not act by a foreign attorney.

Defendant in person: where the Defendant is acting in person, he must give his post office box number and the physical address of his residence or, if he does not reside in the Cayman Islands, he must give an address in Grand Cayman where communications for him should be sent. In the case of a limited company, "residence" means its registered or principal office.

Indorsement by plaintiff's Attorney (or by plaintiff if suing in person) of his name, address and reference, if any, in the box below.

Indorsement by defendant's Attorney (or by defendant if suing in person) of his name, address and reference, if any, in the box below.