King Khalid University Hospital
King Abdulaziz University Hospital

MEDICAL STAFF BYLAWS

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PREAMBLE

These Medical Staff Bylaws, Rules and Regulations are established to govern the King Khalid University Hospital (KKUH) and the King Abdulaziz University Hospital (KAUH) Medical Staff, herein referred to as “Hospitals”. The bylaws provide guidelines for organizational processes to govern and evaluate practitioners applying for the hospital’s medical staff and/or clinical privileges; utilization review, quality improvement activities, corrective action, hearing and appellate, responsibilities and accountability, education, training, and overall communication channels, as described herein.

These Bylaws shall not contradict any legally binding law and shall comply with the Rules and Regulations of King Saud University, the Ministry of Health, and the Laws of the Kingdom.

By the provision of these Bylaws, KKUH/KAUH acknowledges that the Medical Staff is responsible for providing quality and safe, care, treatment, and services to all its patients. To comply with this obligation, all Medical Staff of the Hospital must be provided with the duly approved and signed Medical Staff Bylaws upon joining the Organization, and all are expected to comply with the bylaws as established.
ARTICLE 1: DEFINITION OF TERMS

The meanings set out in the Definition of Terms are to be attributed to such terms as used in these Bylaws and will be capitalized unless otherwise clearly required by the context in which such terms are used. In consulting these Bylaws the reader should first become familiar with the Definition of Terms.

When used in connection with the Medical Staff Bylaws, the following terms shall have the meaning given below, unless otherwise specified, or unless otherwise clearly required by the context in which they are used:

**Allied Health Professional** - an individual, other than a Practitioner (see definition below), possessing qualifications in one of the categories of ancillary health care, which may be determined from time to time to be beneficial to and required for patient care within the Hospital.

**Appeal** - an application from a Practitioner, who is the subject of a warning or limitation of clinical privileges, and is requesting a reconsideration of the decision.

**Attending Physician** - the qualified medical practitioner or surgeon, possessing inpatient privileges, who is responsible for care of inpatient.

**Categories** - descriptions of the types of Medical Staff according to status (e.g., "Permanent", "Trainee", "Temporary").

**Clinical Privileges** - specific rights granted to individual Practitioners authorizing the admitting of patients and/or carrying out of designated investigations and/or procedures.

**Corrective Action** - the process activated in the event of the finding of substandard professional practice.

**Emergency** - a situation in which there is an immediate danger of loss of life or serious disability and in which any delay in treatment might increase that danger.
Ethics - moral principles and values adopted by the particular profession of each Practitioner and Allied Health Professional, which shall be consistent with the policies of the Hospitals and Laws governing the practice of medicine within Kingdom of Saudi Arabia.

Ex-Officio Member - a person who serves as a member of a body by virtue of another position which he holds in the Medical Staff, the Hospitals, or Administration. Except where otherwise specifically provided to the contrary, an Ex – Officio member shall not have the right to vote.

Job Description - the legal document which describes in detail each authorized employee's position in terms of organizational relationships, duties, responsibilities, and qualifications.

Licensure - A license to practice in the indicated field of medicine issued from the Saudi Commission for Health Specialties.

Memorandum: the written transmission of information, distributed to the intended recipients/department or for general announcements to inform and/or to carry out certain functions or activities.

Notice - the oral or written transmission of information by posting within the Hospitals, inclusion in publications distributed to the intended recipients, general announcements, telephone, personal delivery, mail delivery, or any other means reasonably calculated to inform.

Policy & Procedures (PPGs) – an authorized document that describe in details staff responsibilities, how to carry out and conduct different processes and procedures and how to act in different situations.

Practice Privileges - specific rights granted to Practitioners and Allied Health Professionals authorizing the carrying out of designated investigations and/or procedures.

Practitioner - any physician or dentist licensed by the Saudi Commission for Health Specialties (SCHS) to practice his profession within the Kingdom of Saudi Arabia.

Pre-requisite - a condition which must be demonstrated to exist with respect to a Practitioner or Allied Health Professional as a prior requirement for a status or position.

Prerogative - a participatory right granted to a Practitioner or Allied Health Professional within the limitations provided by these Bylaws and other Policies of the Hospitals.
Primary Physician: the qualified Medical Practitioner or Surgeon holding a consultant position, who possesses inpatient privileges, who is responsible for patient admissions, the overall care of the patient, and for the maintenance of adequate documentation in the patient's medical records.

Qualifications - all of the factors which are prerequisites to eligibility for, or which are relevant to, the evaluation of an individual for a particular appointment or undertaking.

Warning - a verbal or written communication issued by way of Corrective Action to a Practitioner or Allied Health Professional indicating that his or her performance has been found to be below acceptable standards and requiring improvement to be demonstrated.

ARTICLE 2: OBJECTIVES

The objectives of KKH/KAH Medical Staff Bylaws are:

➢ To ensure that all patients admitted to or treated in any part of the Hospitals shall at all times receive the best and same standards of possible care and attention.

➢ To ensure the maintenance of the highest level of professional performance and behavior by all Medical Staff.

➢ To provide an appropriate educational setting that will maintain high standards, and will advance professional experience and knowledge of the Medical Staff of the Hospitals.

➢ To serve as a reference for all administrators, medical staff members, and others when required on matters concerning the Medical Staff, such as the appointment and re contracting of Medical Staff and the policies and procedures to be followed by the Medical Staff in the performance of their duties.

➢ To ensure compliance of all medical staff with high quality international practice and quality standards.
ARTICLE 3: PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

☐ PURPOSES

- To ensure that all patients admitted to or treated in any of the facilities, departments, or divisions of the hospitals receive the best possible quality patient care and treatment.

- To comply with the standards set forth by National and the relevant International Accreditation Agency that has been selected by the Hospitals and perform duties necessary to support and achieve accreditation.

- To constitute a professional collegial body to provide its members mutual education, consultation, and professional support, and to maintain a level of quality and efficiency at the Hospitals, which is optimally achievable given the state of the healing arts and the available resources.

- To serve as the collegial body through which individual practitioners may obtain membership prerogatives and clinical privileges at the Hospitals in order to provide clinical services to patients and to engage in teaching and research.

- To provide a method whereby the Medical Staff may participate in the decision-making process pertaining to medical matters.

- To provide a means or method by which members of the Medical Staff can formulate recommendations for the Hospitals’ policy-making and planning processes, and through which such policies and plans are communicated to and implemented by each member of the Staff.

- To prepare a mechanism whereby all physicians are systematically integrated into the Medical Staff.

- To assume the responsibility for the quality of professional services provided by individuals with clinical privileges.
To provide a framework whereby medical staff members can understand their duties and obligations to be able to act with a reasonable degree of freedom and confidence.

MEDICAL STAFF RESPONSIBILITIES

Membership Responsibilities:

- Each member shall provide his/her patients with care at the highest professional level of quality and efficiency.

- Each member shall abide by the Medical Staff Bylaws, Hospital Policies and Procedures, the Ministry of Health laws, laws of the Kingdom of Saudi Arabia, and such national and international standards as adopted by the Hospitals.

- Each member shall discharge the duties of the Medical Staff, Department and Committee(s) for which he/she is responsible.

- Each member is responsible to prepare and complete, in a timely and legible manner, the appropriate medical record and other required records for all patients to whom he/she provides care.

- Consultant Staff shall have a strong interest in teaching and be willing to contribute the necessary time and effort to the relevant educational program.

- Members of the Consultant Staff shall participate in regional and national scientific societies, associations, meetings, and science clubs as well as in medical research related to their specialty.

- Each member of the Medical Staff shall report practice occurrence variances and/or incidents, as well as any involvement in professional liability action.

- In an emergency, any Medical Staff member is responsible to provide any type of patient care necessary as a life-saving measure, or to save the patient from serious harm, regardless of his medical staff status or clinical privileges, as long as the care provided is within the scope of the individual's licensure.
**Membership Ethical Responsibility:**

- Medical Staff conduct shall be governed by the rules and regulations of the Ministry of Health, the Saudi Commission for Health Specialties, and the applicable ethics of the relevant medical profession.

- All Medical Staff must abide by all ethical policies and regulations detailed in the Hospital’s ethics documents.

- The Medical Staff shall evaluate practitioner and institutional performance, through valid and reliable measurement systems based on objective, clinically-sound criteria, and internationally accepted standards.

- The Medical Staff shall recommend to the Hospitals Administration the establishment and provision of professional standards in accordance with the Ministry of Health Rules and Regulation, the Rules of the Saudi Commission for Health Specialties, and the relevant, recognized worldwide standards and applicable advances in medical care.

- The Medical Staff shall conduct or obtain others to conduct and arrange for Medical Staff participation in education programs, designed to meet the needs of staff members.

- The Medical Staff shall evaluate practitioner credentials for appointment and recontacting to membership in the Medical Staff organization and for the delineation of clinical privileges that may be exercised by each individual practitioner in the Hospitals.

- The Medical Staff shall assure that medical and health care resources at the Hospitals are appropriately employed for meeting patients' medical, social, and emotional needs, consistent with sound health care resource utilization practices.

- The Medical Staff shall conduct a systematic review of all members regarding the quality of care provided by the medical staff, departments, division, and members in relation to the established standards as part of the Hospitals’ Quality Management Program.

- The Medical Staff shall analyze the results of review activities in order to identify problems in the provision of care.
• The Medical Staff shall review and, if necessary, revise these Bylaws every two (2) years or as by the Hospital Board.

• The Medical Staff shall ensure that all members are subject to the Medical Staff Bylaws rules and regulations and the relevant department policies and procedures.

ARTICLE 4: EXECUTIVE MEMBERS OF THE MEDICAL STAFF AND THEIR APPOINTMENT

➢ **The Executive Members of the Medical Staff shall include the:**

1. Dean of the College of Medicine and Supervisor of the University Hospitals who represents the Chief Executive Officer (CEO)
2. Vice Dean for Hospital Affairs.
3. Vice Dean for Quality and Development
4. The Medical Director of KKUH
5. The Medical Director of KAUH
6. Deputy Medical Director of KKUH
7. Deputy Medical Director of KAUH
8. Chairmen of each department

➢ **Qualifications of Executive Members of the Medical Staff**

The Executive Members of the Medical Staff must be members of the active Consultant category at the time of selection and must remain members in good standing during their term of office. Failure to maintain such status shall immediately cause the staff member in question to lose their executive membership and shall create a vacancy in the office(s) involved.

➢ **Terms of Office**

Executive members of the Medical Staff shall serve as an executive for **two years** and may be extended for additional period(s).
The Dean of the College of Medicine and Supervisor of the University Hospitals (CEO) will be appointed by the Rector of King Saud University based on recommendations from the Deans’ Appointment Committee.

The Vice Dean for Hospital Affairs will be appointed by the Rector of King Saud University based on recommendations from the Dean (CEO) and Academic leaders’ selection committee.

The Vice Dean for Quality and Development will be appointed by the Rector of King Saud University based on recommendations from the Dean (CEO) and Academic leaders’ selection committee.

The Medical Director at KKUH will be appointed by the Rector of King Saud University based on recommendations from the Dean (CEO) and the Academic leaders’ selection committee.

The Medical Director at KAUH will be appointed by the Rector of King Saud University based on recommendations from the Dean (CEO) and the Academic leaders’ selection committee.

The Deputy Medical Director at KKUH will be appointed by the Rector of King Saud University based on recommendations from the Dean (CEO) and the Academic leaders’ selection committee.

The Deputy Medical Director at KAUH will be appointed by the Rector of King Saud University based on recommendations from the Dean (CEO) and the Academic leaders’ selection committee.

The Chairman of a Department will be appointed by the Rector of King Saud University based on recommendations from the Dean (CEO) and Academic leaders’ selection committee.
ARTICLE 5: CLINICAL DEPARTMENTS, DIVISIONS, AND UNITS

The Medical Staff is organized in clinical management groups, as follows:

- **Department**
  The Department shall be defined as a principal independent group of Medical Staff, usually specialized and shall be managed by a chairman. The chairman of the department will report to the Medical Director in all clinical and hospital related matters. The chairman of the department may assign a deputy chairman to handle clinical issues in order for him to focus more on academic matters. However, the chair is ultimately responsible for all activities of the department.

- **Division**
  The Division shall be defined as a semi-autonomous organizational group of Medical Staff that is present in the same facility where the parent department is located or present in other facilities. A division shall be managed by a Head, who shall report to the chairman of an applicable department.

- **Unit**
  The Unit shall be defined as an organizational structure of Medical Staff within a specialty, or sub-specialty, and shall be managed by a Head of Unit. The unit may have diagnostic, preventive, palliative, or therapeutic functions. The head of unit shall report to the Chairman of an applicable Department.

ARTICLE 6: FUNCTIONS OF DEPARTMENTS

- Each Department shall participate in the evaluation of medical care by members of the department through the mechanisms of quality improvement tools and meetings. Such regularly scheduled meetings shall review mortality, morbidity, incidents, and untoward occurrences, which relate to patient care and utilization of hospital resources.

- Each Department shall develop and make recommendations for the establishment of operational policy and procedures.
Each Department shall develop and make recommendations for the establishment of standards of clinical practice, which are expected to be met by Practitioners who are awarded privileges in the Department.

Each Department shall develop and conduct programs to monitor and evaluate the provision of clinical services performed by the Department.

Each Department shall develop and conduct programs of continuing education for Practitioners who are awarded privileges in the Department.

Each Department shall meet monthly for the purpose of promoting the quality of care rendered by the Department including, but not limited to:

- The review of appropriate performance improvement reports and studies.
- The formulation of recommendations to the Hospital Executive Committee.
- The development and conduct of clinical studies and research programs.
- Submission to the Hospital Executive Committee and to Quality Improvement Department, minutes of its meetings and other reports concerning its activities and recommendations.

ARTICLE 7: MEDICAL STAFF MEETINGS

Meetings shall be conducted in accordance with the provisions of the Hospitals’ Rules and Regulations:

- Each Department of the Medical Staff shall conduct the following meetings:
  - Regular departmental meeting (Scheduled monthly with at least nine (9) held per year).
  - Departmental Mortality and Morbidity meetings, once per month for applicable Departments.
- Following items must be part of the agenda:
  ◆ Patient safety
  ◆ Quality improvement
  ◆ System and outcome improvements; including among other items, a discussion of incident, appropriate indicators, length of stays, appropriate audits and surveys.
  ◆ Staff Development.
  ◆ Other departmental improvement issues.

- The Head of Division/Unit must also conduct monthly meeting and send minutes to the relevant department chairman.

- Chairman of the Department/Division should encourage all staff to participate in mission achievement activities, and work collaboratively to develop improvement plans and Policies, Procedures, and guidelines.

- **Departmental Mortality and Morbidity Meeting**
  ◆ All clinical departments must conduct Mortality and Morbidity meetings in their Department.
  ◆ Copies of the minutes of the Mortality and Morbidity meetings must be sent to the chairman of the central Mortality and Morbidity Committee.

- **Right of Ex-Officio Members**

  Persons attending departmental meetings as ex-officio members shall have all rights and privileges of regular members, except that they shall not have the right to vote.

- **Minutes**

  ◆ Minutes of each regular meeting of a Department shall be prepared and shall include a record of the attendance of members. The minutes of the meetings shall be sent to the Medical Director, vice Dean for Hospital Affairs and the CEO.
_minutes of all division/unit meetings shall be sent to the chairman of the department.

- **Intra-Departmental Functional Committees/Meetings**

  The Chairman of departments has the right to form/hold intra-departmental functional committees/meetings to facilitate the organization of certain aspects of Departmental/Divisional activities or regulate such activities as a means of involving the Medical Staff in the management of the Department/Division.

- **Attendance Requirements**

  - The Chairman of Department/Head of Division shall report all excessive absences to the hospital administration.

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**ARTICLE 8: RULES AND REGULATIONS OF MEDICAL STAFF**

The Medical Staff shall adopt and implement rules and regulations, policies and procedures, as may be necessary to prescribe the proper conduct of Medical Staff activities and the level of practice required by each Medical Staff member in the Hospitals. The rules and regulations may be general in nature, applicable to the whole staff, or may be specific to a department, division, specialty, or unit. Once approved, all Medical Staff shall abide by these rules and regulations. Any deviation from the established rules and regulations will constitute a deviation from hospital standards and will subject the person to disciplinary action, according to policy.

**ARTICLE 9: CATEGORIES, CLASSIFICATION AND RELATED DUTIES OF THE MEDICAL STAFF**

- **Categories of the Medical Staff**

  There shall the following categories of the Medical Staff:-

- **Permanent Medical Staff**

  This category applies to Medical Practitioners appointed to the Medical Staff on full time permanent basis. Members of the Permanent Medical Staff have defined clinical
privileges, shall serve on the Hospital Standing Teams as appointed, and shall be required to attend the respective meetings.

- **Visiting Medical Staff**
  This category applies to Medical Practitioners appointed to the Medical Staff subject to an invitation by the Hospital Administration to undertake the care of patients, teaching, or research within the Hospitals for a short period of time. Visiting Medical Staff shall not be eligible to hold a position nor serve on Hospital Standing Teams. A Visiting Medical Staff appointment may not exceed three (3) months.

- **Temporary (Locum) Medical Staff**
  This category applies to Medical Practitioners appointed to the Medical Staff on a locum basis. The appointment of a locum staff may not exceed six (6) months.

- **Part Time Staff**
  This category applies to Medical Practitioners appointed to the Medical Staff on a part time basis.

- **Trainee Staff**
  This category consists of interns, residents, fellows, or any other individual who is a trainee. Except in the case of rotating interns, trainee staff shall be assigned to a specific clinical department, and shall be required to meet the educational and training standards of that department and their training program.

- **Clinical Supportive Staff: (Pharmacist, Technicians, and Therapist)**
  All of the above categories may be applied to the clinical supportive services staff who are not physicians.

- **Classification and Related Duties of the Medical Staff**

  The reference for the classification of Physicians will be the Professional Classification Manual for Health Practitioners of the Saudi Commission for Health Specialties, fifth edition, the year 1430 (2009) and this bylaws and other regulations of the Hospitals.
**Consultant**

Physician on consultant level must be a holder of Saudi Specialization certificate or equivalent and completed a period of experience not less than three years in the field of specialization in a recognized hospital or health center one year of which at least is an experience abroad in an advanced medical center approved by the Hospital Administration. A consultant, in addition to his routine clinical duties may be assigned as the Chairman/Head of a medical department/division and carryout the duties of a department chairman.

- A consultant is responsible for supervising and teaching the senior registrar, Registrar, and junior medical staff attached to their department.

**Acting Consultant**

Physician maybe assigned as Acting Consultant if he/she is a holder of Saudi Specialization certificate or equivalent and completed a period of experience not less than two years in the field of specialization in a recognized hospital or health center.

An Acting Consultant will perform all the clinical duties of a full consultant, except that he/she must be supervised by a Consultant. He/she will perform all other duties assigned to him/her by the Chairman of the Department. In addition to his/her clinical duties, an Acting Consultant will also perform the following responsibilities:

- Adhere to Medical Staff Bylaws, Code of Medical Ethics, and policies, procedures, and guidelines specific to their respective department.

- Provide the highest attainable standard of medical care for the patients for whom he/she is responsible.

- Supervise the work of his/her team including the professional performance and ethical behavior of the medical staff assigned to him/her.

- Participate in departmental and educational activities.
- Participate in the disaster and emergency drills, including the Major Disaster Plan, Code Blue, Code Red Plan of the hospital, as per assignment.

- Carry out other duties/responsibilities within the realm of his/her specialty and skills, as assigned by their supervisor.

**Senior Registrar**

Physician on Senior Registrar level must be a holder of Saudi Specialization certificate or equivalent.

A Senior Registrar shall be accountable to a named member of the Consultant Staff for the care of both inpatients and outpatients and shall be responsible for advising, supervising, and teaching the Junior Medical Staff (1st and 2nd year residents) in the Department, in addition to his/her clinical responsibilities.

**Registrar**

Physician on Registrar level must be a holder of a specialty certificate of not less than two (2) years and who had completed the required experience where the total training spent for the certificate and experience is four (4) years.

A Registrar shall be accountable to a named member of the Consultant Staff for the care of both inpatients and outpatients and shall be directed by the Consultant and/or Senior Registrar in the fulfillment of his/her duties. He/she shall be responsible for advising, supervising, and participating in the teaching of the Junior Medical Staff in the Department, in addition to his/her clinical responsibilities.

In addition to the above duties, a consultant, acting consultant, senior registrar, and registrar must also adhere to the following functions and responsibilities as applicable:

- Adhere to Medical Staff Bylaws, Code of Medical Ethics, and policies, procedures, and guidelines specific to their respective department.

- Provide the highest attainable standard of medical care for the patients for whom he/she is responsible.
- Supervise the work of his/her team including the professional performance and ethical behavior.

- Participate in departmental educational activities.

- Represent his/her department and/or Hospital in assigned departmental and/or cross functional teams.

- Participate in medical education programs and maintain the necessary current clinical licenses as required by the Saudi Commission for Health Specialties.

- Perform a full range of clinical activities in his/her field of specialty as an active consultant, including on-call duties.

- Participate in the disaster and emergency drills, including the Major Disaster Plan, Code Blue, Code Red Plan of the hospital, as per assignment.

- Carry out other duties/responsibilities within the realm of his/her specialty and skills, as assigned by their supervisor.

**Medical Staff on Training:**

**Fellow**

A Fellow shall be the holder of a training post occupied by a doctor who has obtained postgraduate qualifications, such as a Saudi Specialty Certificate, Arab Board, or equivalent in the field of his/her specialty and will progress through a period of higher professional training in a major or a sub-specialty discipline. The training period will range from two (2) to three (3) years according to the requirements of his/her sub-specialty.

**Resident**

Physician on Resident level must be

A. Holder of Bachelor Degree and completed one year of internship in addition to one year in the field of specialization.
B. Holder of higher post graduate (diploma not less than 2 years – or master) in any medical specialty, but has not completed required years of experience to become eligible to be classified as a specialist (registrar).

C. Holder of one year diploma in any medical specialty.

The Resident does not have independent privileges to admit or treat patients. Residents shall be accountable to a named member of the Consultant Staff for the care of both inpatients and outpatients within the limits of his/her clinical privileges, based on their training program guidelines and shall be directed by the Consultant, Senior Registrar, and Registrar in the department in which he/she is employed. An official list of current Residents will be kept in the Postgraduate Medical Office.

Intern

An Intern is undergraduate trainee (medical student) fulfilling his/her practical training before officially graduating from medical school. Interns do not have independent privileges to admit or treat patients at the hospitals and are not eligible for Medical Staff membership and clinical privileges. An Intern’s scope of practice is defined by the Internship Office based on the Internship Training Bylaws. Interns will act under the supervision and credentials of a Medical Staff member in accordance with all Hospital policies. Administrative responsibility for the Interns shall be held by the Interns’ Office.

ARTICLE 10: APPOINTMENT AND RE-CONTRACTING OF MEDICAL STAFF

- **Membership of the Medical Staff:**
  - Appointment to the Medical Staff shall be extended only to clinically competent and fully licensed physicians who continuously meet the qualifications standard and requirements stated in these Bylaws, Rules and Regulations.
  - The appointment to the Medical Staff shall be conferred on the applicant only after the recommendation of the Credential, Promotion and Privileging Committee
  - All members of the Medical Staff shall be employees of KKUH/KAUH.
- Each applicant shall provide information regarding the following situation, which may have occurred during any time in their training and/or medical career, when applicable:

  - An investigation and/or suspension of any licensure or registration
  - A voluntary or involuntary relinquishment of licensure or registration
  - A voluntary or involuntary termination of medical staff membership
  - A voluntary or involuntary limitation, reduction, or loss of clinical privileges
  - Any ongoing professional liability, which includes a final judgment and/or settlement in which he/she is involved.

- The initial appointment and/or re contracting are based on the Hospitals’ Policies and Procedures.

- The initial appointment of every member of the Medical Staff shall be provisional for a probationary period. Before the end of this period, the respective department chairman shall recommend via the Vice Dean for Hospital Affairs to the Department of Human Resources, whether or not the appointment of the Medical Staff member shall be continued, and whether or not the clinical privileges granted on appointment shall be continued. Such recommendation shall be based on direct observation by the chairman of the relevant department or his designee, a review of medical records of patients the Medical Staff member under review has treated, and reviews of the results of the departmental quality activities and indicators.

- Continuation of the Medical Staff member’s contract shall be dependent upon the receipt of the recommendation from the Chairman of the Department by Human Resources Department. The Medical Staff member has no right to appeal the termination or modification of his/her clinical privileges resulting from the assessment of his/her performance during the probationary period.

- Appointment to the Medical Staff implies that he/she will strictly abide by the KKKUH/KAUH Medical Staff Bylaws, Rules and Regulations, Code of Medical Ethics, and laws governing the practice of Medicine in Saudi Arabia. Each applicant for Medical Staff privileges will sign an agreement to this effect.
- It is expected that the Medical Staff member shall provide continuous medical care and supervision of his/her patients, accept assignments, accept consultation requests where appropriate, and participate in emergency care on request.

- Permanent appointment to the Medical Staff will automatically prohibit the appointee from practicing medicine at any other institution, whether governmental or private, unless officially approved by the Hospital or college Board.

**Membership Requirements and Criteria:**

Any candidate requesting appointment to the Medical Staff shall be required to meet at least the following qualifications in order for his/her candidacy to be pursued:

- Be a graduate of an accredited medical or dental school.

- Hold a current licensure to practice medicine and/or dentistry in his/her country of origin or a current and valid License by the Saudi Commission for Health Specialties.

- Meet the qualification requirements outlined in the job description and as per the Professional Classification Manual for Health Practitioners of the Saudi Commission for Health specialties and the Medical Staff Bylaws.

- Provide evidence of current competency, through relevant training and/or experience in his/her specialty, and in particular for the specific clinical privileges requested.

- Provide evidence of a physical and mental health status necessary to meet the practice requirements, and agree to submit to a physical and mental assessment, if deemed necessary.

- Provide at least three (3) references from medical professionals with whom they have recently worked over a reasonable period of time and who can attest to the applicant’s good standing and adherence to the principles of professional ethics, patient rights, and medical code of ethics.

- Report on the application, any voluntary and/or involuntary terminations, and any limitations, reductions, and/or loss of clinical privileges at another hospital.
- Document his/her experience, background, training, and physical and mental health status to demonstrate to the Medical Director, Credential, Promotion and Privileging Committee that the applicant has the ability and experience to treat assigned patient with high quality medical care.

**The applicant shall also:**

- Be willing to appear for an interview in regard to his/her application.
- Authorize KKUH/KAUH, or its recruiting agent, to consult with members of Medical Staff of other hospitals with which the applicant has been associated, and with others who may have information bearing on his/her competence, character and ethical qualifications.
- Consent to allow KKUH/KAUH or its recruiting agents to inspect all records and documents that may be material to his/her professional, moral, and ethical qualifications of competence.
- Release from any liability all representatives of KKUH/KAUH for their actions performed, in good faith and without malice, in connection with evaluating the applicant.
- Submit a completed application, which shall be processed as indicated in the KKUH/KAUH policies governing the appointment process.

**Appointment Process:**

- All applications shall be forwarded by the Human Resources Department to the Medical Director for the initial review. The applications will be sent back to the Human Resources Department with initial recommendations/directives.
- Applications recommended for further review, shall be forwarded by the Human Resources Department to the relevant Department Chairman for his/her evaluation and recommendation.
If the application is disapproved by the department, the application will be forwarded to the Human Resources Department where the application may be discarded and the applicant will be advised of the status of his/her application.

If the department recommends the application, it shall be forwarded to the Medical Director.

The Medical Director will forward the application to the Credentialing, Promotion and Privileging Committee.

The Credentialing, Promotion and Privileging Committee, upon receiving the initial application that is recommended for approval, will examine the evidence of the character, professional competence, qualifications and ethical standing of the practitioner, and shall determine in conjunction with the relevant clinical Department’s Chairman, through information contained in the references given by the applicant, and from all other sources available to them, whether the applicant meets all the necessary prerequisites for the category, duties of staff, and the clinical privileges relevant to the post.

The Credentialing, Promotion and Privileging Committee will forward their recommendation to the Hiring Committee for their review and recommendation. The recommendation for the appointment of a Medical Practitioner to the Medical Staff must specify the vacant post to which he/she is being appointed.

The Hiring Committee shall forward their recommendation to the CEO for the final approval.

If approved, the CEO’s office will send the approved application to the Human Resource Department for further processing.

The Human Resources Department will update the relevant department of the progress of the recruitment process.

Upon the arrival of the new employee, his/her contract shall be authorized and approved by the Vice Dean for Hospital Affairs.
Renewal of contracts for non Saudi Medical Staff

- The renewal of contracts shall be initiated by the recommendation of the Practitioner’s Chairman/Head of Department/Division. This will be based on the performance appraisal of the Medical Staff member, which shall take place annually, at least four (4) months before the end of the current contract.

- The recommendation to renew a Medical Staff member will be submitted to Vice Dean for Hospital Affairs who will consult the Dean. If both agree, the Vice Dean will approve the renewal of the Medical Staff member and send the documents to the Human Resource Department for further processing.

- In the situation that the Chairman/ Head of the Department/Division wishes not to renew the contract of the staff, he/she shall discuss the case with the Medical Director and Vice Dean for Hospital Affairs. If the Medical Director and Vice Dean for Hospital Affairs agree with the Chairman/Head, a recommendation will be submitted to the CEO not to renew the contract the Medical Staff member under consideration and the concerned staff must be notified of the decision at least two (2) months before the end of his/her contract.

ARTICLE 11: EVALUATION OF MEDICAL STAFF

The evaluation process for Medical Staff members is a multi-level procedure. Each different level completes their evaluation and forwards it to their superior for consideration, as described below:

- The Dean of the College of Medicine and Supervisor of the University Hospitals (CEO): The annual evaluation of the Dean (CEO) will be completed by the Rector of the University

- The Vice Dean for Hospital Affairs, the Vice Dean for Quality and Development, the Medical Director and his Deputy: The evaluations will be completed by the CEO.

- Chairman of Departments: The annual evaluation will be filled by the CEO.
• Head of Division or Unit: The annual evaluation of Head of Divisions or Units will be completed, initialed by Chairman of Department and forward to CEO for approval.

• Medical & Paramedical Staff: The annual evaluation form of Medical & Paramedical Staff will be completed and initialed by the Head of Division and Chairman of Departments, and forwarded for consideration to the Medical Director, and approved by the Vice Dean for Hospital Affairs.

• All hospital staff must receive a formal evaluation annually.

• Medical Staff members are requested to sign their evaluation forms.

• All evaluation forms shall be submitted to the Human Resources Department.

**ARTICLE 12: CLINICAL PRIVILEGES**

- No physician shall admit or provide services to patients in the Hospital unless he/she has been appointed to the Medical Staff and has been granted privileges as provided in these Bylaws.

- Every member of the Medical Staff shall be entitled to exercise only those approved clinical privileges.

**Process of temporary privileging:**

- Physicians shall complete the special form of application of clinical privileges on the commencement of their assignment, based on their assessment of their capabilities and training. The form should be forwarded to the Chairman of the relevant department.

- The Chairman of the relevant department, after consultation with the Unit Head, will recommend granting or denying the requested medical staff privileges.

- The Chairman of the relevant department will forward his/her recommendation to the Medical Director, and if he/she is recommending the approval of requested privileges, the request will be forwarded to the Vice Dean for Hospital Affairs who has the authority to grant temporary privileges for one month.
The Vice Dean for Hospital Affairs, with recommendation of the Chairman of the relevant department and Medical Director may renew the temporary privileges up to a maximum of three (3) months until the physician is granted a permanent privileges by the Credentialing, Promotion and Privileging Committee.

**Process of permanent privileging**

- The Medical Director, in consultation with the Chairman of the relevant department, will forward the privileging request to the Credentialing, Promotion and Privileging Committee to be reviewed on their next meeting following to the Physician's commencement of assignment.

- All recommendations shall be based upon the practitioner's education and training, qualifications, professional experience, current licensure to practice in the country from which the person was recruited, health status (physical and mental) and any other relevant information, including the capabilities and facilities of the Hospitals.

- The Credentialing, Promotion and Privileging Committee shall review the department Chairman’s recommendation and shall recommend granting privileges valid for up to three (3) years to the Physician. The recommendation will then be forwarded to the Vice Dean for Hospital Affairs who has the authority to grant the privileges.

- The initial granting of clinical privileges shall be provisional. Periodic re-determination of clinical privileges shall be based on the direct observation of the care provided, review of the reports of the chairman of the relevant department in which the practitioner is employed.

- The clinical privileges to be granted on re-contracting shall be based upon the Medical Staff member’s record of professional competence and clinical judgment in the treatment of patients, including:

  - An examination of the individual’s pattern of care as demonstrated by peer reviews that have been conducted and based on the following points:
    - The individual’s maintenance of timely, accurate and complete medical records.
    - The individual’s attendance at required staff departmental meetings.
    - The individual’s ethical conduct and general behavior.
The individual’s general application to his/her work.

The individual’s compliance with the Hospitals’ Policies, Medical Staff Bylaws, and Rules and Regulations.

The individual’s physical and mental health.

The individual’s administrative and academic activities in his/her department/division.

The individual’s attendance and performance at required cross functional team meetings.

The appropriate use of discharge planning and efficient use of hospital resources, including patient length of stay among other factors.

Prompt morbidity and error reporting.

Timely completion of mortality reports.

Participation in the Hospitals’ quality programs.

Process for emergency privileges

In case a Physician who is not a member of the Medical Staff is required to provide medical services after working hours or during holidays/weekends, he/she shall complete the special form of application of clinical privileges. The Medical Director or his designee shall authorize the emergency privileges. The form must then be forwarded to the Medical Director and to the Vice Dean for Hospital Affairs on the following working day for authentication.

In cases of emergency, any member of the Medical Staff, even junior doctors, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility at the hospital necessary, including the calling of any consultation necessary or
deemed appropriate. When an emergency situation no longer exists, the appropriate member of the Medical Staff shall assume treatment of the patient and the emergency clinical privileges shall no longer be in effect.

- An emergency is defined as a condition in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

**ARTICLE 13: REVOCATION AND SUSPENSION OF CLINICAL PRIVILEGES**

- **Temporary Suspension of Clinical Privileges**
  - Notwithstanding adherence to the General Terms and Conditions of Employment of KKUH/KAUH if the professional standards of conduct of any member of the Medical Staff is considered to be lower than the desired standards, or where it is thought that the member of staff is acting in a professionally incompetent manner, the matter will be referred to the Medical Director by the Chairman of the respective department.

  - The matter shall be dealt with in the Credentialing, Promotion and Privileging Committee as soon as possible and a recommended decision will be reached.

  - The recommendation of the Credentialing, Promotion and Privileging Committee will be forwarded to the Vice Dean for Hospital Affairs.

  - The CEOs, having been informed by Vice Dean for Hospital Affairs, has the authority to suspend temporarily and immediately all, or any portion of the clinical privileges, of any member of the Medical Staff, whenever it is felt that the personal or professional conduct of that member of the staff:

    - Jeopardizes, or may jeopardize the safety or best interest of a patient if immediate action is not taken.

    - Constitutes a willful disregard of the Hospitals' policies.
• Such temporary suspension shall become effective immediately upon the decision of the CEO.

• Immediately following the temporary suspension, the Vice Dean for Hospital Affairs shall send a special written notice to the suspended staff member, confirming the said suspension and stating the reasons for the suspension.

• To decide on further action and the future of clinical privileges, the affected medical staff shall be requested to appear before the Credentialing, Promotion and Privileging Committee for an interview at the place and time specified in the special written notice.

• The affected Medical Staff member shall have the following rights:
  ♦ To call and examine witnesses.
  ♦ To introduce documentary evidence.
  ♦ To cross-examine witnesses.
  ♦ To challenge any evidence.
  ♦ To call a colleague from the same hospital to the hearing as his/her spokesman and advisor.

• The Credentialing, Promotion and Privileging Committee, after examining all the evidence and listening to Chairman of applicable department and to any relevant witnesses, will recommend action regarding the suspended clinical privileges. Possible actions may include the recommendation to:
  ♦ A return to usual clinical privileges immediately.
  ♦ A return to usual clinical privileges after a certain probation period.
  ♦ Special direct supervision of additional extra training or education.
  ♦ Suspension of clinical privileges permanently.
  ♦ Suspension from medical staff membership.

• In case of conflict the matter shall be raised to the CEO for the final decision.
**Automatic Suspension of Clinical Privileges**

- Revocation or suspension of a Medical Staff member’s license to practice in any country shall automatically suspend all his/her clinical privileges at Hospitals.

- A Medical Staff member who makes false or incorrect statements in his/her application for appointment to the Medical Staff shall be subject to temporary suspension. Failure of a Medical Staff member who is credentialed to notify Hospitals' Administration of significant changes of status, as outlined on the credentials application, shall be grounds for temporary suspension.

- If at any time a Medical Staff member or applicant fails to provide the requested information pursuant to a formal request by the Credentialing, Promotion and Privileging Committee, the clinical privileges shall be deemed to be temporarily suspended until the required information is provided to the satisfaction of the requesting party.

- A Medical Staff member who does not comply with the Hospitals' Communicable Disease Policy by failing to be tested for tuberculosis, hepatitis B/C, HIV, or other diseases identified by such policy, or by failing to submit the results of such screenings, shall have his/her admitting and clinical privileges suspended immediately and automatically until he/she are in compliance with the policy.

- It shall be the duty of the Medical Director to apply and follow these automatic clinical privileging suspension policies.

**Mandatory Revocation**

- Loss of License:
  If a Medical Staff member’s license to practice his/her profession is revoked, or if he/she fails to renew such license, then the admitting and clinical privileges of such Medical Staff member shall immediately and automatically be revoked.

- Conviction of a Felony:
  Any Medical Staff member, upon exhaustion of appeals after conviction of a felony in any court in Saudi Arabia, or proved in any other country court, the Medical Staff member’s appointment and clinical privileges shall be automatically revoked. Revocation
pursuant to this section of the Bylaws does not preclude the Medical Staff member from subsequently applying for Medical Staff appointment.

ARTICLE 14: APPEAL IN THE EVENT OF TERMINATION OF APPOINTMENT, REDUCTION, OR LOSS OF CLINICAL PRIVILEGES AND CORRECTIVE ACTIONS

➢ Appeal

▪ When a Medical Staff member has been recommended to be terminated or have his/her clinical privileges reduced or suspended through any of the above mentioned ways, that member of staff should be notified in writing immediately by Vice Dean for Hospital Affairs. This letter must have attached a copy of the current Medical Staff Bylaws with the section on appeal rights highlighted.

▪ The affected member shall have the right to appeal.

▪ The affected member, within seven (7) working days of being informed of an adverse decision, must inform the Medical Director in writing that he/she wishes to make an appeal and shall submit the reasons for doing so. If he/she fails to do so within the specified time, he/she shall be deemed to have waived his/her right of appeal and the action shall stand.

▪ Within thirty (30) calendar days after the conclusion of the appeal review, the Credentialing, Promotion and Privileging Committee will make a final recommendation regarding the appeal. The CEO will issue the final decision regarding the appeal and its outcome.

▪ Notwithstanding any other provision of these Bylaws, no Medical Staff member shall be entitled as a right to more than one (1) hearing, and one (1) appeal review, on any matter which shall have been the subject of adverse action.
There is no right to appeal for an individual who is not approved for initial appointment for continuation following completion of the probationary period or for re-contracting to the Medical Staff.

Corrective Actions

Nature of Misconduct

- Professional misconduct
  The failure or inadequacy of performance, or unacceptable behavior, arising from the exercise of medical or dental skills, or professional judgment.

- Personal Misconduct
  The failure of performance or unacceptable behavior due to factors other than those associated with the exercise of medical or dental skills.

- Medical Malpractice
  In case of unacceptable mortality or morbidity resulting from inappropriate performance, medical incompetence, or proven negligence – even in the absence of patient’s complaint – it is the responsibility of Medical Director to follow the Regulations of Practicing Medical Professions in the Kingdom of Saudi Arabia.

Investigation

- When a concern or issue involving professional or personal misconduct comes to the attention of the Medical Director, Vice Dean for Hospital Affairs, or the CEO, they should decide either to discuss the matter with the practitioner concerned, or to begin an investigation. If, in their opinion, the issue does not merit an investigation; the Medical Director shall invite the concerned Practitioner to a personal interview to discuss the matter.

- If the Medical Director or the Vice Dean for Hospital Affairs deems an investigation advisable, they may delegate the issues to the a special investigation committee within a period of two (2) weeks. The Medical Director or the Vice Dean for Hospital Affairs shall promptly notify the CEO in writing that an investigation is in progress.
The individual being investigated shall have an opportunity to meet with the investigation committee before it starts its investigation. At this meeting the individual shall be informed of the general nature of the evidence supporting the question being investigated and shall be invited to discuss, explain, or refute it. He should be provided as soon as possible with copies of correspondence and with any statements made. He may present witnesses and/or documentary evidence to support his/her case. The investigation committee shall hold its meetings in private and any action taken and/or recommendation made pursuant to these Bylaws shall be treated confidentially.

The investigation committee shall present its findings and recommendations for corrective actions in writing to the Medical Director. The Medical Director should submit this report to the Vice Dean for Hospital Affairs for action. If the disciplinary action requires a higher authority, the case will be sent to the University Administration for action.

Disciplinary actions

Any of the following disciplinary actions may be taken based on the recommendation of the investigation committee:

- Imposed terms of probation
- Letter of reprimand
- Letter of warning
- Disciplinary transfer
- Termination of employment
- Referred to the applicable medical/legal court if a criminal act has occurred

If the recommendation involves revocation, suspension or reducing of clinical privileges, the recommendation will be referred to the Credentialing, Promotion and Privileging Committee to be dealt with as indicated in these bylaws.
ARTICLE 15: PROMOTION

- Medical Staff members seeking promotion have to submit an application to the Chairman of the relevant department for the position that he/she is seeking with supporting documents (Curriculum Vitae, certificates/degree, experience, three (3) letters of recommendations from members of the unit, valid registration from the Saudi Commission for Health Specialties and Research participation for members seeking promotion to a consultant level).

- The Chairman of the relevant department after reviewing the application and the supporting documents will make his/her recommendation.

- The recommended application will be submitted to the Head of Credentialing, Promotion and Privileging Committee. The committee will make the recommendation as per the Professional Classification Manual for Health Practitioners of the Saudi Commission for Health Specialties, fifth edition, the year 1430 (2009), this bylaws and other regulations of the Hospitals.

- The recommended application will be forwarded to the Vice Dean for Hospital Affairs. The Vice Dean will make the final approval after consulting with the CEO.

- The papers will then be sent to the Human Resources Department for processing, based on the availability of positions.

- Salary raises and changing of status will be determined by the Human Resources Department according to the University Bylaws and the Civil Services Bureau regulations.

- Once the promotion has been approved and the Medical Staff has been officially promoted, he/she should apply for a change in clinical privileges, if necessary. The usual clinical privileging process will be applied.

ARTICLE 16: LEAVE COVERAGE

- Chairmen of departments shall obtain approval from the CEO for any leave or absence of duty and assign appropriate coverage at least one (1) week prior to the leave. For emergency leave, a verbal notification must be obtained.
Division/Unit heads shall obtain approval from the chairman of the department for any leave or absence of duty and assign appropriate coverage at least one (1) week prior to the leave. For emergency leave, a verbal notification must be obtained.

Leaves of the staff will be signed by the respective head of the division, then chairman of the department, then forwarded to the personnel department, and finally approved by the Vice Dean for Hospital Affairs. All consultants shall complete and sign the clinical duties coverage form and make certain that ALL of their clinical duties are appropriately covered. The signature of the covering consultant must also be obtained.

It is the duty of the division/unit head and the chairman of the department to assure that all the clinical services are appropriately and sufficiently covered by a qualified alternative before approving any medical staff leave.

**ARTICLE 17: DRAFTING, ADOPTING, AND AMENDING THE MEDICAL STAFF BYLAWS:**

- **Drafting and Adopting**
  - The amended Medical Staff Bylaws shall be approved by the CEO and the Hospital Board.
  - The approved Medical Staff Bylaws will be distributed to all Medical Staff and departments.

- **Periodic Review:**
  The Medical Staff Bylaws shall be reviewed periodically every two (2) years by the Medical Director and approved by the Hospital Board.

- **Amendment and Addition:**
  - Any Medical Staff member may submit a proposed amendment, which must be referred to the appropriate departmental meeting, which shall discuss the validity and necessity of the proposal.
  - If the proposed amendment is recommended for adoption by the Department/Division, the chairman of the Department/Head of the Division shall recommend the proposal to the Medical Director.
• If appropriate, the Medical Director will refer the amendment to the Quality Department for its opinion and recommendation.

• If deemed appropriate, the amendment will be forwarded to the Vice Dean for Hospital Affairs to be included in the agenda of the Hospital Board to obtain the approval.

• If approved, the Medical Staff Bylaws will be changed accordingly and the new changes announced.

Prepared/Revised by: ___________________________ Date: ____________

Quality Management Department

Reviewed by: ___________________________ Date: ____________

DR. FARHEEN SHAIKH
Policy and Procedure Review Committee

Authorized by: ___________________________ Date: ____________

DR. BADR AL JABRI
KKUH – medical director

Authorized by: ___________________________ Date: ____________

DR. ABDUL RAHMAN AL MUAMMAR
KAUH – medical director

Authorized by: ___________________________ Date: ____________

DR. AYMAN ABOO
Vice Dean for Quality and Development Affairs

Authorized by: ___________________________ Date: ____________

DR. ABDULAZIZ AL SAIF
Vice Dean University Hospital Affairs

Approved by: ___________________________ Date: ____________

PROF. MUSSAAD AL SALMAN
Dean of College of medicine
CEO