

# **BARTLETT REGIONAL HOSPITAL**

## **MEDICAL STAFF BYLAWS**

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**BARTLETT REGIONAL HOSPITAL**  
**RESTATED MEDICAL STAFF BYLAWS**

**PREAMBLE.**

WHEREAS, the Bartlett Regional Hospital is a community-owned and operated hospital, is an administrative division of the City and Borough of Juneau, and is organized under the laws of the State of Alaska and the City and Borough of Juneau Code; and

WHEREAS, the Bartlett Regional Hospital Medical Staff is responsible for the oversight of provision of medical care in the Hospital and implementation of reasonable performance improvement measures, and accepts this responsibility, subject to the ultimate authority of the Hospital Board in accordance with CBJ 40.15.020.; and

WHEREAS, the cooperative efforts of the Medical Staff, the Chief Executive Officer and the Board are necessary to fulfill the Hospital's obligations to its patients;

THEREFORE, all members of the Medical Staff agree to organize and act in conformity with these Bylaws.

**ARTICLE I: GENERAL**

**1.1 Definitions.**

1. *Hospital* means Bartlett Regional Hospital of Juneau, Alaska.
2. *Board or Hospital Board* means the City and Borough of Juneau Hospital Board, which is the governing body of the Hospital.
3. *Chief Executive Officer* means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.
4. *Medical Staff or Staff* means the Medical Staff of Bartlett Regional Hospital, including all duly licensed doctors (MDs), doctors of osteopathic medicine (DOs), oral and maxillofacial surgeons (OMSs), podiatrists (DPMs) and dentists (DMDs, DDSs) who have been appointed to the Medical Staff.
5. *Medical Staff Executive Committee (MSEC) or Executive Committee* means the executive committee of the Medical Staff unless specific reference is made to the executive committee of the Hospital Board.

6. *Physician* means an individual with an MD, DO, OMS or DPM degree who is licensed or authorized to practice medicine in Alaska.
7. *Practitioner* means, unless otherwise expressly qualified, any physician, dentist or Advanced Practice Clinician applying for or exercising privileges in the Hospital.
8. *Medical Staff Year* means the period from January 1st through December 31st.
9. *Attending Physician* means a physician staff member with appropriate privileges who admits, discharges and has primary responsibility for a patient during the course of hospitalization.
10. *Inpatient Admission* means the formal acceptance by the hospital of a patient who is to be provided with room, board and continuous nursing service in an area of the hospital where patients generally stay at least overnight.
11. *Joint Conference Committee.* The Joint Conference Committee is composed of the Medical Staff Executive Committee, the Administrator and the Executive Committee of the Hospital Board.
12. *Advanced Practice Clinician* or *APC* means a licensed independent health care clinician who are properly licensed or certified by the state or federal law, who are not a licensed physician, podiatrist or dentist, including but not limited to physician assistants. APC provide health care to patients, satisfies the qualification requirements of these Bylaws, and is applying for or has been granted privileges to provide or order specified services in the Hospital.
13. *Psychiatric Mental Health Nurse Practitioner(PMHNP)* means a licensed independent health care advanced nurse practitioner, who is licensed or certified by state or federal law to provide health care to patients, satisfies the qualification requirements of these Bylaws, and is applying for or has been granted privileges to provide or order specified services in the Hospital.
14. *Clinical privileges* or *privileges* means permission granted to a practitioner by the Board to render or order specific professional, diagnostic, therapeutic, medical, dental, podiatric or surgical services.

15. *Special notice* means written notification sent by certified or registered mail, return receipt requested, with a copy by secure electronic mail to the practitioner's most current address on file with the Hospital.

## **1.2 Time Limits.**

Time limits referred to in these Bylaws and related policies and manuals are advisory only and are not mandatory, unless it is expressly stated. Medical Staff leaders will strive to be fair under the circumstances.

## **1.3 Delegation of Functions.**

- (1) When a function provided for in these Bylaws, Rules and Regulations or policies, as applicable, is to be carried out by a member of the Hospital Administration, 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 appropriately qualified designees.
- (2) When a Medical Staff member is unavailable or unable to perform an assigned function, one or more of the Medical Staff leaders may perform the function personally or delegate it to another appropriate individual.

# **ARTICLE II: CATEGORIES OF THE MEDICAL STAFF**

## **2.1 The Medical Staff.**

The Medical Staff consists of the Active, Associate, Honorary, and Consulting/Locums Tenens staff categories. A member may be appointed to only one staff category at any time. Members are appointed to staff categories by the Hospital Board on the recommendation of the Medical Staff Executive Committee.

## **2.2 The Active Medical Staff.**

The Active Medical Staff consists of physicians, dentists and podiatrists who regularly admit, consult or treat patients at the hospital, are actively involved in the medical affairs of the hospital and provide continuous care to their patients at the hospital.

- a. **Citizenship:** Active Medical Staff are valued members of the hospital-based medical community and provide for the continuous care of patients within the hospital. Active Medical Staff members participate in the hospital's on-call



medical coverage (with exceptions as applicable to certain specialists, e.g., hospitalists and emergency physicians). The Active Medical Staff performs all organizational and administrative functions of the Medical Staff and are responsible for seeking to maintain the quality of all medical care in the Hospital. Active Medical Staff members serve on Medical Staff committees and attend Medical Staff meetings. Active Medical Staff members are eligible to vote at Medical Staff meetings and Medical Staff committee meetings, and are eligible to hold Medical Staff office.

- b. Activity:** Active Medical Staff members share an active interest in the hospital's clinical and administrative affairs, and have regular or ongoing hospital patient contacts, including inpatient admissions, inpatient consultations, inpatient or outpatient procedures, or referrals for hospital-based services.
- c. Competence:** Active Medical Staff are expected to participate in sufficient patient care for the Medical Staff to be able to assess and evaluate their current clinical competence. Active Staff members participate in focused and on-going professional practice evaluations.

### **2.3 The Associate Medical Staff.**

The Associate Medical Staff consists of physicians, dentists, podiatrists who are qualified for Medical Staff membership but do not admit or treat patients at the hospital.

- a. Citizenship:** Associate Medical Staff members are valued members of the hospital-based medical community. Associate Medical Staff members may but are not required to attend Medical Staff meetings, do not vote at Medical Staff meetings and are not eligible to hold Medical Staff office. Associate Medical Staff may serve on Medical Staff committees when invited by the Chief of Staff or the committee chair. Associate Medical Staff members appointed to a committee are required to attend the committee's meetings and may vote on committee business, but may not hold office.
- b. Activity:** Associate Medical Staff members do not admit patients or exercise clinical privileges in the hospital, with the exception of "refer and follow"

privileges when approved by the Credentials Committee, and do not participate in on-call medical coverage. Associate Medical Staff members have access to hospital-based services in accordance with hospital policy.

- c. **Competence:** Associate Medical Staff do not admit patients or hold clinical privileges in the hospital, except for “refer and follow” privileges, and are therefore not subject to focused or on-going professional practice evaluations, unless specifically directed by the Credentials Committee.

#### **2.4 The Consulting Medical Staff and Locums Tenens.**

The Consulting Medical Staff consists of physicians and dentists who are recognized specialists, who meet all of the prerequisites for Medical Staff membership, who hold clinical privileges, and who come to the hospital on a schedule or by request of an Active Staff member. Consulting Medical Staff members do not admit patients to the hospital but are required to assure the continuous care of any patients seen or treated at the hospital. Locum Tenens are physicians or dentists substituting on a temporary basis for Active Staff members who are absent from Juneau or who otherwise are practicing on a short-term basis but longer than would be applicable for temporary privileges.

- a. **Citizenship.** Consulting Medical Staff members and Locum Tenens are invited to participate in Medical Staff meetings, committees or other functions when present at the hospital. Consulting Medical Staff members and Locum Tenens are not required to attend Medical Staff meetings, do not count towards quorum and are not eligible to vote, serve on Medical Staff committees or hold Medical Staff office.
- b. **Activity.** Consulting Medical Staff members may consult on the care of patients in the Hospital in person, by telephone or electronically, and may write or give telephonic or electronic orders on a patient at the request of the patient’s attending physician.
- c. **Telemedicine.** The Consulting Medical Staff includes practitioners who hold telemedicine privileges at the hospital.

- d. **Locums Tenens.** Locum Tenens members may exercise any clinical privileges, including admitting privileges, recommended by the Credentials Committee and approved in accordance with these Bylaws. Locum Tenens members participate in the on-call obligations of the Active Staff member for whom they are substituting.

## 2.5 **Advanced Practice Clinician (APC) Staff.**

The APC Staff consists of licensed independent practitioners other than physicians, dentists and podiatrists, including but not limited to physician assistants, who are properly licensed, qualified and credentialed and who regularly provide care to patients at the Hospital. They are not Medical Staff members but are included in this Article for convenient reference.

- a. **Citizenship.** APC Staff members are valued members of the hospital-based community and may but are not required to attend Medical Staff meetings. APC Staff members do not count toward quorum and are not eligible to vote at Medical Staff meetings and may not hold Medical Staff office. APC Staff members may be appointed as voting members to Medical Staff committees, and are expected to actively participate in Medical Staff quality assurance activities. They are required to comply with applicable bylaws, rules & regulations and policies.
- b. **Activity.** APC Staff members' clinical privileges shall be no greater than the scope of their licensure or certifications. APC Staff members must have an Active Medical Staff physician sponsor or supervisor unless their licensure allows otherwise and the Credentials Committee grants an exception to this requirement. The Credentials Committee may set conditions for the sponsorship or supervision.
- c. **Competence.** APC Staff members' performance and practice are subject to quality review appropriate to their licensure and clinical privileges.

## **2.6 The Honorary Medical Staff.**

The Honorary Medical Staff consists of Medical Staff members of any category whom the medical staff wishes to recognize for distinguished past service. Honorary Staff members are relieved of Medical Staff duties and attendance requirements, do not count towards quorum, and do not vote at Medical Staff meetings or hold Medical Staff office. Honorary Staff members may attend meetings of the medical staff.

### **ARTICLE III: OFFICERS**

## **3.1 Officers of the Medical Staff.**

The officers of the Medical Staff are the Chief of Staff, Chief of Staff-Elect, Immediate Past Chief of Staff and Secretary/Treasurer.

## **3.2 Qualifications of Officers.**

Officers shall be members in good standing of the Active Medical Staff and remain members in good standing during their term in office. The Chief of Staff must be a physician, dentist or podiatrist.

## **3.3 Election of Officers.** Medical Staff Officers are nominated and elected to fill vacancies on the MSEC by the Active Medical Staff at the annual meeting. Each candidate must consent to the nomination in order to be elected.

- a. The nominee for each office receiving the most votes shall be elected. Tie votes are resolved by a coin toss.
- b. A quorum for the election shall be the number of Active Medical Staff members present and voting at the annual meeting.

## **3.4 Term of Office.**

Officers' terms begin on the first of January after their election or, if appointed to fill a vacancy, on the date of appointment. Elected officers serve a one year term. Officers appointed to fill a vacancy serve out the remainder of their predecessor's term. All officers may serve multiple terms, and remain in office until a successor is named.

## **3.5 Vacancies in Office.**

Vacancies in office during the Medical Staff year, except for the Chief of Staff, shall be filled by appointment by the MSEC. If there is a vacancy in the office of the Chief of Staff, the Chief of Staff-Elect shall serve the remainder of the Chief of Staff's term.

### **3.6 Removal of Officers.**

Any Medical Staff officer or other MSEC member may be removed from office at any time, by a two-thirds (2/3) majority vote of the Active Medical Staff present at a Medical Staff meeting. Grounds for removal of an elected officer or other member of the MSEC are:

- a. failure to comply with applicable policies, Bylaws, or the Rules and Regulations;
- b. failure to perform the duties of office;
- c. conduct detrimental to the interests of the Medical Staff or the Hospital; or
- d. an infirmity that renders the individual incapable of fulfilling the duties of that office.

The individual will be given at least ten days' special notice of the date of the meeting at which removal is to be considered. The individual will be afforded an opportunity to address the Medical Staff prior to a vote on removal.

### **3.7 Duties of Officers.**

- a. The Chief of Staff is the chief administrative officer of the Medical Staff, and shall:
  - 1. Act in coordination and cooperation with the Chief Executive Officer and Hospital Board in all matters of mutual concern within the Hospital;
  - 2. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
  - 3. Serve as chair of the Medical Staff Executive Committee;
  - 4. Be responsible for the enforcement of the Medical Staff Bylaws and Rules and Regulations; implementation of sanctions where indicated; and for the Medical Staff's compliance with the procedural safeguards in all instances where a professional review action has been proposed involving a Medical Staff member;

5. Appoint, unless otherwise provided in these Bylaws or the Rules and Regulations, the Medical Staff members of all Medical Staff committees except the Executive Committee, and be an *ex officio* member of all Medical Staff Committees;
  6. Represent the views, policies, needs and grievances of the Medical Staff to the Hospital Board, the Hospital Board President, and the Chief Executive Officer;
  7. Receive and interpret the policies of the Hospital Board to the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;
  8. Be responsible for the quality improvement and educational activities of the Medical Staff;
  9. Be the spokesperson for the Medical Staff in its external professional and public relations; and
  10. Attend all Board meetings and attend other Hospital Board subcommittee meetings as assigned.
- b. In the absence of the Chief of Staff, the Immediate Past Chief of Staff shall assume all the Chief of Staff's duties and authority. In the absence of both, the Secretary/Treasurer shall assume all the Chief of Staff's duties and authority.
- c. The Chief of Staff-Elect shall perform such duties as may be assigned by the Chief of Staff.

**3.8. Medical Staff Executive Committee ("MSEC").**

- a. Composition:
1. The MSEC will include the officers of the Medical Staff.
  2. The Chief of Staff will serve as chair of the MSEC, with vote.
  3. The Chief Executive Officer may attend meetings of the MSEC, *ex officio*, without vote.

4. Other individuals may be invited to MSEC meetings as guests, without vote.

b. Duties:

The MSEC is delegated the primary authority over activities related to the Medical Staff and to performance improvement activities. This authority may be removed or modified by amending these Bylaws. The MSEC is responsible for the following:

1. acting on behalf of the Medical Staff in the intervals between Medical Staff meetings;
2. recommending directly to the Board on at least the following:
  - i. the Medical Staff's structure;
  - ii. the mechanism used to review credentials and to delineate individual clinical privileges;
  - iii. applicants for Medical Staff appointment and reappointment;
  - iv. delineation of clinical privileges for each eligible individual;
  - v. participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;
  - vi. the mechanism by which Medical Staff appointment may be terminated;
  - vii. hearing procedures; and
  - viii. reports and recommendations from Medical Staff committees, departments, and other groups, as appropriate;
3. consulting with Administration on quality-related aspects of contracts for patient care services;
4. providing oversight and guidance with respect to continuing medical education activities;
5. reviewing or delegating the review of quality indicators to facilitate uniformity regarding patient care services;

6. providing leadership in activities related to patient safety;
  7. providing oversight in the process of analyzing and improving patient satisfaction;
  8. ensuring that, periodically as appropriate, the Bylaws and applicable policies are reviewed and updated;
  9. providing and promoting effective liaison among the Medical Staff, Administration, and the Board;
  10. recommending clinical services, if any, to be provided by telemedicine;
  11. reviewing and approving all standing orders for consistency with nationally recognized and evidence-based guidelines; and
  12. performing any other functions as are assigned to it by these Bylaws or applicable policies.
- c. Meetings:
- The MSEC will meet at least ten times a year and more often if necessary to fulfill its responsibilities and maintain a permanent record of its proceedings and actions.

#### **ARTICLE IV: COMMITTEES OF THE MEDICAL STAFF**

##### **4.1 Composition of Committees.**

All Active, Associate, Honorary and Advance Practice Clinician Staff members may be appointed by the Chief of Staff to serve on Medical Staff committees. Committee chairs are appointed by the Chief of Staff. Hospital members of Medical Staff committees are appointed by the Chief Executive Officer. The Chief of Staff and the Chief Executive Officer are *ex-officio* members of all committees.

##### **4.2 Term of Service.**

Unless otherwise specified by the Chief of Staff at the time of appointment, a committee member serves an indefinite term.

##### **4.3 Removal and Vacancies.**

Except for the Medical Staff Executive Committee, a Medical Staff committee member may be removed by the Chief of Staff, and a Hospital committee member may be



removed by the Chief Executive Officer, at any time and for any reason. A committee vacancy shall be filled in the same manner in which appointments to the committee are ordinarily made.

**4.4 Quorum.**

Quorum for a committee meeting is two members.

**4.5 Manner of Action.**

The action of a majority of the committee members present at a meeting at which a quorum is present is the action of the committee. Action may be taken without a meeting by unanimous consent setting forth the action taken, signed in writing or confirmed via electronic mail by a majority of committee members. The committee chair will tabulate the votes.

**4.6 Ex officio Members.**

*Ex officio* committee members may attend and participate in committee meetings, but do not count for quorum and do not vote.

**4.7 Attendance by Active Medical Staff Members.**

Active Medical Staff members are required to attend at least fifty percent (50%) of their primary committee meetings during the calendar year. The committee chair may excuse a member due to illness, attending a patient in an emergency, on-call status or other extenuating circumstances.

**4.8 Meetings.**

Committees shall meet regularly and as often as necessary to accomplish their tasks. The chair shall set the time and day for regular meetings, consulting with the Chief of Staff to avoid conflicting with other committee schedules.

**4.9 Special Committee Meetings.**

A special meeting of a committee may be called by the Chief of Staff, the committee chair or two (2) committee members.

**4.10 Minutes.**

The committee chair or designee shall prepare minutes of all regular and special committee meetings, including a record of the attendance of committee members and

votes taken. The minutes shall be submitted for approval at the next regular meeting of the committee and, after such approval is obtained, shall be forwarded to the Medical Staff Executive Committee. Each committee shall maintain a permanent file of all meeting minutes.

## **ARTICLE V: MEETINGS OF THE MEDICAL STAFF**

### **5.1 Regular Medical Staff Meetings.**

Regular Medical Staff meetings shall generally be held monthly or at least quarterly. The Chief of Staff or designee will serve as chair. Any business of the Medical Staff may be conducted at a regular meeting. Medical Staff committees, the Chief of Staff and the Chief Executive Officer may present reports and recommendations, and clinical work at the Hospital may be reviewed.

### **5.2 Annual Medical Staff Meeting.**

The Medical Staff annual meeting shall be the December regular meeting.

### **5.3 Special Medical Staff Meetings.**

Special Medical Staff meetings may be called at any time by the Hospital Board, the Chief of Staff or the MSEC. At any special meeting no business shall be transacted except that stated in the notice calling the meeting. Sufficient notice of a special meeting shall be electronically mailed to each member of the Medical Staff at least seventy-two (72) hours prior to the time set for the meeting.

### **5.4 Attendance by Active, Associate, Honorary and Allied Medical Staff Members.**

Active Medical Staff members are required to attend at least six (6) regular Medical Staff Meetings during each calendar year.

- a. The Chief of Staff may excuse a member due to illness, attending a patient in an emergency, on-call status or other extenuating circumstances. The Medical Staff member must notify the Chief of Staff before the meeting for an absence to be excused.
- b. An Active Medical Staff member who fails to meet attendance requirements may be assessed a fine by the Chief of Staff. Persistent and unexcused failure to attend Medical Staff Meetings may result in professional review.

- c. Members of the Associate, Honorary and Allied staff categories are not required to attend meetings, but are invited to attend and participate. They do not count towards quorum and may not vote.

#### **5.5 Quorum.**

Quorum for any regular, annual or special Medical Staff Meeting is one member of the MSEC plus a minimum of 25 Active Medical Staff members.

#### **5.6 Minutes.**

The Chief of Staff or designee shall keep accurate, complete, written minutes of all Medical Staff meetings.

### **ARTICLE VI: STAFF MEMBERSHIP**

#### **6.1 Nature of Staff Membership.**

Membership on the Medical Staff or APC Staff shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment to and membership on the Medical Staff or APC Staff shall confer on the appointee or member only such clinical privileges as have been granted by the Board in accordance with these Bylaws. Only practitioners who are members of the Medical Staff with appropriate privileges may admit patients in the Hospital.

#### **6.2 Basic Qualifications for Membership.**

The burden of establishing eligibility for membership on the Medical Staff or APC Staff is on the practitioner seeking membership. Eligibility for membership is limited to practitioners licensed by the State of Alaska, authorized to practice in Alaska by federal law, or employed by the federal government, who:

- a. sufficiently document, and promptly update material changes to, their background, experience, training, ability and physical and mental health fitness, to demonstrate to the satisfaction of Medical Staff and the Board that they are capable of providing medical care in accordance with the applicable standards of care;

- b. provides patient care in accordance with the following general competencies, as those may be updated and revised from time to time:
  - 1. technical quality of care: effective skill and judgment; appropriate performance of clinical privileges;
  - 2. quality of service: ability to meet the customer service needs of patients and other caregivers;
  - 3. relationships: positive and constructive interpersonal interactions with colleagues, hospital staff and patients;
  - 4. citizenship: participation and cooperation with medical staff responsibilities;
  - 5. patient safety and patient rights: cooperation with rules and procedures that protect patient safety and rights; and
  - 6. resource utilization: effective and efficient use of the Hospital's clinical resources;
- c. are qualified to provide a needed service within the hospital;
- d. adhere to generally recognized standards of professional ethics;
- e. have documented the capability to work cooperatively with other practitioners, and are willing to participate in the discharge of Medical Staff or APC Staff responsibilities;
- f. provide proof of, and maintain at all times, professional liability insurance in not less than the minimum amounts required for the practitioner's specialty by the Hospital Board after consultation with the Medical Staff Executive Committee;
- g. (applicable to applicants for Medical Staff appointment subsequent to the adoption of this section) must be certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, the American Dental Association, or the American Board of Foot and Ankle Surgery ("ABFAS"), as applicable. Applicants who are not board certified at the time of application but who have completed

their residency or fellowship training within the last five years will be eligible for Medical Staff appointment. However, in order to remain eligible for reappointment, those applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training. (Maintenance of certification is not required for reappointment.) In exceptional circumstances, the five-year time frame for initial applicants to obtain certification and the time frame for recertification by existing members may be extended for one additional appointment term, not to exceed two years, in order to permit an individual an opportunity to obtain certification. In order to be eligible to request an extension in these situations, an individual must, at a minimum, have been on the Medical Staff for at least three consecutive years; have had no documented peer review concerns related to the individual's competence or behavior at the Hospital during the individual's tenure that have risen to the level of the involvement of the MSEC; and provide a letter from the appropriate certifying board confirming that the individual remains eligible to take the certification examination within the next two years; and

- h. if seeking to practice as an APC, have a written agreement with a Supervising/Collaborating Physician, which agreement must meet all applicable requirements of Alaska law and Hospital policy, and satisfy the education, training and certification requirements for delineation of privileges relating to their specific area of practice.

Membership or particular clinical privileges shall not be denied on the basis of race, gender, gender identity, ethnicity, age, religion, color, cultural identification, sexual orientation, national origin or physical or mental disability that does not affect the quality of patient care; or on the basis of any other criterion that does not affect the delivery of quality patient care in the Hospital, professional qualifications, the Hospital's purposes, needs and capabilities, or community need.

### **6.3 Waivers.**

Any applicant who does not satisfy one or more of the threshold eligibility criteria may request that it be waived. Waivers of threshold eligibility criteria will not be granted routinely. The applicant requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question. A request for a waiver must be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the applicant in question, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee will forward its recommendation, including the basis for such, to the MSEC. Any recommendation to grant a waiver must include the specific basis for the recommendation. The MSEC will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation. The Board's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and the individual who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent. A determination to grant a waiver does not mean that appointment will be granted, only that processing of the application can begin.

No practitioner shall have a right to appointment, reappointment or privilege renewal, nor shall any practitioner be automatically entitled to membership or to the exercise of particular clinical privileges merely because the practitioner is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board or had, or presently has, staff membership or privileges at this Hospital or at another health care facility or in another practice setting.

#### **6.4 Conditions of Appointment to the Medical Staff or APC Staff.**

The following conditions apply to all members:

- a. The member shall not deceive a patient as to the identity of a practitioner providing treatment or service or delegate the responsibility for diagnosis or care of hospitalized patients to another person who is not qualified to undertake such responsibility.
- b. Acceptance of membership shall constitute the member's agreement to abide by the Medical Staff Bylaws and Rules and Regulations, other applicable policies and procedures of the Medical Staff and Hospital, and the principles of medical ethics applicable to the member's branch of health care or specialty.
- c. Each member is responsible to:
  1. provide for continuous care for his or her patients at the Hospital;
  2. practice in accordance with generally accepted principles of professional performance and utilization;
  3. appropriately document patient illness and care in a timely manner, including, as required by the Bylaws, Rules and Regulations and other applicable policies and procedures of the Medical Staff or Hospital, a medical history and physical examination completed no more than thirty (30) days before or within twenty-four (24) hours after admission or registration, and prior to surgery or a procedure requiring anesthesia services, that is completed and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual and contains the information specified in the rules and regulations;
  4. assist in the peer review, ongoing professional practice evaluation ("OPPE"), focused professional practice evaluation ("FPPE") and utilization programs;
  5. accept committee assignments;
  6. participate in continuing education programs;

7. work cooperatively, professionally and constructively with other practitioners at the Hospital; and
  8. participate in the on-call schedule, emergency services and other special care units, as required by staff category.
- d. The member shall promptly notify the Chief Executive Officer of the revocation, suspension or lapse of his professional license, or the imposition of terms of probation or limitation of practice by any licensing agency; his loss of staff membership or loss, curtailment or restriction of privileges at any hospital or health care institution; the cancellation or restriction of his professional liability coverage or DEA registration; the commencement of a formal investigation by the Department of Health and Human Services or any agency of the United States or the State of Alaska, or any other state; or the member's knowledge of a claim or potential claim relating to or arising out of care provided by the member at the Hospital.
  - e. The member shall promptly notify the Chief Executive Officer of any federal or state, investigations, charges or sanctions that may debar, disqualify, preclude or exclude the member from participation in Medicare, Medicaid, or any other publically funded health care program, or that otherwise may disqualify the member from treating patients at the Hospital. A practitioner shall not render care to any patient at the Hospital while subject to any such sanction.

#### **6.5 Duration of Appointment.**

- a. A practitioner's initial grant of privileges shall be subject to one (1) year of FPPE and observation of clinical competence and ethical conduct under conditions of supervision as determined by the Credentials Committee.
- b. Reappointment and reassignment of privileges shall be for a period not to exceed two (2) years.
- c. Failure of an initial appointee to the Medical Staff to exercise privileges sufficiently to permit FPPE shall result in expiration of the practitioner's membership and privileges. However, an extension of the initial FPPE period



may be granted if the practitioner, for reasons beyond the practitioner's control, has not had a sufficient number of cases to facilitate a fair evaluation of his or her performance. An initial appointee whose privileges expire shall have the right to request a hearing if the expiration is based on a professional review action related to professional competence or professional conduct reportable to the National Practitioner Data Bank or the state of Alaska.

## **ARTICLE VII: APPOINTMENT, REAPPOINTMENT, CLINICAL PRIVILEGES, AND LEAVES OF ABSENCE**

### **7.1 Application for Appointment, Reappointment and Clinical Privileges.**

- a. Contents of application.** Each application for appointment, reappointment or clinical privileges shall be presented in writing on the prescribed form and signed by the applicant. The applicant is responsible for the contents of the form. The applicant has the burden of producing all information requested in the application form and any additional information that would reasonably be material to the Credentials Committee's recommendation to the MSEC and Board on the application. It is the responsibility of the applicant to complete the application and any requests for additional information to the satisfaction of the Credentials Committee. The application form shall require detailed information that may include, but is not limited to:
  1. The applicant's qualifications, including, but not limited to, professional training and experience, current unrestricted licensure, current DEA registration, continuing medical education and information related to the clinical privileges to be exercised by the applicant;
  2. An account of the applicant's professional activities with respect to each year since completion of medical, podiatric or dental education;
  3. References from peers familiar with the applicant's current professional competence and ethical character, medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism, together with names and contact information

for the applicant's supervisor or department head and other individuals with whom the applicant has worked directly and substantially;

4. Requests for membership categories and clinical privileges;
5. Past or pending disciplinary or professional review actions; voluntary resignations from a medical staff during the process of an investigation or to avoid an investigation; license and clinical privilege limitations; formal collegial interventions; performance improvement plans; termination of health care employment or resignation in lieu of termination of health care employment; substance abuse evaluations and treatments required by any licensing agency, medical staff or employer; and similar matters;
6. Physical and mental health fitness to exercise the privileges requested and the responsibilities of medical staff appointment, including any particular matters relevant to the specific clinical privileges requested;
7. Past, pending or potential claims, suits or settlements involving allegations of abuse, malpractice or professional liability. For each malpractice claim, the applicant must provide the name of the claimant; the county and state where the claim arose; the approximate date the claim was made; the status of the claim; the amount of any judgment or settlement against the applicant; and an objective statement of the claim against the applicant and the applicant's response;
8. Written evidence that the applicant meets Alaska State Medical Board requirements for continuing medical education (CME); and
9. Certificate of insurance or other written verification acceptable to the Hospital showing that the applicant is covered by professional liability insurance in the amount established for the applicant's specialty by the Board after consultation with the Medical Staff, including information regarding pending and previous malpractice claims.

- b. Conditions of Application.** By applying for appointment, reappointment or clinical privileges, each applicant:

1. agrees to appear for interviews with regard to the application;
2. authorizes the Hospital to consult with members of other hospital medical staffs with which the applicant has been associated and with others who may have information bearing on competence, character and ethical qualifications, substance abuse, disciplinary or professional review actions, criminal record, and other relevant information;
3. consents to query by the Hospital to the National Practitioner Data Bank regarding the applicant or member and submission of any resulting information to the Credentials Committee for inclusion in the applicant's credentials file;
4. consents to inspection by the Hospital and Medical Staff of all records and documents that may be material to an evaluation of professional and ethical qualifications and competence for staff membership, and to the exercise of the clinical privileges requested;
5. agrees to refrain from fee-splitting;
6. releases from liability, to the fullest extent allowed by law, all representatives of the Board, Hospital and Medical Staff for their acts performed in connection with evaluating the application;
7. releases from liability, to the fullest extent allowed by law, all individuals and organizations who provide information to the Hospital concerning the applicant's competence, ethics, character, past employment, past medical staff memberships, clinical history and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information; and
8. attests to the correctness and completeness of all information furnished and acknowledges that any material misstatement in or omission from the application constitutes grounds for the Hospital and Medical Staff office to stop processing the application, with no entitlement to a hearing or appeal. The individual will be informed in writing of the nature of the

misstatement or omission and permitted to provide a written response. The Chief of Staff will review the individual's response and provide a recommendation to the Medical Staff Executive Committee. The Medical Staff Executive Committee will recommend to the Board whether the application should be processed further. If the material misstatement or omission is not discovered until after the individual is appointed, a similar process will be followed and is grounds for automatic relinquishment of staff membership or clinical privileges with no entitlement to a hearing or appeal. For purposes of this paragraph, "material" means that the misstated or omitted information would be considered by a reasonable person to be relevant to the evaluation of the application.

- c. **Information and Documentation.** An applicant for appointment, reappointment or clinical privileges has the burden of providing clear and convincing information and documentation concerning the applicant's experience, background, training, demonstrated ability, current competence, emotional stability, availability, and physical and mental health fitness, with sufficient adequacy to demonstrate to the satisfaction of the Credentials Committee, the Medical Staff Executive Committee, and the Hospital Board that the applicant is capable of providing care to patients in conformance with generally recognized professional standards, taking into account patients' needs, the available Hospital facilities and resources, and utilization standards in effect at the Hospital. Failure to meet this burden is grounds for denial of the application.
- d. **Complete Application.** The Credentials Committee will not take action on an incomplete application. An application for appointment, reappointment or clinical privileges is not complete unless and until the Credentials Committee is satisfied that the requirements of this section are met.
  - 1. The applicant must submit a signed written application, using the prescribed form, in which all of the requested information is provided. All entries and attachments must be legible, understandable, and

substantively responsive on every point of inquiry. It shall be the applicant's responsibility to promptly provide updated information on any changes or additions to the application after it is submitted.

2. The applicant must respond to all further requests from the Medical Staff, through its authorized representatives, for clarifying information or for submission of additional information. This may include, but not necessarily be limited to, (i) personal interviews with the applicant and (ii) submission to a medical or psychiatric fitness evaluation, at the applicant's expense, by a physician selected by the Credentials Committee, if deemed appropriate by the Executive Committee to resolve questions about the applicant's fitness to perform the physical and/or mental functions associated with requested clinical privileges. If the requested information is in the exclusive possession of another person or entity, the applicant shall take such measures as are necessary to obtain that information or to arrange for it to be submitted to the Credentials Committee directly by the source.
3. The applicant's credentials must be verified from primary sources, including educational institutions, training programs, federal and state license, certification and law enforcement agencies, the Drug Enforcement Administration, CMS, the OIG and the National Practitioner Data Bank, as appropriate.
4. The Credentials Committee must receive written evaluations from the applicant's references and directed references from other potential sources of relevant information.
5. The applicant's identity must be verified through government-issued photo identification.
6. The applicant must certify that he or she has received, read and agrees to be bound by the terms the Medical Staff Bylaws and Rules and Regulations.

- e. **Application for Privileges.** An application for new or additional clinical privileges by a practitioner in good standing, for which there may not be a prescribed form, is not complete unless and until:
1. The applicant submits a written request for the privileges, supported by a complete description of the applicant's training, experience, and other qualifications for the requested privileges, with all additional requested information.
  2. The applicant's current licensure, certifications and National Data Bank reports have been verified from primary sources.
  3. In the case of new privilege categories, the Credentials Committee verifies that the Hospital has adequate equipment and facilities to support the requested privileges.
- f. **Incomplete Application.** An application for appointment, reappointment or clinical privileges that is found to be incomplete by the Credentials Committee does not qualify the applicant for an appointment, reappointment or credentialing recommendation, regardless of any assessment or determination that may have been made as to its completeness at an earlier stage in the process. Should the applicant fail to make the application complete after a reasonable time (normally 90 days), the application will be deemed withdrawn and the credentialing process will be terminated. Termination of the credentialing process under this provision is not considered an adverse action and does not entitle the applicant to request a hearing; provided that, if the applicant disagrees that the application is incomplete, on request the applicant may attend the next regular Credentials Committee meeting and explain why, in the applicant's view, the application should be considered complete or why the applicant should be granted additional time to complete the application.
- g. **Assembly of Information.** The application for appointment, reappointment or clinical privileges shall be presented to the Chief Executive Officer for assembly of the necessary information and a preliminary determination of the

completeness of the application. If the application appears to be complete, the Chief Executive Officer shall transmit the application and all other pertinent information to the Credentials Committee.

## **7.2 Appointment Process.**

- a. The Credentials Committee shall examine the application for completeness and determine whether the applicant must provide additional documentation or other information. When the application is complete, the Credentials Committee shall evaluate the application on its merits and determine whether the applicant meets the qualifications for the category of staff membership and the clinical privileges requested.
- b. Within ninety (90) days after receipt of a complete application for membership, the Credentials Committee shall transmit to the Medical Staff Executive Committee the application and all other information it considered in arriving at its recommendation. The Credentials Committee will recommend that the applicant be appointed to the Medical Staff, that Medical Staff appointment be denied, or that action on the application be deferred. Where rejection or deferment is recommended, the reasons for the recommendation shall be stated.
- c. Within ninety (90) days after receipt of an application from the Credentials Committee, the Medical Staff Executive Committee shall evaluate the application on its merits, and shall forward to the Hospital Board a written report and recommendations as to staff appointment and, if appointment is recommended, as to staff category, clinical privileges, and any special conditions to be attached to the appointment. The Medical Staff Executive Committee may in its discretion defer a decision and refer the application back to the Credentials Committee for further consideration or to obtain additional information. The reasons for each recommendation shall be noted in the application file.
  1. Deferral: When the Medical Staff Executive Committee refers an application back to the Credentials Committee for further consideration

or to obtain additional information, the Credentials Committee shall promptly address the matter. The Credentials Committee will return the application to the Medical Staff Executive Committee for final action, with any additional recommendations or information, within a reasonable time (normally 60 days).

2. Favorable Recommendation: When the recommendation of the Medical Staff Executive Committee is favorable to the applicant, the Medical Staff Executive Committee shall promptly forward the application, together with all supporting information, to the Hospital Board. For the purposes of this provision, “all supporting information” includes the application and all other information considered by the Medical Staff Executive Committee, the reports and recommendations of the Credentials Committee and minority views.
  3. Adverse Recommendation: When the recommendation of the Medical Staff Executive Committee is adverse to the applicant, the Chief Executive Officer shall promptly notify the practitioner in writing, including notice that the applicant is entitled to request a hearing. For the purposes of this provision an “adverse recommendation” by the Executive Committee means any action that constitutes grounds for a hearing pursuant these Bylaws.
- d. The Hospital Board shall either accept the recommendation of the Medical Staff Executive Committee or reject it.
  - e. The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and the MSEC and there is no evidence of any of the following:
    1. a current or previously successful challenge to any license or registration;
    2. an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or



3. an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Any decision reached by the Board Committee to appoint will be effective immediately and will be forwarded to the Board for its information at its next meeting.

- f. If the Hospital Board accepts the recommendation of the Medical Staff Executive Committee, the Chief Executive Officer shall transmit the decision in writing to the applicant.
- g. If the Hospital Board does not accept the recommendation of the Medical Staff Executive Committee, the Hospital Board shall refer the application to the Joint Conference Committee. The Joint Conference Committee shall meet promptly (normally within 30 days) after referral from the Hospital Board to address the differences in the recommendation of the Medical Staff Executive Committee and the decision by the Hospital Board. The Joint Conference Committee may invite the Credentials Committee Chair to participate. The Joint Conference Committee meeting shall be held in executive session.
- h. The Joint Conference Committee will prepare a recommendation in writing. The recommendation will be delivered to the applicant and the Hospital Board by the Joint Conference Committee Chair. The Hospital Board shall either accept the recommendation or reject it. If the Hospital Board's decision is adverse to the applicant, the applicant shall be entitled to request a hearing. If the applicant does not request a hearing, the decision shall be the Hospital Board's final administrative decision on the application.
- i. An applicant who has received a final adverse decision regarding appointment or clinical privileges, or who has withdrawn an application for appointment of privileges after being informed of an adverse recommendation by the Credentials Committee, the Medical Staff Executive Committee, the Joint Conference Committee or the Hospital Board, shall not be eligible to reapply for such appointment or privileges for a period of twenty-four (24) months, unless

expressly allowed to reapply by the Medical Staff Executive Committee for good cause shown. Any such re-application shall be processed as an initial application. The applicant shall submit such additional information as the Medical Staff Executive Committee may require demonstrating that the basis of the earlier adverse action no longer exists. The applicant shall be entitled to request a hearing in the event the Medical Staff Executive Committee denies the request to allow the applicant to reapply.

### **7.3 Reappointment Process.**

- a. At least ninety (90) days prior to the expiration of each medical staff member's appointment, the member may reapply for membership in writing, on the prescribed form. In accordance with Section 7.1(g) of these Bylaws, the application shall be presented to the Chief Executive Officer for assembly of the necessary information, a preliminary determination of the completeness of the application, and transmittal to the Credentials Committee. Reappointment and renewal of privileges are not a matter of right. The burden of proof is on the member to demonstrate competence for reappointment and reassignment of privileges.
- b. The reappointment application form shall request information necessary to update the medical staff file on the member's health care related activities relevant to reappointment and the renewal of privileges as requested. This form may include, by way of example and not by limitation, requests for information about any continuing training, education and experience relating to the member's qualifications for reappointment; the applicant's requests for reappointment, change in staff status or renewal or modification of clinical privileges; current physical and mental health fitness, with reference to the specific clinical privileges to be renewed; proof of current licensure and DEA registration; the name and address of any other health care organization or practice where the member provided services during the preceding period; membership, awards, or other recognition conferred or granted by any

professional society; sanctions of any kind imposed or contemplated by any other health care organization or licensing authority; professional liability insurance coverage; and pending or potential claims, suits, or settlements involving the member's professional ethics and qualifications that may bear on his ability to provide appropriate patient care in the hospital. One peer recommendation is required for reappointment.

- c. The reappointment process will follow the process of initial appointment. Only complete applications for reappointment will be considered. The applicant has the burden of completing the application and establishing his or her qualifications for reappointment and the clinical privileges requested.
- d. Each recommendation concerning the reappointment of a Medical Staff member and the granting of clinical privileges upon reappointment shall be based on the member's professional competence and clinical judgment in the treatment of patients, including the results of the Ongoing and Focused Professional Practice Evaluation processes; professional ethics and conduct, attendance at Medical Staff meetings and participation in staff affairs, compliance with the Hospital's policies regarding matters affecting patient care and with the Medical Staff Bylaws and Rules and Regulations, cooperation with Hospital personnel and colleagues in matters affecting patient care, and other factors relevant to the applicant's quality of care and treatment of patients in the Hospital.
- e. Reappointments to the Medical Staff shall be for a period not to exceed two (2) years. Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of a member's compliance with performance improvement requirements. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle a member to request a hearing or appeal unless such a recommendation is reportable to the State of Alaska.
- f. Applications for reappointment and renewal of privileges should be considered in a reasonable and timely manner by all persons and committees required to

act on them. It is anticipated that a timely application will be fully processed prior to the expiration date of the member's current term of appointment.

- g. In the event the applicant for reappointment is the subject of an investigation or a hearing at the time reappointment is being considered, a reappointment for a period of less than two years may be granted pending the completion of that process, subject to monitoring.

#### **7.4 Limitation of Clinical Privileges.**

The Hospital Board shall state in writing the clinical privileges granted to the applicant. If the clinical privileges granted by the Hospital Board are more restrictive than those requested by an applicant, the Hospital Board shall state in writing its reasons for restricting the applicant's privileges. The applicant shall be entitled to a hearing in the event the privileges granted are less than requested.

#### **7.5 Modification of Staff Category or Clinical Privileges.**

A member may, either in connection with reappointment or at any other time, request modification of staff category or clinical privileges by submitting a written application to the Chief Executive Officer. The modification process will follow the process of initial appointment. The applicant shall be entitled to a hearing in the event the request for modification is denied.

#### **7.6 Leave of Absence.**

- a. A Medical Staff member may, upon written request, be given a leave of absence by the Medical Staff Executive Committee. A leave of absence may be granted for a period of not less than ninety (90) days or more than two (2) years.
  - 1. A request for leave of absence shall state the approximate period of absence. The request must be submitted at least 60 days in advance of the beginning date for the leave of absence requested, unless the MSEC determines that the member has demonstrated good cause for a shorter advance notice.

2. During the leave of absence, the member may not exercise clinical privileges at the Hospital, and membership rights and responsibilities shall be inactive.
  3. Before returning from the leave of absence, the member must submit a request for reinstatement of privileges. The application must be in writing, and provide information pertinent to the leave of absence, including a written report or documentation of professional or other activities during the absence.
  4. If the leave of absence was for health reasons (except for maternity leave), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is capable of resuming a hospital practice and safely exercising the clinical privileges requested.
  5. If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges will expire at the end of the appointment period, and the individual will be required to apply for reappointment.
  6. Members of the Medical Staff must report to the Chief of Staff any time they are away from Medical Staff or patient care responsibilities for longer than 60 days and the reason for such absence is related to their physical or mental fitness or otherwise to their ability to care for patients safely and competently. Upon becoming aware of such circumstances, the Chief of Staff, may trigger an automatic medical leave of absence at any point after becoming aware of the Medical Staff member's absence from patient care.
- b. Failure, without good cause, to request reinstatement as provided above shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic expiration of Medical Staff membership and privileges. A practitioner whose membership is automatically resigned and privileges so expire may

request to be heard on the good cause issue at a meeting of the Medical Staff Executive Committee. A request for membership and privileges subsequently received from a practitioner whose appointment was automatically resigned shall be submitted and processed in the manner specified for applications for initial appointment.

- c. Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for failure to request reinstatement, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal, because this does not constitute a professional review action.

#### **7.7 Applications for Telemedicine Privileges.**

- a. Applications for Consulting Medical Staff membership to provide telemedicine services will be considered by the Credentials Committee under this section.
- b. In lieu of the other requirements of these Bylaws, the Credentials Committee may rely upon the credentialing and privileging decisions made by a distant-site hospital or distant site entity when making recommendations on privileges for the individual distant-site physicians and practitioners providing such services, provided that a written telemedicine agreement approved by the Hospital Board is in place between the Hospital and the distant-site hospital or distant site entity that meets current CMS Conditions of Participation, and ensures that:
  - 1. the distant-site hospital providing the telemedicine services is a Medicare-participating hospital or, if a distant site entity, the entity furnishes services and information that permit the Hospital to comply with all applicable CMS conditions of participation;
  - 2. the individual distant-site physician or practitioner is privileged at the distant-site hospital or by the distant site entity to perform the telemedicine services provided;

3. the distant-site or distant site entity has provided a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or distant site entity;
  4. each individual distant-site physician or practitioner requesting telemedicine privileges holds a license issued or recognized by the State of Alaska, or is authorized to practice in Alaska by federal law;
  5. the distant-site physician's or practitioner's performance of privileges at the Hospital will be reviewed and sent to the distant-site hospital or distant site entity for use in the periodic appraisal of the distant-site physician or practitioner including, at a minimum, all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the Hospital's patients and all complaints the Hospital has received about the distant-site physician or practitioner;
  6. the distant-site hospital or distance site entity furnishes services that, in accordance with 42 CFR §482.12(e), permit the hospital to comply with all applicable conditions of participation for the contracted services; and
  7. the distant-site telemedicine hospital's or distant site entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR §482.12(a)(1) through (a)(7) and §482.22(a)(1) through (a)(2).
- c. Each distant-site physician or practitioner specifically understands that by applying for Consulting Medical Staff membership at the Hospital and by providing telemedicine services to patients at the Hospital, he or she irrevocably agrees to the provisions of Sections 7.1(b)(6) and (7) ("Applications"), 11.3 ("Waiver and Full Release of Liability") and 11.4 ("Release of Information") of these Bylaws, as those sections may be amended or revised from time to time.

## **ARTICLE VIII: CLINICAL PRIVILEGES**

### **8.1 Exercise of Clinical Privileges.**

Only practitioners granted privileges through the medical staff process shall be permitted to engage in clinical activities in the Hospital. Practitioners employed by the Hospital whose duties are medical-administrative in nature and include clinical responsibilities involving their capacity as practitioners, must be members of the Medical or APC Staff. Every practitioner practicing in the Hospital by virtue of Medical or APC Staff membership or otherwise shall be entitled to exercise only those clinical privileges specifically granted by the Hospital Board or, in the case of temporary or disaster privileges, by the Chief Executive Officer as provided in these Bylaws.

### **8.2 Criteria for Delineation of Privileges.**

Criteria for the delineation of privileges shall be developed by the Credentials Committee and approved by the Medical Staff Executive Committee.

### **8.3 Temporary Privileges While Awaiting Approval.**

Temporary privileges may be granted to an appropriately licensed practitioner who has submitted a complete application that raises no concerns listed in this section for medical staff appointment and clinical privileges while awaiting review and approval by the MSEC. Temporary privileges will be granted for a defined period of time, not to exceed 120 calendar days, upon the written recommendation of the Chief Executive Officer and the Chief of Staff.

- a. Temporary privileges may not be used at the time of reappointment to accommodate administrative delays.
- b. Temporary privileges may only be granted when the application is complete and the applicant's credentials file contains verified information establishing the practitioner's qualifications, ability and judgment to exercise the privileges requested, including:
  1. current licensure;
  2. relevant training and experience;
  3. current competence;



4. ability to perform the privileges requested;
  5. National Practitioner Data Bank reports;
  6. no current or previously successful challenges to licensure, registration, certification, or involuntary staff membership or privilege discipline action at another hospital or medical organization.
- c. An initial FPPE plan is required as a condition of temporary privileges under this section.

**8.4 Temporary Privileges for Specific Purposes.** Temporary privileges for specific purposes when there is an important patient care, treatment and service need may be granted to a practitioner by the Chief Executive Officer upon presentation of satisfactory proof to the Chief Executive Officer and to the Chief of Staff that the practitioner is appropriately licensed and qualified. Current licensure and current competence will be verified. Such temporary privileges will not exceed 120 days.

- a. Temporary privileges may be granted for the care of one or more specific patients by a practitioner who is not an applicant for staff appointment, but who is otherwise fully qualified for appointment and has specific expertise, skills or knowledge needed for the patient's or patients' care.
- b. Any patient cared for by a practitioner granted temporary privileges under this section will be assigned to the care of a member of the Active Medical Staff who will be responsible to supervise and coordinate the patient's care. Practitioners granted temporary privileges under this section may not be granted admitting privileges.
- c. Temporary privileges may be granted to a practitioner with similar privileges at another hospital for the purpose of obtaining or providing training under the supervision of a member of the Active Medical Staff.

**8.5 Termination of Temporary Privileges.** The Chief of Staff or the Chief Executive Officer may immediately terminate any temporary privileges upon discovery of any information or the occurrence of any event that raises questions about the practitioner's professional qualifications, ability or suitability for temporary privileges. The

practitioner's patients will be assigned to another practitioner by the Chief of Staff. The practitioner may request a hearing on the termination of temporary privileges.

**8.6 Emergency and Disaster Privileges.** In an acute patient emergency, a medical staff member with clinical privileges is permitted to provide any type of patient care, treatment, and services within the scope of their license necessary as a life-saving measure or to prevent serious harm. In the case of a disaster, the Chief Executive Officer or designee may grant disaster privileges to licensed practitioners as necessary to meet patient care needs. When the emergency or disaster no longer exists, patient care shall be transferred to appropriately privileged medical staff members.

**8.7 Dental Privileges.**

Privileges granted to dentists shall be based on their training, experience and demonstrated competence. The scope and extent of the privileges shall be specifically delineated and granted in the same manner as all other privileges. All dental patients shall have a history and physical performed by an Active Medical Staff member or APC Staff member who has been granted appropriate privileges. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

**8.8 Podiatry Privileges.**

Privileges granted to podiatrists shall be based on their training, experience and demonstrated competence. The scope and extent of the privileges shall be specifically delineated and granted in the same manner as all other privileges. All podiatry patients shall have a history and physical performed by an Active Medical Staff member or APC Staff member who has been granted appropriate privileges. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

**8.9 Physicians and Other Practitioners in Training:**

Physicians and other practitioners in training, including but not limited to medical students, residents, advanced practice nurses, and physician assistants in training programs ("trainees"), will not be granted clinical privileges or appointment to the

Medical Staff or the Advanced Practice Clinician Staff. The hospital Program Director, sponsoring physician or attending staff member, as set forth in hospital policy, will be responsible for the direction and supervision of the on-site or day-to-day patient care activities of each trainee, who will be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, or training protocols. The hospital Medical Staff Services Department and the director of the applicable training program at the sponsoring organization will be responsible for verifying and evaluating the qualifications of each Trainee as set forth in hospital policy.

## **ARTICLE IX: PROFESSIONAL REVIEW ACTIVITY AND ACTIONS**

### **9.1 Collegial Intervention.**

- a. The Medical Staff encourages collegial intervention to address and, where possible, resolve concerns relating to a practitioner's clinical practice or professional conduct. The goal of collegial intervention is to arrive at voluntary, responsive actions by the practitioner to resolve concerns before the professional review process is initiated.
- b. Collegial intervention may be initiated by the Executive Committee, the Chief of Staff, the Quality Review Committee or any department head.
- c. Collegial intervention may include counseling, sharing of comparative data, monitoring, proctoring, FPPE, arranging additional training or education, or any other method reasonably expected to resolve the concerns.
- d. The Chief of Staff may request that one or more members of the Medical Staff conduct a collegial intervention.
- e. Collegial intervention is encouraged but is not mandatory. It is not a prerequisite to an investigation, a professional review action or the precautionary suspension of a practitioner's clinical privileges.
- f. Collegial intervention is a professional review activity and confidential to the fullest extent allowed by law.

**9.2 Professional Review.** Any member of the Medical Staff, the Chief Executive Officer, the Medical Staff Executive Committee, the Quality Review Committee or the Credentials Committee may request professional review.

- a. Professional review may be requested when there are concerns that action in the furtherance of quality health care at the Hospital may be necessary because the activities, conduct, skills, currency or physical or mental health of any practitioner:
  1. may be detrimental to patient or staff safety;
  2. may not meet the ethical or professional standards of the Medical Staff;
  3. may be contrary to or fail to meet the requirements of the Medical Staff Bylaws, Rules and Regulations or Policies;
  4. may be contrary to the Hospital's policies or procedures;
  5. may, or have the potential to, undermine a culture of safety;
  6. have resulted in a criminal charge or conviction;
  7. have led to an adverse action by a professional association, licensing board or administrative agency;
  8. have not responded to collegial intervention; or
  9. have otherwise called into question the practitioner's credentials or qualifications for Medical Staff membership or privileges.
- b. A request for professional review must be in writing and include copies of any readily available relevant documents, charts and other information.
- c. The Medical Staff Executive Committee shall review the request and determine whether there is a reasonable basis to believe that professional review in the furtherance of quality health care may be prudent. If so, the Medical Staff Executive Committee will determine the manner in which the professional review will be conducted. The Medical Staff Executive Committee may notify the individual that a request for professional review has been received and may discuss the matter with the individual, prior to determining whether to initiate an investigation or to handle the matter pursuant to another policy. An

investigation cannot be initiated and does not commence unless and until a determination to conduct an investigation is made by the MSEC. The MSEC will inform the individual when an investigation has begun and the nature of the concerns raised. Notification may be delayed if, in the judgment of the Medical Staff Executive Committee, informing the individual immediately might compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

- d. In the event of an investigation, the Medical Staff Executive Committee may investigate the matter itself or appoint an individual or committee ("Investigating Entity") to do so. The Investigating Entity may include an individual or individuals not on the Medical Staff. The Investigating Entity will not include as a voting member any individual who: is in direct economic competition with the individual being investigated (provided that, a peer in the same specialty may serve as a non-voting resource); is professionally associated with, or a relative of, the individual whose care or conduct is being investigated; has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or actively participated in the matter at any previous level. During its investigation, the Medical Staff Executive Committee or Investigating Entity may collect and review medical records, committee minutes and other documents, and may consult with or interview witnesses, Hospital administration and staff, experts, counsel, members of the medical staff or other individuals, as it deems appropriate.
- e. Upon being notified of the investigation, the practitioner may submit a written statement and any pertinent documents to the Investigating Entity. The practitioner shall be provided an opportunity for an interview with the Investigating Entity. Prior to this meeting, the individual will be informed of the questions being investigated and will be invited to discuss, explain, or refute the questions. A summary of the interview will be made and included with the Investigating Entity's report. This meeting is not a hearing, and none of the

procedural rules for hearings will apply. Lawyers will not be present at this meeting. The Medical Staff Executive Committee or Investigating Entity, as applicable, will make a reasonable effort to complete the investigation and issue its report within 30 days, provided that an external peer review by an expert is not necessary. When an external peer review is used, the report should be issued within 30 days of receiving the results of the external peer review. These time frames are intended to serve as guidelines and, as such, will not be deemed to create any right for an individual to have an investigation completed within such time periods.

- f. If the practitioner with respect to whom an investigation or professional review is being conducted is a member of the Medical Staff Executive Committee, the practitioner shall not participate in the investigation of, or deliberation on, any recommendations.
- g. At the conclusion of its investigation, the Medical Staff Executive Committee shall decide, in writing:
  - 1. that no professional review action is necessary;
  - 2. to defer action for a reasonable time when circumstances warrant;
  - 3. to issue a letter of admonition, censure, reprimand or warning;
  - 4. to refer the practitioner for FPPE;
  - 5. to impose probation or limitations on the practitioner's medical staff membership;
  - 6. to reduce, restrict, suspend or revoke the practitioner's clinical privileges;
  - 7. to impose Precautionary suspension;
  - 8. to suspend or revoke the practitioner's medical staff membership; or
  - 9. to take any other action appropriate under the circumstances.
- h. The Medical Staff Executive Committee Chair shall promptly notify the Chief Executive Officer and the Quality Director of all requests for professional review and its decisions on those requests.

**9.3 Right to Hearing, Notice and Request for Hearing.** A practitioner may request a hearing whenever these Bylaws provide for a right to a hearing or when the Medical Staff Executive Committee, for reasons of competency or conduct and for a period of more than thirty (30) days (and thus reportable to the NPDB or the state of Alaska):

- a. recommends limitations on the practitioner's medical staff membership or clinical privileges,
- b. recommends reduction, restriction, suspension or revocation of the practitioner's clinical privileges,
- c. imposes Precautionary suspension, or
- d. recommends suspension or revocation of the practitioner's medical staff membership.
- e. In those instances, the Chief Executive Officer shall promptly provide special notice to the practitioner of the Medical Staff Executive Committee's recommendation. The notice will:
  1. state that a professional review action has been proposed to be taken;
  2. describe the proposed action and state the reasons for the proposed action;
  3. inform the practitioner that he or she has the right to request a hearing on the proposed action by delivering a written request for hearing to the Chief Executive Officer within thirty (30) days after the date the notice was received by the practitioner; and
  4. provide a copy of this Article 9 of these Bylaws.

**9.4 No Hearing Requested.** If the practitioner does not timely request a hearing as provided in this Article, the Chief Executive Officer will transmit the Medical Staff Executive Committee's recommendation to the Hospital Board for its review and consideration, together with the information gathered in the investigation. The Hospital Board will, in writing:

- a. accept the recommendation, if it is supported by substantial evidence in the investigative record, or remand to the Medical Staff Executive Committee for

additional investigation or reconsideration of the recommendation, with a statement of reasons.

- b. The Chief Executive Officer will promptly provide special notice of the Hospital Board's decision to the practitioner.
- c. If the Medical Staff Executive Committee declines to investigate a request for professional review, the Hospital Board, after consultation with the Medical Staff Executive Committee, may direct the Medical Staff Executive Committee to conduct an investigation and to issue a written recommendation on the matter.

#### **9.5 Authority and Confidentiality.**

- a. At all times the Executive Committee, the Chief Executive Officer and the Chief of Staff retain full authority and complete discretion to take whatever action may be warranted by the circumstances and in the furtherance of quality health care, including precautionary suspension of a practitioner's clinical privileges as provided in Section 9.6.
- b. All aspects of the professional review process are confidential to the fullest extent allowed by law.

#### **9.6 Precautionary Suspension or Restriction for Reasons of Competency or Conduct.**

- a. The Chief of Staff and the Chief Executive Officer each have authority to precautionarily suspend or restrict a practitioner's clinical privileges for reasons of competency or conduct. Precautionary suspension may be imposed whenever there is a reasonable basis to believe that failure to take such an action may result in an imminent danger to the health or safety of any individual.
- b. The Chief of Staff or Chief Executive Officer, whichever imposed the suspension, shall promptly provide the practitioner and the Executive Committee written notice of the suspension and a brief statement of reasons.
- c. A Precautionary suspension or restriction under this section may be for an initial period of no longer than seven days.
- d. During the initial period the Medical Staff Executive Committee shall conduct a preliminary investigation to determine whether there is a reasonable basis to



continue the suspension or restriction of the practitioner's clinical privileges pending a professional review.

- e. If the Medical Staff Executive Committee determines that there is no reasonable basis to believe that there may be an imminent danger to the health of any individual if the practitioner exercises the clinical privileges in question during the professional review process, the Medical Staff Executive Committee may lift the suspension or restriction. Otherwise, the Medical Staff Executive Committee will continue the suspension or restriction during the professional review process.
- f. The Medical Staff Executive Committee will issue a short written decision explaining its reasons for continuing or lifting the Precautionary suspension or restriction as expeditiously as practicable and within 14 business days of the date the Precautionary suspension or restriction was imposed. The matter will then proceed as a request for professional review.
- g. If the suspension remains in effect the professional review process will proceed as expeditiously as practicable.

#### **9.7 Administrative Relinquishment.**

Any of the occurrences described in this Section must be disclosed immediately by the practitioner as provided in Section 6.4 d. and e., and will cause administrative relinquishment of an individual's appointment and clinical privileges. Such relinquishment is not an adverse professional review action, and, as such, it does not trigger a report with the National Practitioner Data Bank. A failure to disclose such matters will itself be referred to the Medical Staff Executive Committee. Except as otherwise provided below, an administrative relinquishment of appointment and privileges will be effective immediately upon actual or special notice to the individual, because such actions by outside entities affect the threshold eligibility qualifications.

- a. The clinical privileges of a practitioner will be deemed to be administratively relinquished if the practitioner's license, certificate, eligibility or registration has been suspended or revoked by the issuing license agency, including any:

- (i) state or provincial medical board or medical board of examiners;
- (ii) state or provincial dental board or board of dental examiners;
- (iii) state or provincial board of nursing;
- (iv) other federal, state or provincial health care licensing agency;
- (v) federal or state controlled substance agency; or
- (vi) federal or state health care program, such as Medicaid or Medicare.

Terms of probation, conditions or limitations with respect to the above items must also be disclosed; steps other than complete administrative relinquishment, if sufficient to protect patients, may be placed into effect by the Medical Staff Executive Committee pending professional review.

- b. The clinical privileges of a practitioner will be administratively relinquished upon receipt of information that the practitioner's medical staff membership or clinical privileges at any other Hospital or medical institution have been revoked or suspended for reasons of competency or conduct. Prior to the effective date of relinquishment, the Chief of Staff or the Chief Executive Officer will offer the affected practitioner an opportunity to discuss reasons that the practitioner believes that such action does not implicate qualifications for continued privileges at Bartlett Regional Hospital. The practitioner shall provide any documents requested, to enable the assessment of the basis for the action.
- c. The clinical privileges of any practitioner will be administratively relinquished upon receipt of information that there has been a lapse or reduction in a provider's professional liability insurance coverage below the minimum amounts required by these Bylaws. The provider may request reinstatement of appointment and appropriate privileges by sending a written notice to the Chief of Staff and Chief Executive Officer, along with
  - (i) documentation of new or renewed insurance coverage in the required amounts and a written statement explaining the circumstances and any limitations on the new or renewed coverage; and

- (ii) a written summary of the practitioner's activities at the Hospital during the period of coverage lapse or reduction.
- d. The Chief of Staff or the Chief Executive Officer may reinstate clinical privileges that have been administratively relinquished once the practitioner shows, to the Chief of Staff or Chief Executive Officer's satisfaction, that reinstatement is appropriate.
- e. If it appears from the circumstances of the administrative relinquishment that there is a reasonable basis to believe that professional review in the furtherance of quality health care may be necessary, the Chief of Staff or the Chief Executive Officer will refer the matter to the Executive Committee. The matter will then proceed as a request for professional review.

## **ARTICLE X: HEARINGS AND APPELLATE REVIEW**

**10.1 General Provisions.** The procedures set out in the following sections apply to hearings concerning:

- a. adverse decisions on an application for appointment or reappointment to the medical staff;
- b. adverse decisions on an application for clinical privileges;
- c. proposed professional review actions;
- d. terminations of temporary privileges for reasons of competency or conduct;
- e. termination of a contract between the Hospital and a practitioner for reasons of competency or conduct and resulting in a reportable restriction or termination of Medical Staff membership or clinical privileges; and
- f. any other professional review action requiring a report to the NPDB or the State of Alaska.

**10.2 Hearing Panel.** A professional review hearing shall be held before a panel comprised of two physicians and one independent presiding officer. The panel shall be appointed by the Hospital Board.

- a. The presiding officer shall preside over the hearing.
- b. The presiding officer's fees and costs and administrative costs of the hearing, if any, shall be paid by the Hospital. Each party shall pay their own costs and attorney's fees, if any.
- c. The presiding officer shall be a neutral and unbiased individual who was not involved in the investigation of the request for professional review or the Executive Committee's investigation, does not represent any individual or entity involved, is not in economic competition with the practitioner, is admitted to practice law in Alaska and is:
  - (i) a retired judicial officer; or
  - (ii) an attorney licensed to practice in the State of Alaska with experience in health care matters; or

- (iii) an attorney on the American Health Lawyers' Association's list of dispute resolvers.
- d. The physician panelists may not be in direct economic competition with the physician involved and may not have a financial or personal interest in the outcome of the hearing. If two qualified physician panelists do not agree to serve on the panel within 30 days of the practitioner's request for a hearing, the matter shall be heard by the presiding officer alone.
- e. The presiding officer shall participate in the panel's deliberations but shall not vote on the decision unless the two physician members disagree, in which case the presiding officer may vote. If the presiding officer hears the matter alone, the presiding officer will make the decision.

**10.3 Notice to Affected Practitioner.** The presiding officer shall promptly provide the affected practitioner with notice of hearing that states:

- a. the place, time, and date of the hearing, which shall not be less than 30 days after the date of the notice and the place, time, and date of a pre-hearing conference, if any;
- b. a list of the witnesses (if any) expected to testify at the hearing in favor of the adverse action (which list may be amended upon provision of reasonable notice); and
- c. prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his or her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided. Upon receipt of this representation, the individual requesting the hearing will be provided with a copy of the following:
  - i. copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;

- ii. reports of experts relied upon by the Medical Staff Executive Committee, if any;
- iii. copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and
- iv. copies of any other documents relied upon by the Medical Staff Executive Committee.

The provision of this information is not intended to waive any privilege.

**10.4 Failure of Practitioner to Appear.** If the affected practitioner fails to personally appear at the hearing without good cause, the practitioner's right to a hearing will be waived, and the recommendation or action being appealed will be final.

**10.5 Role of Chief of Staff.** The Chief of Staff or his or her designee will represent the Medical Staff Executive Committee at the hearing and shall diligently prosecute the matter.

**10.6 Rights of Affected Practitioner and Chief of Staff.** At the hearing, the affected practitioner and the Chief of Staff, or his or her designee, have the rights:

- a. to be represented by an attorney or other person;
- b. to have a record made of the proceedings, upon payment of any reasonable charges associated with the preparation of the record;
- c. to call, examine, and cross-examine witnesses;
- d. to present evidence determined to be relevant by the presiding officer, regardless of its admissibility in a court of law; and
- e. to submit a written statement at the close of the hearing.

**10.7 Duties of the Presiding Officer.** The presiding officer shall have authority to conduct the hearing.

- a. The hearing shall be conducted as informally and expeditiously as is consistent with the interests of fairness.
- b. The presiding officer may convene a pre-hearing conference. Ten days prior to the pre-hearing conference, or on dates set by the presiding officer or agreed upon by both sides, each party will provide the other party with its proposed

exhibits and a list of witnesses the party intends to call. All objections to exhibits or witnesses will be submitted, in writing, in advance of the pre-hearing conference as set by the presiding officer. The presiding officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause. The presiding officer shall rule on pre-hearing matters and all questions of procedure, discovery and evidence, and shall admit any relevant evidence presented that a reasonably prudent person would rely upon in the conduct of serious affairs, regardless of admissibility in a court of law.

- c. The individual will have no right to formal discovery. No information will be provided regarding other practitioners. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing. The parties will cooperate in the exchange of information so as to provide fair notice and reasonable access to information to prepare for the hearing.
- d. Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees or Medical Staff members whose names appear on the Medical Staff Executive Committee's witness list or in documents provided pursuant to this section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the individual who requested the hearing once it has contacted such employees or Medical Staff members and confirmed their willingness to meet. Any employee or Medical Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.
- e. The parties will use their best efforts to develop and agree upon stipulations to provide for a more efficient hearing.
- f. The presiding officer may contact the parties directly (*ex parte*) on scheduling matters only, and shall not have discussions or other communications on any substantive matter relating to the hearing unless both parties are present. The

physician panel members shall not discuss the matter with the parties or with any other medical staff member or third party.

- g. The panel shall deliberate outside of the parties' presence. The parties and any representatives of the parties or the administration shall not be present during, participate in, or attempt to influence the presiding officer's deliberations.
- h. The panel shall decide the matter and shall promptly issue a written recommendation. The recommendation shall contain findings of fact, conclusions of law, and any recommended professional review action.
- i. The presiding officer shall file the recommendation with the Chief Executive Officer, together with the recordings or transcript and the exhibits, pleadings and other documents or materials that were considered during the hearing process. These documents and materials shall constitute the administrative record.

**10.8 Confidentiality.** The hearing is a confidential professional review matter. The hearing will be held in executive session. All documents, testimony and argument presented during the hearing shall be confidential to the fullest extent of the law.

**10.9 Notice of the Recommendation.** The Chief Executive Officer will promptly forward copies of the recommendation to the practitioner and the Chief of Staff. The Chief Executive Officer shall retain the administrative record until the matter is final.

**10.10 Appeal.** The practitioner or the Chief of Staff may appeal the decision to the Hospital Board by filing a notice of appeal within ten (10) working days after the date the practitioner receives the decision.

**10.11 No Appeal Filed.** If neither party appeals the decision, the Chief of Staff will forward the administrative record to the Hospital Board for review and action under Section 10.13, except that appeal statements and oral argument will not be required.

**10.12 Appeal Filed.** If the practitioner or the Chief of Staff files a timely notice of appeal, the Hospital Board will review the matter and issue a final administrative decision on the merits.



- a. The Hospital Board will review the decision and, to the extent it deems appropriate and necessary, the administrative record.
- b. The Hospital Board will hear receive written appeal statements from the parties or their representatives and may hear oral argument before taking action on the appeal. No new or additional evidence or testimony will be heard by the board. The Hospital Board will be represented by the Hospital's counsel.

**10.13 Final Decision.** The Hospital Board shall issue a written decision that includes a statement of the basis for its decision. The decision will be in writing and will:

- a. approve the decision if it is supported by substantial evidence in the administrative record, in which case the decision will be the Hospital Board's final decision; or
- b. remand for the taking of additional evidence, or reconsideration of the decision, with a statement of reasons and directions. If the decision is remanded, the panel (or the presiding officer if the matter was decided by a presiding officer alone) will follow the Board's direction and prepare a revised decision, which will be distributed to the parties by the Chief Executive Officer under Section 10.9. The revised decision will be considered by the Hospital Board pursuant to Sections 10.10-10.12 and, if adopted, will be the Hospital Board's final decision.

**10.14 Effective Date; Notice.** The Hospital Board's final decision shall be effective on the date it is issued. The Chief Executive Officer will promptly deliver copies of the Hospital Board's decision to the Medical Staff Executive Committee, to the practitioner, and to the panel or to the presiding officer if the matter was decided by a presiding officer alone. The decision will be sent to the practitioner by first class mail within ten (10) days of the date it is issued, with a copy by electronic mail to the practitioner's most current address on file with the Hospital.

**10.15 Assembly Appeal.** The Hospital Board's final decision shall be the final administrative decision of the Hospital.

- a. If the practitioner or the Medical Staff Executive Committee is not satisfied with the Hospital Board's final decision, the party may appeal that decision to the City and

Borough of Juneau Assembly within twenty days of the date of the Board's decision, per § 3.16 of the Charter of the City and Borough of Juneau and the Administrative Appeal Procedures of the City and Borough of Juneau Code, Chapter 01.50.

- b. Any further appeal of the Assembly's decision must be taken in accordance with Alaska law and Alaska court rules.

## **ARTICLE XI: CONFIDENTIALITY, IMMUNITY AND RELEASES**

### **11.1 Confidentiality of Information.**

All information provided to or obtained by the Medical Staff relating to a practitioner's qualifications or patient care shall, to the fullest extent permitted by law, be kept confidential. Except as required by law, without the consent of the practitioner, information related to that practitioner may not be disseminated to anyone other than the Board, Chief Executive Officer, Chief of Staff, Medical Staff, committee members, the Quality Director, other representatives of the Hospital or Medical Staff, or other individuals, agencies or organizations engaged in an authorized activities for which disclosure is necessary. Such information may not be used for purposes other than as provided in the Bylaws or as required by law. The confidentiality of information extends to information provided by third parties. Information generated in Medical Staff quality review, quality improvement, wellness or professional review activities shall not be included in patient medical records. Patient health information is confidential and may only be disclosed by a practitioner in accordance with federal and state law. It is expressly acknowledged by each practitioner that breach of the terms of this paragraph may be grounds for professional review action.

### **11.2 Authorization and Conditions.**

By submitting an application for Medical Staff appointment or reappointment or by applying for or exercising clinical privileges, a practitioner:

- a. Authorizes representatives of the Hospital and Medical Staff to solicit, provide and act upon information and documents bearing on the practitioner's professional ability, suitability, utilization practices and other qualifications;

- b. Agrees to be bound by the provisions of these Bylaws and the Medical Staff's Rules, Regulations and Policies , to the maximum extent allowed by law; and
- c. Acknowledges that the provisions of these Bylaws are express conditions precedent to the practitioner's application for or acceptance of Medical Staff appointment and clinical privileges, and to the continuation of such appointment and exercise of clinical privileges at the Hospital.

### **11.3 Waiver and Full Release of Liability.**

Each applicant for Medical Staff appointment or reappointment, membership or clinical privileges, agrees that he or she irrevocably waives and releases, to the fullest extent allowed by law, and forever discharges from any liability, the City and Borough of Juneau, the Hospital Board and its members, Chief Executive Officer, Chief of Staff, the Medical Staff and its members, Medical Staff and Hospital committee members, the Hospital's or Medical Staff's attorneys, auditors, advisors, experts and all other representatives, employees or officers and their heirs, agents, successors and assigns from any and all claims, demands, actions and causes of action whatsoever, of any sort, whether known or unknown, present or future, arising from or relating to the applicant's application or reapplication for Medical Staff membership or clinical privileges or any action taken or not taken relating to that application, including approval, denial, refusal, modification, any actual or proposed professional review action, professional review and peer review activity and any other act or omission, whether based on harassment, personal injury, statute, civil rights, tort, contract, negligence or any other basis or theory, including specifically all federal and state regulatory statutes and regulations, and common law claims of any and every sort. This release is to be broadly construed and is intended to extend to all claims whatsoever, whether included specifically in this section or not. This release includes, but is not limited to, all claims or causes of action for damages or other relief arising from or relation to any decision, opinion, action, refusal to act, statement, recommendation or disclosure made by the above listed individuals or entities in furtherance of the purposes of these Bylaws, even if mistaken. Each applicant or re-applicant irrevocably

forever waives, releases and renounces any claim or cause of action whatsoever against any of the above listed individuals or entities that may, might or could be asserted to give rise to a claim, complaint or cause of action.

#### **11.4 Release of Information.**

Each practitioner shall execute general and specific releases to allow access to information pertinent to the practitioner's application for appointment, reappointment or clinical privileges, or in connection with a licensure or professional review action. Failure to execute such releases shall be deemed a voluntary withdrawal of such application; or, if in connection with a licensure or professional review action, shall result in a presumption that the facts or circumstances that are the subject matter of the releases reflect adversely on the practitioner, and such presumption shall stand unless the practitioner presents verifiable facts to the contrary. "Information" as used in this section means any oral or written reference, record or communication of any kind about a practitioner that is created, received or maintained concerning a practitioner's professional licensure or certification, education, training, clinical ability, judgment, utilization practices, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect the quality or efficiency of patient care. Each practitioner irrevocably forever waives, releases and renounces any claim or cause of action whatsoever against any person or entity providing information to the Hospital or the Medical Staff pursuant to this section, to the fullest extent permitted by federal and state law.

### **ARTICLE XII: ACCESS TO MEDICAL STAFF RECORDS**

#### **12.1 Access by Persons within the Hospital or Medical Staff.**

- a. All requests for Medical Staff records by persons described below shall be made to and recorded by the Medical Staff Office, which shall be responsible for preserving the confidentiality of the records. Requests by other persons must be made to the Chief of Staff. Unless authorized by the Chief of Staff, a person permitted to inspect Medical Staff records shall be given a reasonable opportunity to inspect the records and to make notes, but not to remove the

records or make copies of them. Removal or copying shall only be upon the express written permission of the Chief of Staff or designee.

- b. Medical Staff officers, Medical Staff committee members, Hospital Board members, the Medical Staff Coordinator, the Chief Executive Officer, the Chief Executive Officer's designee and the Quality Director shall have access to Medical Staff records to the extent necessary to perform their official functions.
- c. General Access by Practitioners to Medical Staff Records
  - 1. A practitioner shall have access to the credentials and professional review files of other practitioners only as set out above.
  - 2. A practitioner shall have the right to review and copy any documents in his own credentials and professional review file which he submitted (e.g., application, re-application, privileges list or correspondence) or which were addressed or sent as copies to him. A practitioner shall not be allowed access to professional references or professional review records except in a professional review action proceeding, or as required by law.
  - 3. A practitioner shall be allowed access to Medical Staff and committee files only with the MSEC's written permission and in accordance with the Medical Staff's Rules, Regulations and Policies.

#### **12.2 Access by Persons or Organizations Outside of the Hospital or Medical Staff.**

- a. An outside agency or organization that has authority pursuant to federal or state law to review the performance of the Hospital or Medical Staff in fulfilling its functions, including accreditation agencies, will be permitted to inspect Medical Staff records to the extent that the Chief of Staff and the Chief Executive Officer agree that disclosure is appropriate. Records shall not be copied or removed from the Hospital's premises without the permission of the Chief of Staff and the concurrence of the Chief Executive Officer.
- b. Information contained in a practitioner's credentials and professional review files may be released in response to a properly authorized, written request from another hospital or its Medical Staff. Such requests must include notification

that the practitioner is a member of the requesting hospital's Medical Staff or is an applicant for Medical Staff membership there. The request must be accompanied by a release of information and a release of liability from the practitioner in a form acceptable to the Chief of Staff and Chief Executive Officer. Disclosure shall be limited to the information requested. All responses to such requests shall be reviewed and concurred in by the Chief of Staff and the Chief Executive Officer.

- c. In deciding whether to release any information, the Chief of Staff and the Chief Executive Officer may consult the Hospital's legal counsel.
- d. Subpoenas of Medical Staff records shall be referred to the Chief of Staff and the Chief Executive Officer. They may consult the Hospital's legal counsel to determine whether the records are protected by law and, if so, how the Hospital and its Medical Staff should respond to the subpoena.

#### **ARTICLE XIII: RULES AND REGULATIONS**

The Medical Staff may adopt Rules and Regulations and Policies to implement these Bylaws, subject to approval of the Board. Rules and Regulations may be amended or repealed, without notice, at any regular Medical Staff meeting at which a quorum is present, or at any special meeting, by a two-thirds (2/3) majority vote of the Active Medical Staff members present and voting. Amendments to Rules and Regulations become effective when approved by the Board. Policies may be adopted, amended or repealed by a majority vote of the MSEC.

#### **[ARTICLE XIV: ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATION**

**Moved to Rules & Regulations]**

#### **ARTICLE XIV: AMENDMENTS**

- 14.1** Any member of the Active Medical Staff may submit a proposed Bylaw amendment to the MSEC at any time.
- a. The proposed amendment shall be referred to the MSEC for review. The MSEC may refer the proposed amendment for comment to any other Medical Staff committee or to an ad hoc Bylaw Committee.
  - b. Following receipt of comments, if any, the MSEC will make a recommendation concerning the proposed amendment and will present the recommendation at a subsequent regular Medical Staff meeting. No action on the proposal will be taken at this meeting.
  - c. The proposed amendment will be considered for adoption at the next regular Medical Staff meeting, and may be adopted by a majority vote of the Active Staff members present and voting.
  - d. Amendments adopted by the Medical Staff are effective when approved by the Hospital Board.
  - e. In the alternative, the MSEC may present any proposed amendments to the voting staff by written or electronic ballot, returned to the Medical Staff Office 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 two-thirds (2/3) majority of the votes cast.
- 14.2** The MSEC may adopt technical amendments to these Bylaws that are, in its judgment, technical or legal modifications or clarification, reorganization or renumbering, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression, inaccurate cross-references, or to reflect changes in committee names. Technical amendments shall be presented to the Medical Staff at a regular meeting, and will be forwarded to the Hospital Board if approved at the meeting.

**14.3** Bylaw amendments of any type do not become effective unless and until approved by the Hospital Board.

**14.4** Neither the Medical Staff nor the Hospital Board may unilaterally amend these Bylaws.

#### **ARTICLE XV: ADOPTION OF REVISED BYLAWS**

These Revised Bylaws may be adopted by a two-thirds (2/3) majority vote of the Active Medical Staff present and voting at a regular or special meeting of the Medical Staff or by mail or electronic ballot provided:

1. Written notice of a proposal to adopt these Bylaws was sent to all members of the Active Medical Staff before the previous regular or special meeting of the Medical Staff, and the proposed Bylaws were presented for discussion at the previous meeting; and
2. Notice of the regular or special meeting at which action is to be taken, if applicable, included notice that these Bylaws are to be considered for adoption.



These Revised Bylaws will be effective when approved by the Hospital Board.

ADOPTED by the Active Medical Staff on December 4, 2018.

ATTEST:

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Chief of Staff

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Medical Staff Secretary

APPROVED by the City and Borough of Juneau Hospital Board on December 11, 2018.

ATTEST:

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Hospital Board Chair

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Chief Executive Officer

2021 12 28 Bylaws 8.9 Physician and Other Practitioners in Training