BYLAWS OF THE MEDICAL STAFF
OF
FAIRBANKS MEMORIAL HOSPITAL

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BYLAWS OF THE MEDICAL STAFF OF
FAIRBANKS MEMORIAL HOSPITAL

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PREAMBLE

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

WHEREAS it is recognized that the STAFF is primarily responsible for the quality of patient care, education and research in the HOSPITAL and must accept and discharge this responsibility in all those areas in which clinical judgment and the evaluation of professional competence and ethical conduct are involved; and

WHEREAS it is recognized that the HOSPITAL has a duty to rely upon the judgment and recommendations of the STAFF in such matters, subject to the ultimate authority of the GOVERNING BODY; and

WHEREAS it is recognized that mutually cooperative efforts of the STAFF, the CEO, and the GOVERNING BODY are necessary to fulfill the HOSPITAL’S obligations to assure the highest quality of patient care standards within the HOSPITAL;

THEREFORE, the PHYSICIANS, dentists and podiatrists practicing in this HOSPITAL hereby organize themselves into a STAFF in conformity with these BYLAWS to initiate and maintain self-government of the MEDICAL STAFF and thereby determine all matters pertaining to medical care in the HOSPITAL; to act on all matters of medical ethics and of patient care quality; and to determine qualifications for membership and for PRIVILEGES of all members of the MEDICAL STAFF and its departments. These BYLAWS, together with the appended Rules and Regulations, shall be adopted at a meeting of the Active MEDICAL STAFF, shall replace any previous BYLAWS, Rules and Regulations, and shall become effective when approved by the majority of the Active MEDICAL STAFF and the GOVERNING BODY. They shall then, when adopted and approved, be equally binding on the GOVERNING BODY and on the MEDICAL STAFF.
DEFINITIONS

A. The term “ADVERSE ACTION” means an action proposed or taken by the Board or by the Medical Staff (which could be acting through the Medical Executive Committee or department), which is reportable to the National Practitioner Databank and/or the Alaska Board of Medicine (or Nursing) upon final action.

B. The term “AFFILIATE” means any and all business entities related to the Hospital.

C. The term “ALLIED HEALTH STAFF” means those Advanced Practice Providers who have been appointed to this Staff by the Board.

D. The term “ADVANCED PRACTICE PROVIDER” (APP) means all individuals other than members of the MEDICAL STAFF that are duly licensed or certified in the State of Alaska and Federally Employed Military Staff authorized by the STAFF and the BOARD to provide patient care services. The categories of Advance Practice Providers providing services are Independent or Dependent as set forth in the Advanced Practice Provider Policy.

1. INDEPENDENT means a provider who is licensed or certified under state law, authorized to function independently in the Hospital, and granted clinical privileges. These individuals generally require no form of direct supervision by a physician.

2. DEPENDENT means providers who are permitted to practice in the Hospital only under the direct supervision of a physician(s) appointed to the MEDICAL STAFF and function pursuant to a defined scope of practice, not to exceed those of the supervising physician. The supervising physician(s) is responsible for the actions of the Advanced Practice Provider.

E. The term “BOARD”, “GOVERNING BOARD”, or “GOVERNING BODY” means the governing board of Foundation Health, Fairbanks, Alaska.

F. The term "BYLAWS" refers to this document governing the MEDICAL STAFF, as approved by the EXECUTIVE COMMITTEE, the Active MEDICAL STAFF, and the GOVERNING BOARD.

G. The term “CHIEF EXECUTIVE OFFICER” or “CEO” means the individual appointed by the Board to act on its behalf in the overall management of the Hospital or his or her designee(s), as appropriate.

H. The term “CHIEF MEDICAL OFFICER” or “CMO” means the chief administrative officer for the MEDICAL STAFF with responsibilities as set forth in the MEDICAL STAFF Bylaws and related documents.

I. The term “EXECUTIVE COMMITTEE” means the Executive Committee of the STAFF, unless specific reference is made to the Executive Committee of the BOARD.

J. The term “HOSPITAL” means Fairbanks Memorial Hospital, an acute care hospital, located at 1650 Cowles Street, Fairbanks, Alaska.

K. The term “IN GOOD STANDING” means, at the time of the assessment of standing, his/her membership and/or PRIVILEGES are not involuntarily limited, restricted, suspended, or otherwise encumbered for disciplinary reasons (excluding leaves of absence).

L. The term “INVESTIGATION” means a process specifically instigated by the EXECUTIVE COMMITTEE to determine the validity, if any, to a concern or complaint raised against a MEDICAL STAFF member or individual holding CLINICAL PRIVILEGES, and does not include activity of the MEDICAL STAFF Wellness Committee.

M. The term “LEADERSHIP COUNCIL” means the subgroup of the Medical Executive Committee consisting of the MEDICAL STAFF Officers.
N. The term “MEDICAL STAFF” or “STAFF” means all PHYSICIANS, dentists, podiatrists and other professionals duly licensed to practice in the State of Alaska and Federally Employed Military Staff who have been granted MEDICAL STAFF membership at the HOSPITAL.

O. The terms "NOTICE", "NOTIFIED" and "NOTIFY" when used in the context of providing a communication to a person under these BYLAWS shall, except where specifically provided otherwise, mean a communication in writing and will be conclusively deemed to have been given: (i) at the time when delivered personally, (ii) on the next business day after being sent by reputable overnight courier service (charges prepaid), (iii) five (5) days following mailing by certified or registered mail, postage prepaid and return receipt requested, to the PRACTITIONER at the address provided by the PRACTITIONER and kept on file in the Medical Staff office, (iv) facsimile, (v) e-mail, or (vi) HOSPITAL mail.

P. The term “PHYSICIAN” means any Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is duly licensed to practice medicine in the State of Alaska and Federally Employed Military Staff.

Q. The term “PRACTITIONER” means a PHYSICIAN, dentist, or podiatrist.

R. The term “PRIVILEGES” or “CLINICAL PRIVILEGES” means the specifically delineated rights requested by and granted to a PRACTITIONER by the GOVERNING BODY, consistent with these BYLAWS, to render professional diagnostic therapeutic, medical, dental, podiatric or surgical treatment in the HOSPITAL, and includes all reasonable and appropriate access to those HOSPITAL resources (including equipment, facilities and HOSPITAL personnel) which are necessary to effectively exercise those PRIVILEGES.

S. The term “RESPONDENT” means any applicant to the STAFF or any member of the STAFF who is responding to an INVESTIGATION or adverse recommendation with respect to STAFF membership or PRIVILEGES.

T. The term “SUPERVISING/COLLABORATING PHYSICIAN” means a member of the MEDICAL STAFF with clinical privileges, who has agreed in writing to supervise or collaborate with and take responsibility for actions of an Advanced Practice Provider at the Hospital.

U. The term “TJC” means The Joint Commission which is an accreditation body that oversees and established standards of quality and performance measurement in health care.
ARTICLE 1 – NAME AND PURPOSE

1.A NAME
The name of this organization shall be “The MEDICAL STAFF of Fairbanks Memorial Hospital.”

1.B PURPOSE
The MEDICAL STAFF is organized to promote high quality care. This shall be accomplished through this organization structure by:

(1) encouraging a high level of professional performance of all members of the STAFF authorized to practice in the HOSPITAL through the appropriate delineation of PRIVILEGES that each member of the STAFF may exercise in the HOSPITAL and by a continuing review and evaluation of each member of the STAFF’S performance in the HOSPITAL;

(2) initiating and maintaining BYLAWS and Rules and Regulations for self-government of the MEDICAL STAFF;

(3) furthering the professional education of all personnel;

(4) providing a means of conflict resolution whereby problems of an administrative nature within the STAFF, and between the STAFF and the GOVERNING BOARD, may be discussed and resolved;

(5) making provision for medical care for mass casualty in the event of a disaster in the community; and

(6) promoting and supervising appropriate research activities of the STAFF.

ARTICLE 2 – GENERAL

2.A TIME LIMITS
Unless explicitly stated, the time limits contained within these Bylaws, Rules and Regulations, and policies of the MEDICAL STAFF are advisory only.

2.B EMPLOYMENT
The appointment and/or clinical privilege of MEDICAL STAFF members, or the mechanism for consideration, are independent of employment processes and policies and, as such, are not applicable.

2.C DELEGATION OF FUNCTIONS
(1) Functions outlined in these Bylaws, Rules and Regulations, and policies may be delegated to one or more designees when the function(s) cannot be performed by a MEDICAL STAFF Leader, Committee or its members, Staff member, or by Hospital Administration.

(2) MEDICAL STAFF Officers may perform or delegate, to one or more designees, functions of MEDICAL STAFF Leaders unable or unavailable to fulfill their obligations.
2.D  DUES

All Staff granted membership to the MEDICAL STAFF will pay annual dues to the Hospital MEDICAL STAFF account that may be used for education, humanitarian, and meeting purposes as well as payment of approved MEDICAL STAFF leadership positions. The Chief of Staff and Secretary/Treasurer will be signatories on the Hospital MEDICAL STAFF account.

ARTICLE 3– STAFF MEMBERSHIP

3.A  NATURE OF STAFF MEMBERSHIP

(1) Membership on the STAFF is a privilege which shall be extended only to professionally competent PRACTITIONERS who continuously meet the qualifications, standards, and requirements set forth in these BYLAWS.

(2) Membership on the STAFF and/or CLINICAL PRIVILEGES shall not be denied or limited on the basis of sex, sexual orientation, race, creed, color, national origin, age, or any other criterion lacking professional justification.

(3) Membership on the STAFF and/or CLINICAL PRIVILEGES shall not be denied or limited on the basis of disabilities, except where such disabilities impair the care provided to the patient, or where such disabilities may not be reasonably accommodated.

(4) Membership on the STAFF and particular CLINICAL PRIVILEGES shall not be granted or denied solely because the requesting professional holds a certain degree, is licensed to practice in this or any other state or nation, is a member of any professional organization, is certified by any clinical board, is employed by this HOSPITAL or its subsidiaries, or because such PRACTITIONER had, or presently has, staff membership or PRIVILEGES at another health care facility or participates or does not participate in a particular medical group, managed care organization, IPA, PPO, PHO, Hospital-sponsored foundation, or other organization or in contracts with a third-party payor which contracts with this HOSPITAL.

(5) Membership on the STAFF and/or CLINICAL PRIVILEGES shall not be denied or limited on the basis of legitimate professional or business interests.

3.B  QUALIFICATIONS FOR STAFF MEMBERSHIP

Only PRACTITIONERS properly licensed and certified to practice in the State of Alaska and Federally Employed Military Staff who can document their background, experience, training, and demonstrated competence, their adherence to the ethics of their profession, and their ability to work with others, with sufficient adequacy to ensure the STAFF and the BOARD that any patient attended by them in the HOSPITAL will be given a high quality of care, shall be qualified for membership on the STAFF.

3.C  BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for the Honorary MEDICAL STAFF, the ongoing responsibilities of each member of the MEDICAL STAFF include:

(1) providing the quality of care meeting the professional standards of the MEDICAL STAFF of this HOSPITAL;

(2) abiding by the BYLAWS and its rules and regulations;
(3) discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of MEDICAL STAFF membership, including committee assignments, as specified in these BYLAWS;

(4) participating in emergency room coverage as recommended by their department and approved by the EXECUTIVE COMMITTEE and the CEO. In the event a department cannot or is unable or unwilling to decide how to fulfill its call obligation in an effective manner, the matter shall be referred to the EXECUTIVE COMMITTEE and CEO for resolution.

(a) On Call Policies: Each department shall recommend reasonable on-call response times in department policies which shall be based on patient need and the workload of providers, subject to approval by the EXECUTIVE COMMITTEE and the CEO.

(b) Exemptions: Each department will establish a system to grant exceptions to this section based on each individual PHYSICIAN’S circumstances and abilities. All exceptions must be approved by the EXECUTIVE COMMITTEE and the CEO.

(c) Call Log: The HOSPITAL and Emergency Department staff shall establish and maintain a log system to refer unassigned patients to physicians on call and to record the referral.

(d) Response Time: Any STAFF on call for the Emergency Room or Labor and Delivery shall respond, and shall be physically present if requested, by the lesser of the following:

(i) response times in approved department policy or

(ii) at a maximum, within thirty (30) minutes of a call from the Emergency Room or Labor and Delivery and, if requested, the STAFF member shall be physically present within forty-five (45) minutes of the request.

(5) preparing and completing in a timely fashion the medical record for all the patients to whom the member provides care in the HOSPITAL;

(6) abiding by the ethical principles of the person’s profession;

(7) aiding in any MEDICAL STAFF approved educational programs for staff PHYSICIANS and dentists, medical students, interns, resident PHYSICIANS, resident dentists, nurses, and other personnel;

(8) working cooperatively with members, nurses, HOSPITAL administration and others so as not to adversely affect patient care;

(9) providing appropriate coverage for his/her patients when absent;

(10) refusing to engage in improper inducements for patient referral;

(11) participating in continuing education programs as determined by the MEDICAL STAFF;

(12) participating in mass casualty preparation as defined in FMH Mass Casualty protocol; and

(13) discharging such other STAFF obligations as may be established from time to time by the MEDICAL STAFF or EXECUTIVE COMMITTEE.

3.D LEAVE OF ABSENCE

(1) Leave Status. Any member of the STAFF who will be unavailable to fulfill his or her duties for greater than 60 days is required to obtain a leave of absence by submitting a written NOTICE to the Medical Staff Office 30 days prior to the start of the desired period. The term of the leave of absence shall not exceed the member’s present term of
membership. Members are not entitled to more than one leave of absence during a two-year membership term unless approved by the EXECUTIVE COMMITTEE.

A member of the STAFF who is on leave of absence shall have none of the PRIVILEGES or obligations of his/her membership during his/her leave of absence except with regard to any INVESTIGATION or corrective action as defined in these BYLAWS.

(2) Limitations of Leave Privilege. Abuse of the privilege to obtain leaves of absence, as determined by the EXECUTIVE COMMITTEE, can be grounds for denial of renewal of membership. However, requests for leave of absence to fulfill military service obligations or to obtain treatment for a medical or behavioral condition or disability shall not be denied or result in denial of renewal of membership if the applicant otherwise qualifies for membership and there are no other adverse recommendations affecting consideration of renewal of membership.

(3) Medical Leave of Absence. The Wellness Committee shall review the circumstances under which a particular member of the STAFF shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. The Wellness Committee shall determine if a member of the STAFF currently on a leave of absence and requesting reinstatement of PRIVILEGES shall require a medical clearance exam performed by an independent practitioner, jointly agreed upon by the Wellness Committee and member on leave, prior to exercising any PRIVILEGES. Said independent practitioner will forward his or her recommendations on ability to exercise PRIVILEGES to the Wellness Committee upon request for reinstatement from the applicable member of the STAFF. Upon recommendation of the Wellness Committee, reactivation of membership and privileges shall be managed as provided by “Termination of Leave (Reactivation)” herein.

(4) Termination of Leave (Reactivation). Upon return from a leave of absence, a member must apply for reactivation of his/her previous PRIVILEGES and to his/her category, or for continuation of his/her leave of absence, not to exceed a period of one (1) additional year. Such application shall be considered in a manner identical to membership renewal provided that the member gives a full written report and all other requested documentation concerning his/her professional activities during his/her absence.

(5) Failure to Request Reinstatement. Failure, without good cause, to request reinstatement at least 30 days prior to the expiration of the leave of absence shall be deemed a voluntary resignation from the MEDICAL STAFF and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall be entitled to appear before the Medical Executive Committee to make a statement on his/her behalf regarding their reinstatement and / or submit a written statement to the Medical Executive Committee on his / her behalf regarding whether the failure to request reinstatement was unintentional or excusable, or otherwise. A request for MEDICAL STAFF Membership subsequently received from a member who has been terminated shall be submitted and processed in the manner specified for applications for initial appointments.

ARTICLE 4 - CATEGORIES OF THE STAFF

4.A ADMINISTRATIVE CATEGORIES

For administrative purposes, the MEDICAL STAFF shall be departmentalized and function as provided under Article 11.

4.B PRACTICE CATEGORIES

The MEDICAL STAFF shall also be divided into Honorary, Active, Courtesy, Consultant, Community-Based and Federally Employed Military Staff categories, each of which shall have specific PRIVILEGES and obligations. ALLIED HEALTH STAFF shall have specific PRIVILEGES and obligations as set forth in the Advanced Practice Providers Policy.
(1) **Honorary Medical Staff**

(a) The Honorary MEDICAL STAFF shall consist of PHYSICIANS, dentists and podiatrists who are not active in the HOSPITAL, who are honored by emeritus positions, and who wish and deserve a continuing relationship with the STAFF. These may be those who have retired from the active practice of medicine or who are of outstanding reputation but not necessarily residing in the community.

(b) Members of this category shall not be eligible for PRIVILEGES, to vote, to hold office or to serve on standing STAFF committees. They may serve as advisory non-voting members of committees. They are encouraged to attend STAFF meetings.

(2) **Active Medical Staff**

(a) The Active MEDICAL STAFF shall consist of PHYSICIANS, dentists and podiatrists who apply for this category, who reside close enough to the HOSPITAL in terms of travel time to provide continuous care to their patients, and who assume all of the functions and responsibilities of membership on the MEDICAL STAFF.

(b) The Active MEDICAL STAFF shall conduct all of the business of the STAFF, except those duties and functions specifically delegated to departments, sections and committees of the STAFF in these BYLAWS.

(c) Members of the Active MEDICAL STAFF shall be appointed to specific departments and sections, shall be eligible to vote, to hold office in this STAFF organization, and to serve on STAFF committees, and shall comply with the attendance requirements specified in Article 13.

(d) To qualify for renewed membership in the Active MEDICAL STAFF, members of the Active MEDICAL STAFF may be required to have attended fourteen (14) or more patients in the HOSPITAL during the two (2) preceding years.

A member of the Active MEDICAL STAFF who does not fulfill his/her obligations as specified in these BYLAWS may be placed on probationary status for a six (6) month period upon membership renewal, during which time he/she shall have no STAFF voting privileges. At the conclusion of the probationary period, his/her status shall be reviewed by the appropriate department or section, the Credentials Committee, and the EXECUTIVE COMMITTEE with a recommendation for reinstatement of Active MEDICAL STAFF status, change of STAFF category, or denial of STAFF membership.

(3) **Courtesy Medical Staff**

(a) The Courtesy MEDICAL STAFF shall consist of PHYSICIANS, dentists and podiatrists otherwise qualified for STAFF membership, but who attend less than fourteen (14) patients in the HOSPITAL in a two (2) year period.

(b) Courtesy MEDICAL STAFF members shall be appointed to specific departments, or sections, but shall not be eligible to vote or hold office in the STAFF organization.

(c) Members of the Courtesy MEDICAL STAFF may be appointed to committees and, if so, may vote on matters before such committees.

(d) PHYSICIANS, dentists and podiatrist who attend fourteen (14) or more patients in any two (2) year period, including outpatient clinic or emergency room patients, must apply for and assume the obligations of Active MEDICAL STAFF membership at the time of membership renewal. Failure to comply with this provision shall cause the member to be denied STAFF membership at the time of the next membership renewal.

(e) A member of the Courtesy MEDICAL STAFF who has not attended any patient in the HOSPITAL for two (2) consecutive years shall be NOTIFIED by the department or section Chair at the time of membership renewal, that he/she is not eligible for membership renewal because of failure to use HOSPITAL facilities unless he/she makes a written request for membership which satisfies the EXECUTIVE COMMITTEE of
his/her intention to use the HOSPITAL facilities. This request must be received by the EXECUTIVE COMMITTEE prior to its meeting when the membership renewal will be reviewed.

(4) **Consultant Medical Staff**

   (a) The Consultant MEDICAL STAFF shall consist of PHYSICIANS, dentists and podiatrists who meet the requirements of one of the following categories:

      (i) they do not practice primarily in the geographic service area of the HOSPITAL or their residence is not located within the geographic service area of the HOSPITAL, or

      (ii) they are a specialist who does not ordinarily have a hospital-based practice.

   (b) A member of the Consultant MEDICAL STAFF shall be allowed to exercise his/her approved clinical privileges, including admission to the HOSPITAL, with the explicit understanding that for any inpatient procedure the member will be located within the geographic service area of the HOSPITAL for the duration of the patient's inpatient stay and has a cross coverage arrangement for complications and follow up after the inpatient stay, acceptable to the EXECUTIVE COMMITTEE, with a member of the Active or Courtesy MEDICAL STAFF who holds appropriate privileges.

   (c) Consultant MEDICAL STAFF members shall be assigned to specific departments or sections but shall not be eligible to vote or hold STAFF office and shall be encouraged but not be required to attend STAFF, department or section meetings.

   (d) Members of the Consultant MEDICAL STAFF may be appointed to committees, and, if so, may vote on matters before such committees.

   (e) A member of the Consultant MEDICAL STAFF who has not attended any patient in the HOSPITAL for two (2) consecutive years shall be NOTIFIED by the Chair after the department or section meeting, when the member’s membership renewal review is made, that he/she is not eligible for membership renewal because of failure to use HOSPITAL facilities, unless he/she makes a written request for membership renewal which satisfies the EXECUTIVE COMMITTEE of his/her intention to use the HOSPITAL facilities. This request must be received by the EXECUTIVE COMMITTEE prior to its meeting when the membership renewal will be reviewed.

(5) **Federally Employed Military Staff**

   (a) The Federally Employed Military Staff shall consist of PHYSICIANS, dentists and podiatrists who hold PRIVILEGES and responsibilities identical to the Active STAFF, with the following exceptions:

      (i) Requirement for Alaska state licensure may be waived in this category; however, Federally Employed Military Staff shall be required to hold a current state license to practice in one of the 50 states.

      (ii) Federally Employed Military Staff must be members IN GOOD STANDING of the active or provisional MEDICAL STAFF of other Federal military facilities with whom the MEDICAL STAFF has a Memorandum of Understanding.

      (iii) Federally Employed Military Staff members are not required to serve on committees, but are appointed to specific departments for the purpose of credentialing and quality assurance review. They shall not be eligible to vote or hold office in the STAFF organization. The Bassett Army Hospital Chief of Staff shall appoint one PHYSICIAN to the EXECUTIVE COMMITTEE and QI/UR Committee. This representative is not required to hold Federally Employed Military Staff membership.

      (iv) Federally Employed Military Staff are restricted to the care of patients who are eligible for care at military health care facilities.

      (v) Federally Employed Military Staff who wish to care for other patients must be Active, Courtesy or Consulting MEDICAL STAFF members.
(b) Specific operation criteria are as detailed in the current Memorandums of Understanding between Bassett Army Community Hospital and Eielson Air Force Base (Appendix A and B) and the MEDICAL STAFF.

(6) **Locum Tenens Medical Staff**

(a) The Locum Tenens MEDICAL STAFF shall consist of PHYSICIANS, dentists and podiatrists who attend patients on behalf of a member of the MEDICAL STAFF at the hospital for extended periods of time, not to exceed Joint Commission requirements.

(b) Locum Tenens MEDICAL STAFF can serve as attending, admitting or the surgeon of record.

(c) Locum Tenens MEDICAL STAFF shall be assigned to specific departments, or section, but shall not be eligible to vote or hold STAFF office.

(7) **Telemedicine Medical Staff**

(a) The Telemedicine MEDICAL STAFF shall consist of PHYSICIANS.

(b) Telemedicine providers must hold current active privileges at another Joint Commission accredited institution.

(c) Telemedicine providers shall be assigned to specific departments, or sections, but shall not be eligible to vote or hold STAFF office.

(8) **Community-Based Practitioners (including physicians, physician assistants and Advanced Practice Providers)**

(a) Community-based practitioners are practitioners who request Medical Center services for their patients and wish to be affiliated with the Medical Center. Community-based practitioners are not members of the MEDICAL STAFF and do not have clinical privileges at the HOSPITAL.

(b) **QUALIFICATIONS:** Practitioners seeking to affiliate with the Medical Center must apply for community-based status and provide evidence of the following qualifications:

(i) Alaska licensure in good standing;

(ii) Ability to participate in Medicare and other federally funded health programs;

(c) **PREROGATIVES:** The prerogatives of community-based practitioners are to:

(i) Order HOSPITAL outpatient diagnostic services for patients;

(ii) Access HOSPITAL information, via Clinical Connectivity, for their own patients;

(iii) Attend Continuing Medical Education programs at the HOSPITAL;

(iv) Receive MEDICAL STAFF Newsletters and other Medical Center Publications;

(v) Attend department and general staff meetings.

(d) **OBLIGATIONS:** Community-based practitioners must agree to use Medical Center patient information only as necessary for treatment, payment or healthcare operations in accordance with HIPAA laws and regulations. Community-based practitioners must abide by the MEDICAL STAFF Bylaws, Rules and Regulations, and hospital policies.

Denial or termination of community-based status: Community-based practitioners seeking community-based status are not entitled to due process rights under the Fair Hearing Plan. A practitioner who believes he or she was wrongly denied community-based status or whose status was terminated may submit information to the Medical Executive Committee, demonstrating why the denial or termination was unwarranted. The Medical
Executive Committee, in its sole discretion, shall decide whether to review the submission. The practitioner has no appeal or other rights in connection with the Medical Executive Committee’s decision.

(9) Allied Health Staff

ALLIED HEALTH STAFF are not members of the MEDICAL STAFF, but are subject to the authority of the MEDICAL STAFF and the HOSPITAL as set forth in the Advanced Practice Provider Policy. ALLIED HEALTH STAFF and, if applicable, their supervising/collaborating MEDICAL STAFF member(s) are subject to the Advanced Practice Provider Policy, these BYLAWS and the bylaws, rules, regulations, policies, procedures, guidelines, and requirements of the HOSPITAL to the extent the GOVERNING BOARD deems any of the foregoing to be applicable to ALLIED HEALTH STAFF.

ARTICLE 5 - PROCEDURE FOR STAFF MEMBERSHIP AND MEMBERSHIP RENEWAL

5.A GENERAL CRITERIA

(1) Applications for initial membership and biennial membership renewal to the STAFF shall be made to the GOVERNING BOARD. The BOARD shall act on initial membership, membership renewal, or membership revocation only upon the recommendation from the EXECUTIVE COMMITTEE.

(2) Initial membership shall be effective upon Board approval and shall be granted for a period not exceed two years. Renewal of membership, approved by the Board, shall be granted for a period not to exceed two years.

(3) MEDICAL STAFF membership shall confer on the member only such PRIVILEGES and membership in such departments and sections as have been requested by the member and granted by the BOARD.

(4) Every application for MEDICAL STAFF membership shall be signed by the applicant and shall contain the applicant’s specific agreement to fulfill his/her obligation to provide continuous quality care and supervision of his/her patients, to strictly abide by the principles and ethics of the appropriate national professional organization for which he/she is eligible, to abide by the BYLAWS and Rules and Regulations, to cooperate with and work closely with the STAFF Officers and the CEO, to accept and satisfactorily perform STAFF committee assignments and consultation assignments, and such other obligations as are further defined in these BYLAWS.

5.B ELIGIBILITY CRITERIA

To be eligible to apply for initial appointment or reappointment to the MEDICAL STAFF, PRACTITIONERS must:

(1) Have a current, unrestricted license to practice in the State of Alaska or have submitted an application for licensure to the Alaska State Medical Board. Regarding licensure for FEDERALLY EMPLOYED MILITARY STAFF see Section B of Article 4.

(2) Where applicable to their practice, have a current, unrestricted DEA registration and state controlled substance license.

(3) Have current, valid, professional liability insurance coverage in a form and in amounts satisfactory to the EXECUTIVE COMMITTEE and HOSPITAL.

(4) Not be currently excluded or precluded from participation in Medicare, Medicaid, or other governmental payer program.

(5) Have not been convicted of any felony.
(6) Be graduates of a medical, dental, or podiatric school fully accredited during the time of their attendance by the Liaison Committee on Medical Education, the American Osteopathic Association (“AOA”), the Commission on Dental Accreditation, the American Podiatric Association, or by a successor agency to any of the following (Foreign medical graduates shall have attended medical schools certified by the Educational Council for Foreign Medical Graduates and have passed the International Medical Graduate Examination in the Medical Sciences.).

(7) Have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education (“ACGME”) or the AOA in a specialty in which the applicant seeks CLINICAL PRIVILEGES, or a dental surgery training program accredited by the Commission on Dental Education of the American Dental Association or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association. Residents within the last two months of an acceptable residency training program, as stated above, that are under contract for employment with an established medical practice within the Fairbanks area upon completion of his/her training, will be considered eligible to apply for initial appointment to the MEDICAL STAFF.

5.C APPLICATION FOR MEMBERSHIP

(1) The Application Form

(a) All applications for STAFF membership shall be in writing, shall be signed by the applicant, and shall be submitted to the Medical Staff Office or its designee, on forms prescribed by the EXECUTIVE COMMITTEE.

(b) The applicant shall state clearly and specifically the STAFF categories, department memberships, and PRIVILEGES for which he/she is applying.

(c) The application shall require detailed information concerning the applicant’s professional qualifications, including education, training, and experience.

(d) The application shall require the names of at least three (3) persons who have had extensive experience in observing and working with the applicant and who can provide adequate reference pertaining to the applicant’s professional competence and ethical character.

(e) The application shall require information as to whether the applicant’s membership status and/or PRIVILEGES have ever been revoked, suspended, or involuntarily or voluntarily reduced, or not renewed at this or any other hospital or institution, and as to whether his/her membership in local, state, or national professional societies is current, has ever been revoked, suspended, reduced or not renewed, and as to whether his/her license or certificate to practice any profession in any jurisdiction has ever been suspended or involuntarily or voluntarily terminated. The application shall require information as to any challenges to any licensure or registration. It shall also require information as to whether the applicant’s DEA license has ever been suspended or revoked or involuntarily or voluntarily relinquished and information regarding any and all professional liability claims.

(f) The application shall include the applicant’s statement that no health problems exist that could affect his or her ability to perform the PRIVILEGES requested.

(2) The applicant shall have the responsibility of producing all of the required information so that a proper evaluation of his/her competence, character, ethics, and other qualifications can be made, and for resolving any doubts about such qualifications.

(3) The Medical Staff Office personnel, or their designee, and the Credentials Committee shall take all reasonable actions to verify the authenticity of the credentials of the applicant.

(4) When applying for STAFF membership, each applicant shall sign a written agreement stating his/her willingness to appear for interviews with the appropriate staff committee in regard to his/her application, authorizing the BOARD,
officers, and appropriate STAFF committee members, in performing their duties, to consult with members of staffs of other hospitals, institutions or organizations with which the applicant has been associated and with others who may have information bearing on his/her competence, character, mental and emotional stability, and ethical qualifications; consenting to the inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the PRIVILEGES requested, as well as of his/her ethical qualifications for STAFF membership; releasing from any liability all representatives of the HOSPITAL and its STAFF for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials; and releasing from any liability all individuals and organizations who provide information in good faith and without malice concerning the applicant’s competence, ethics, character, mental and emotional stability, and other qualifications for STAFF membership and PRIVILEGES, including otherwise privileged or confidential information.

(5) The application form shall include a statement that the applicant has received the BYLAWS, Rules and Regulations of the STAFF, and that he/she agrees to be bound by the terms thereof if granted membership and/or PRIVILEGES and to be bound by terms thereof without regard to whether or not he/she is granted membership and/or PRIVILEGES in all matters relating to consideration of his/her application.

(6) Any material misstatement or omission discovered in the credentialing process may be grounds to stop processing the application. The application will be placed on hold until the applicant provides a written response to the material misstatement or omission. The Chief of Staff and CMO will determine if the application should proceed.

5.D STAFF MEMBERSHIP PROCESS

(1) As soon as the completed application is filed with the Medical Staff Office, or their designee, and all the required verifications (including AK licensure), references, reports, and recommendations are assembled, the Medical Staff Office shall submit the file to all departments and sections in which membership and/or PRIVILEGES are sought.

(2) Each clinical department and section in which the applicant seeks PRIVILEGES or membership shall make a thorough, impartial and objective evaluation of the character, professional competence, qualifications, and ethical standing of the applicant through information contained in the application form, in references given by the applicant, any available morbidity and mortality data, comparing applicant specific data with aggregate data, when available, and from other sources available. The department and/or section(s) shall also determine whether the resources, such as equipment and personnel, necessary to support the service or procedure are currently available or could be reasonably procured. A written report shall be submitted by each department and/or section to the Credentials Committee.

(3) At its next meeting, if the file is complete, including evaluations from all of the appropriate departments and sections, the Credentials Committee shall examine the file. It shall then forward to the EXECUTIVE COMMITTEE the completed application and all references, reports, and recommendations accompanying the application, and a recommendation that the applicant be appointed to the STAFF, rejected for STAFF membership, or that the application be deferred for further consideration. If the recommendation is for initial membership, the Credentials Committee will also recommend staff category, department and section assignment and PRIVILEGES to be granted.

(4) At its next regular meeting, after receipt of the application and report and recommendations of the Credentials Committee, the EXECUTIVE COMMITTEE shall recommend to the BOARD that the applicant be appointed to the STAFF, that he/she be rejected for STAFF membership, or that his/her application be deferred for further consideration by the Credentials Committee or the EXECUTIVE COMMITTEE. All recommendations for membership must also specifically recommend PRIVILEGES to be granted, which may be qualified by probationary provisions relating to such PRIVILEGES.

(5) Whenever the action of any committee, except the EXECUTIVE COMMITTEE, is to defer recommendation because of insufficient information or an incomplete file, or because the committee requests a personal interview
with the applicant, it shall be referred back to the Medical Staff Office who shall promptly NOTIFY the applicant of such action, and further action shall be taken at the next regular meeting or special meeting of the committee for that purpose. Any committee may require personal interviews of any applicant.

(6) When the recommendation of the EXECUTIVE COMMITTEE is to defer the application for further consideration, it must be followed within sixty (60) days with a subsequent recommendation for membership with specific PRIVILEGES, or for rejection for STAFF membership.

(7) When the recommendation of the EXECUTIVE COMMITTEE is favorable, the Medical Staff Office shall promptly forward it, together with all supporting documentation, to the BOARD with recommendations for STAFF category, departmental and section assignments, and PRIVILEGES to be granted.

(8) When the recommendation of the EXECUTIVE COMMITTEE is adverse to the applicant, either in respect to membership or granting of requested CLINICAL PRIVILEGES, the CEO shall promptly NOTIFY the applicant. No such adverse recommendation need be forwarded to the BOARD until the RESPONDENT has exercised or has been deemed to have waived his/her rights to a hearing before an Ad Hoc Committee of the STAFF.

(9) If timely requested by the applicant, he/she shall be granted a hearing before an Ad Hoc Committee of the STAFF, as provided in Article 9 of these BYLAWS.

(10) The EXECUTIVE COMMITTEE shall consider the report and recommendations of the hearing committee and the hearing record at its next regular meeting after receipt of a report, and shall make a recommendation on the matter to the GOVERNING BOARD.

(11) When acting in matters of membership, all STAFF members and other PRACTITIONERS, all appropriate HOSPITAL personnel, including members of the BOARD and Administration, shall be acting pursuant to the rights, privileges, and immunities, as provided in Article 16 of these BYLAWS.

5.E BIENNIAL STAFF MEMBERSHIP RENEWAL

(1) Each recommendation concerning the membership renewal of a STAFF member and the PRIVILEGES to be granted upon membership renewal shall be based upon objective evidence of such member’s professional competence and clinical judgment in the treatment of patients, his/her ethics and conduct, his/her attendance at STAFF, department, section, and committee meetings, and participation in STAFF, department, and section affairs, his/her compliance with the BYLAWS, Rules and Regulations, his/her cooperation with HOSPITAL personnel, use of the HOSPITAL’S facilities for his/her patients, his/her relationships with other STAFF members and his/her general attitude toward patients, the HOSPITAL and the public.

(2) MEMBERSHIP RENEWAL PROCESS

(a) The department and section committees shall review all pertinent information available on each STAFF member, for the purpose of determining recommendations for membership renewal, category assignment, and for the granting of PRIVILEGES for the following two (2) years. Recommendations will be made on all STAFF members of the department and submitted in writing to the Credentials Committee. In those departments in which sections have been organized, the section committees shall make prior recommendations to the department regarding PRIVILEGES for their members. Surgical PRIVILEGES of all members of the STAFF shall be reviewed by the appropriate department at this time.

(b) The Credentials Committee shall review the recommendations of the department and section committees and all pertinent information available on each STAFF member for the same purpose, and shall submit its recommendations, in writing, to the Executive committee.
(c) The EXECUTIVE COMMITTEE shall review the recommendations of the department committees and the Credentials Committee and all pertinent information on each STAFF member for the same purpose and shall submit its recommendations, in writing, to the GOVERNING BOARD.

(d) The GOVERNING BOARD or its committee shall make its decisions for membership renewal or non-renewal of membership or change in PRIVILEGES and shall transmit this, in writing, to the members of the STAFF.

(3) Whenever the action of any committee is to defer recommendation because of insufficient information or an incomplete file, or because the committee requests a personal interview with the member, it shall be referred back to the CEO who shall promptly NOTIFY the member of such action, and further action shall be taken at the next regular meeting or special meeting of the committee for that purpose. Any committee may require personal interviews of any member.

(4) When the recommendation of the EXECUTIVE COMMITTEE is adverse to a member, either in respect to membership or PRIVILEGES, the procedure to be followed is provided in Article 9 of these BYLAWS.

(5) If an application for membership renewal has not been fully processed by the expiration date of the member’s membership, the staff member shall maintain membership and CLINICAL PRIVILEGES until such time as the processing is completed, and the BOARD has acted, unless the delay is due to the member’s failure to complete and return the membership renewal application.

(6) Failure of Timely Completion of Membership Renewal Application. Failure without good cause to file a completed application for membership renewal within ninety (90) days of the end of the member’s current membership may result in loss of MEDICAL STAFF PRIVILEGES and membership, unless otherwise extended by the EXECUTIVE COMMITTEE. In the event membership terminates for this reason, the procedures set forth in Article 9 do not apply.

(7) In acting on matters of membership renewal, all STAFF members and other PRACTITIONERS, and all appropriate HOSPITAL personnel, including members of the BOARD OF TRUSTEES and HOSPITAL management, shall be acting pursuant to the rights, privileges, immunities, and authority as are provided for in Article 16 of these BYLAWS.

5.F EXTERNAL PEER REVIEW

External peer review will take place in the context of application processing, INVESTIGATION, or at any other time only under the following circumstances, if and only if deemed appropriate by the relevant MEDICAL STAFF department or committee, the EXECUTIVE COMMITTEE, CEO, or the GOVERNING BODY; however, a PRACTITIONER subject to professional review or INVESTIGATION can request the CEO or the EXECUTIVE COMMITTEE to obtain external peer review. If an external peer review is deemed necessary, the Quality Improvement Committee, Peer Review Committee, Credentialing Committee and/or the EXECUTIVE COMMITTEE will be NOTIFIED in writing of the review and of the findings from the review.

(1) Ambiguity when dealing with vague or conflicting recommendations from committee review(s) where conclusions from this review could directly and adversely affect an individual’s membership or PRIVILEGES.

(2) Lack of internal expertise, in that no one on the MEDICAL STAFF has adequate expertise in the clinical procedure or area under review.

(3) When the MEDICAL STAFF needs an expert witness for any hearing conducted pursuant to Article 9 of these bylaws, for evaluation of a credential file or for assistance in developing a benchmark for quality monitoring.

(4) To promote impartiality in peer review.

(5) Upon the reasonable request of a PRACTITIONER.
(6) The EXECUTIVE COMMITTEE, CEO, or GOVERNING BODY may require external peer review in any other circumstances deemed appropriate by either of these bodies.

5.G CREDENTIALS FILES

(1) All MEDICAL STAFF Credentials files shall be subject to confidentiality requirements and protections of state and federal law. In the event of closure of the HOSPITAL, the credentialing files shall be placed with an appropriate custodian.

(2) MEDICAL STAFF members shall be granted access to their own Credentials files upon determination by the EXECUTIVE COMMITTEE (or the Chief of Staff as designee) when access in the specific case is necessary to further the purposes of peer review or credentialing, but only under the following conditions:

   (a) The member shall request access in writing, directed to the Chief of Staff or the Chief of Staff's designee;

   (b) The member may review the files only in the Medical Staff Office, at a time convenient to the member and the Chief of Staff or designee, in whose presence the member’s review will take place. The member may receive a copy of only those documents provided by or addressed personally to the member. A written summary of all other information, including MEDICAL STAFF committee findings, letters of reference, proctoring reports, complaints, and incident reports, shall be provided, if requested, to the member by the Chief of Staff or designee, within a reasonable period of time, as determined by the EXECUTIVE COMMITTEE. No summary shall disclose the source of the original information.

   (c) The member may request in writing that the EXECUTIVE COMMITTEE expunge, correct or remove information from the Credentials file. Information supporting the request should be included. The member shall be NOTIFIED promptly, in writing, of the decision of the EXECUTIVE COMMITTEE.

   (d) In any case, upon written request to the EXECUTIVE COMMITTEE, a member shall have the right to add a statement to his or her Credentials file responding to any information contained in the files.

   (e) In the event a NOTICE of action or proposed action is filed against a member, applicant, or holder of CLINICAL PRIVILEGES, access to that member's Credentials files shall be governed by the hearing procedures established in these BYLAWS.

ARTICLE 6 - PRIVILEGES

6.A PRIVILEGES RESTRICTED

Each member of the STAFF shall be entitled to exercise only those PRIVILEGES granted to him/her by the BOARD at the recommendation of the EXECUTIVE COMMITTEE.

6.B PRIVILEGES REQUESTED

(1) Every application for STAFF membership and membership renewal must contain requests for the clinical, research, and education PRIVILEGES desired by the applicant.

(2) The evaluation of such requests shall be based upon the applicant’s education, training, experience, demonstrated competence and judgment, references, and other relevant information, including an appraisal by the department and section in which such PRIVILEGES are sought and compliance with applicable department and section requirements. All evaluations shall be in writing to the Credentials Committee.
(3) Assignment to departments and sections for all STAFF members shall be made by the EXECUTIVE COMMITTEE.

(4) CLINICAL PRIVILEGES may be voluntarily relinquished only in a manner that provides for the orderly transfer or completion of applicable MEDICAL STAFF obligations, including those defined in Article 3, Section C of these BYLAWS.

6.C ADMITTING PRIVILEGES

(1) PHYSICIANS may admit patients under those departments and sections in which they have been granted PRIVILEGES.

(2) The podiatric and dental STAFF may admit patients, but prior to all admissions, arrangements must be made for co-admission with a MEDICAL STAFF member who shall be responsible for a medical appraisal, including a current medical history and physical examination, prior to any surgical procedure, and for the care of any medical problems that may be present at the time of admission or that may arise during hospitalization. Oral/Maxillofacial surgeon members of the STAFF may be granted independent admitting PRIVILEGES without a requirement of co-admission with a MEDICAL STAFF member through the credentials process.

(3) A medical history and physical examination must be completed within twenty-four (24) hours after admission, but prior to surgery or a procedure requiring general anesthesia or moderate sedation. This requirement may be satisfied by a complete history and physical that has been performed within the 30 days prior to admission so long as an examination for any changes in the patient’s condition is completed and documented in the patient’s record within 24 hours after admission or prior to surgery or a procedure. The examination must be completed and documented by a physician or oral/maxillofacial surgeon with privileges at the HOSPITAL.

6.D CLINICAL PRIVILEGES

(1) The scope and extent of practices and procedures that each PRACTITIONER may perform shall be delineated.

(2) Rules and Regulations pertaining to PRIVILEGES, or changes in same, in all departments and sections must be approved by the EXECUTIVE COMMITTEE and the GOVERNING BOARD, and are not effective until so approved.

6.E REDETERMINATION OF PRIVILEGES

Redetermination of PRIVILEGES and the increase or curtailment of same of a STAFF member shall be based upon new and additional education, training, and experience, the continuing observation of the member’s performance in patient care, research, or education functions in the HOSPITAL, review of patient records in this or other hospitals, and records of the STAFF in this and other hospitals which document the evaluation of the member’s performance.

6.F TEMPORARY PRIVILEGES

(1) All applications for temporary PRIVILEGES shall be in writing, shall be signed by the applicant, and shall be submitted to the Medical Staff Office or their designee on forms prescribed by the EXECUTIVE COMMITTEE, and shall state the reasons for requesting temporary PRIVILEGES, the specific PRIVILEGES requested, acknowledgment that the applicant has received copies of the BYLAWS, Rules and Regulations, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary PRIVILEGES.
(2) Upon receipt of an application for STAFF membership from an applicant, the CEO and Chief of Staff may, if requested by the applicant, grant temporary PRIVILEGES to the applicant if such application for initial PRIVILEGES is awaiting review and approval of the EXECUTIVE COMMITTEE and the GOVERNING BODY, after verification of the following:

(a) a complete application for MEDICAL STAFF membership and PRIVILEGES has been received and
(b) credentials, including but not limited to:
   (i) current licensure;
   (ii) relevant training or experience;
   (iii) current competence;
   (iv) ability to perform the CLINICAL PRIVILEGES requested;
   (v) other criteria required by the BYLAWS;
   (vi) query and evaluation of National Practitioner Data Bank information;
   (vii) absence of current or previously successful challenge to licensure or registration; and
   (viii) absence of involuntary termination of MEDICAL STAFF membership at any hospital or other entity, absence of any involuntary limitation, reduction, denial or loss of CLINICAL PRIVILEGES.

The decision to grant temporary PRIVILEGES is also based upon the written recommendation of the department and section chairs concerned. In exercising such PRIVILEGES, the applicant shall act under the supervision of the chair of the department and/or section to which he/she is assigned, or his/her designee. Temporary PRIVILEGES can be granted for a maximum of 120 days. Temporary PRIVILEGES shall automatically terminate if the applicant’s initial membership application is withdrawn.

(3) Temporary PRIVILEGES may be granted by the CEO and Chief of Staff to a PRACTITIONER who is not an applicant for membership to fulfill an important patient care, treatment or service need, after verification of current licensure and current competence, under the following circumstances:

(a) For the care of a specific patient or patient population. Such temporary PRIVILEGES shall be restricted to the treatment of the specific patient or patient population. When the temporary privileges are no longer needed to treat the specific patient or patient population, after which such PRACTITIONER shall be required to apply for membership on the STAFF before being allowed to attend additional patients.

(b) To a PHYSICIAN serving as a “locum tenens” to attend patients on behalf of a member of the MEDICAL STAFF or the HOSPITAL, without applying for membership on the STAFF, for a period not to exceed 120 days.

(4) Termination of Temporary PRIVILEGES

(a) The CEO or his designee may, at any time after consulting and concurring with the Chief of Staff, terminate temporary PRIVILEGES.

(b) If the care or safety of patients might be endangered by continued treatment by the PRACTITIONER granted temporary PRIVILEGES, the CEO or his designee or the Chief of Staff may immediately terminate all temporary PRIVILEGES. The Chief of Staff shall assign to other members of the MEDICAL STAFF responsibility for the care of such terminated PRACTITIONER’s patients until they are discharged.

(c) Neither the denial nor termination of such PRIVILEGES shall entitle the PRACTITIONER to any of the procedural rights provided for in these BYLAWS.
6.G  EMERGENCY PRIVILEGES

In the case of emergency, any qualified PHYSICIAN, dentist or podiatrist member with CLINICAL PRIVILEGES shall be permitted and assisted within the scope of the member’s license to do everything possible to save the life of a patient, using every facility of the HOSPITAL necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such member must request the PRIVILEGES necessary to continue to treat the patient, or, in the event such PRIVILEGES are not appropriate, denied, or he/she does not desire to request PRIVILEGES, the patient shall be assigned, by the department or section chair, to an appropriate member of the STAFF. For the purposes of this section, an “emergency” is defined as a condition in which serious permanent harm would result to a patient, or in which the life of a patient is in immediate danger, and any delay in administering treatment would add to that danger.

6.H  DISASTER PRIVILEGES

(1)  Conditions

(a) Disaster PRIVILEGES may be granted only when the HOSPITAL Emergency Management Plan has been activated. Individuals with disaster PRIVILEGES shall be identified and managed as described in the HOSPITAL Emergency Management Plan. The exercise of disaster PRIVILEGES is subject to the BYLAWS, rules, regulations and policies.

(b) MEDICAL STAFF department chairs or their designees shall oversee the exercise of disaster PRIVILEGES.

(2)  Circumstances

(a) The CEO, or the Chief of Staff, or their designees, may, on a case-by-case basis, grant disaster PRIVILEGES but must obtain a valid state or federal government-issued photo identification and at least one of the following:

(i) A current hospital picture identification that clearly identifies professional designation.

(ii) A current license to practice.

(iii) Identification establishing that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corp (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or other state or federal organizations or groups.

(iv) Identification granted by a federal, state or municipal entity establishing that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances.

(v) Identification by current HOSPITAL staff or MEDICAL STAFF member(s) with personal knowledge regarding the PRACTITIONER’S identity and ability to act during a disaster.

(b) Verification of the credentials of individuals with disaster PRIVILEGES is a high priority. Verification shall be initiated by the Medical Staff Office as soon as the immediate situation is under control and shall follow the procedures established in these BYLAWS for granting temporary PRIVILEGES to meet an important care need.

(c) The PRACTITIONER with disaster PRIVILEGES will be paired with and act only under the supervision of a MEDICAL STAFF member.

(d) When the disaster situation no longer exists, all disaster PRIVILEGES shall terminate.
6.1 TELEMEDICINE PRIVILEGES

(1) For those services which the EXECUTIVE COMMITTEE has recommended for provision as telemedicine services for patients at the HOSPITAL, licensed independent PRACTITIONERS at the distant site may be granted telemedicine PRIVILEGES upon application and favorable recommendation of the EXECUTIVE COMMITTEE and approval by the GOVERNING BODY, in the following circumstances:

(a) the distant site is currently Joint Commission accredited and the PRACTITIONER is privileged there to provide the same services provided at the HOSPITAL. The PRACTITIONER will not be a member of the STAFF and may not provide direct patient care; or

(b) the PRACTITIONER is a member of the Consultant STAFF and qualifies for PRIVILEGES for the services provided at the HOSPITAL.

(2) Application For Telemedicine PRIVILEGES

Any PRACTITIONER who is not a member of the Consultant STAFF and wishes to be considered for telemedicine PRIVILEGES will provide the following documentation to the Medical Staff Office or its designee:

(a) Application for telemedicine PRIVILEGES;

(b) Signed consent and release form;

(c) Current licensure to practice medicine in one of the 50 states;

(d) Curriculum Vitae;

(e) Current copy of DEA if applicable;

(f) Current copy of professional liability insurance coverage certificate in such minimum amount as may be required by the HOSPITAL;

(g) Evidence of no exclusion from any federal health care program;

(h) Evidence of MEDICAL STAFF appointment and CLINICAL PRIVILEGES IN GOOD STANDING at another TJC accredited or equivalent hospital;

(i) The application fee; and

(j) Such additional information as may be requested by the HOSPITAL.

(3) Processing and Approval of Telemedicine Services and PRIVILEGES:

(a) The Medical Staff Office or its designee upon receipt of a complete application for telemedicine PRIVILEGES shall verify the authenticity of the documents submitted and query the National Practitioner Data Bank.

(b) The complete application and all required documents shall be forwarded to the applicable department chair for recommendation.

(c) The Credential Committee shall make its recommendation to the EXECUTIVE COMMITTEE regarding whether the PRACTITIONER’S request for Telemedicine PRIVILEGES should be granted.

(d) The EXECUTIVE COMMITTEE shall make its recommendation to the GOVERNING BODY whose decision shall be final.
6.J CONTRACTS FOR CLINICAL SERVICES

(1) From time to time, the HOSPITAL may enter into contracts or employment relationships with individuals, partnerships, or corporations for the performance of certain health care or clinical services, including but not limited to, those in medico-administrative positions. All individuals functioning at the HOSPITAL pursuant to such contracts shall obtain and maintain MEDICAL STAFF appointment and/or CLINICAL PRIVILEGES at the HOSPITAL, in accordance with the terms of these BYLAWS.

(2) In the event any such contract provides that the PHYSICIANS or other PRACTITIONERS subject to it have the exclusive right to provide the clinical services covered by the contract, the MEDICAL STAFF recognizes that the HOSPITAL, not the MEDICAL STAFF, will not allow any other PHYSICIAN or PRACTITIONER to exercise CLINICAL PRIVILEGES at the HOSPITAL to provide the clinical services in question while that contract is in effect unless otherwise provided for by the contract.

(3) Contracts for clinical services shall be subject to initial and annual review by the EXECUTIVE COMMITTEE.

ARTICLE 7 – CONDUCT

7.A DEFINITION AND SEVERITY OF INAPPROPRIATE BEHAVIOR

(1) Disruptive behavior or harassment by any member of the MEDICAL STAFF is inappropriate behavior, is prohibited, and will be corrected, or if correction fails or the conduct warrants, disciplined.

(2) Disruptive behavior includes conduct which jeopardizes quality patient care or jeopardizes the ability of others to provide quality patient care at the HOSPITAL, or threatens, or constitutes verbal, physical or visual abuse of patients or others involved with providing patient care at the HOSPITAL.

(3) Harassment includes conduct which jeopardizes quality patient care or jeopardizes the ability of others to provide quality patient care at the HOSPITAL and violates federal or state civil rights laws, including:

(a) unwelcome and abusive or offensive conduct, whether verbal, physical or visual, based on a person’s race, color, national origin, sex, religion, physical/mental disability, age or veteran status; and

(b) unwelcome sexual advances, requests for sexual favors, or other physical, verbal or visual conduct of a sexual nature that:

(i) is required as a term or condition of employment or is the basis for an employment action; or

(ii) unreasonably interferes with an individual’s work performance or creates an intimidating, hostile or offensive work environment, including but not limited to: sexual propositions, suggestive comments or printed material, sexually oriented jokes or teasing, or unwelcome physical contact such as patting, hugging, pinching or intentionally brushing against another.

(4) Where it appears from the evidence that inappropriate behavior by a MEDICAL STAFF member is the result of a physical, mental or emotional condition the member will be referred to the MEDICAL STAFF Wellness Committee or otherwise evaluated to promote the health of the MEDICAL STAFF member while taking appropriate steps to protect others.

(5) Inappropriate behavior is classified here into three levels of severity. Level III behavior is the most severe. Any corrective action will be commensurate with the nature and severity of the behavior.
(a) **Level I**

Examples of Level I behavior violations include, but are not limited to: Verbal abuse which is directed at-large, but has been reasonably perceived by a witness to be inappropriate behavior as defined above; non-compliance of hospital policies that has minimal or no impact on patient care or staff.

(b) **Level II**

Examples of Level II behavior violations include, but are not limited to:

Verbal abuse such as unwarranted yelling, swearing or cursing; threatening, humiliating, sexual or otherwise inappropriate comments directed at a person or persons verbally; visual abuse such as threatening, humiliating, sexual or otherwise inappropriate writing or picture(s) directed at a person or persons, or physical violence or abuse directed in anger at an inanimate object; non-compliance of hospital policies resulting in minor potential to actual harm to patients or staff; demeaning or rude interactions with patients.

(c) **Level III**

Examples of Level III behavior violations include, but are not limited to: Physical violence or other physical abuse which is directed at people; sexual harassment or harassment involving physical contact; non-compliance of hospital policies resulting in major or potential or actual harm to patients or staff; substance abuse; inappropriately accessing the medical record.

### 7.B CORRECTIVE ACTION FOR INAPPROPRIATE BEHAVIOR

Inappropriate behavior by members of the MEDICAL STAFF that affects or may affect patient care, or refusal of members to cooperate with the inappropriate behavior procedures, may result in corrective action, which shall be carried out according to these BYLAWS. The HOSPITAL may also investigate inappropriate behavior in accordance with HOSPITAL policy and procedure and coordinate its investigation with the EXECUTIVE COMMITTEE. Repeated instances of inappropriate behavior will be considered cumulatively and action shall be taken accordingly. Three behavior referrals within a six month period will result in a meeting with the Chief of Staff or Department Chair.

### 7.C MEDICAL STAFF INAPPROPRIATE BEHAVIOR COMPLAINT PROCESS

(1) Complaints about a MEDICAL STAFF member’s conduct alleging inappropriate behavior must be reduced to writing, signed and directed to the EXECUTIVE COMMITTEE. The EXECUTIVE COMMITTEE, through the Chief of Staff or designee, must review the complaint immediately, and:

(a) NOTIFY the affected PRACTITIONER that the complaint has been received;

(b) Provide information regarding the nature of the complaint to the affected PRACTITIONER;

(c) Advise the PRACTITIONER:

   (i) to cooperate to permit a complete investigation of the allegations;

   (ii) not to initiate contact with the affected employee(s);

   (iii) not to discuss the allegations or the complaint with any person outside the MEDICAL STAFF or People Resources Department review process; and

   (iv) that retaliation will not be tolerated.

(d) Provide the complainant with a written acknowledgement of the complaint.
(e) The HOSPITAL may also investigate inappropriate behavior in accordance with HOSPITAL policy and procedure and coordinate its investigation with the EXECUTIVE COMMITTEE.

The Chief of Staff, Department Chair or designee shall make an initial determination of authenticity and severity, and arrange for an inquiry accordingly. If no corrective action is taken, a confidential memorandum summarizing the disposition of the complaint shall be retained in the member’s Active Credentials file and may be placed in the Inactive Credentials file according to the procedures defined in Article 5 of these BYLAWS, if no related action is taken or pending.

(2) At the discretion of the Chief of Staff or at the discretion of the EXECUTIVE COMMITTEE, the duties here assigned to the Chief of Staff can be delegated to a different officer of the MEDICAL STAFF, on a case-by-case basis or for the Chief of Staff’s term of office.

(3) Complaints will be processed according to the Level of Severity assigned:

(a) Level III: The Chief of Staff, or designee, shall interview the complainant and, if possible, any witnesses within 24 hours of receiving the complaint. The Chief of Staff and another member of the EXECUTIVE COMMITTEE shall interview the MEDICAL STAFF member within 24 hours. The Chief of Staff shall provide the member the opportunity to respond in writing. The Chief of Staff shall do one or more of the following:

(i) determine that no action is warranted.

(ii) issue a verbal warning and counsel the member of the MEDICAL STAFF.

(iii) issue a written warning and counsel the member of the MEDICAL STAFF.

(iv) refer member to the MEDICAL STAFF Wellness Committee.

(v) initiate corrective action pursuant to the BYLAWS.

(b) Level II: The Chief of Staff, Department Chair, or designee shall interview the complainant and, if possible, any witnesses within 5 working days of receiving the complaint. The Chief of Staff and another member of the EXECUTIVE COMMITTEE shall interview the MEDICAL STAFF member within 5 working days. The Chief of Staff shall provide the member the opportunity to respond in writing. The Chief of Staff shall take one of the actions (a through e) set forth in paragraph 1 above.

(c) Level I: The Chief of Staff, Department Chair, or designee shall interview the complainant and, if possible, any witnesses within 10 days of receiving the complaint. The Chief of Staff shall provide the member the opportunity to respond in writing. The Chief of Staff shall take one of the actions (a through e) set forth in paragraph 1 above.

7.D CONDUCT COMPLAINTS NOT HANDLED BY MEDICAL STAFF COMPLAINT PROCESS

(1) Inappropriate behavior which is directed against a MEDICAL STAFF member by a HOSPITAL employee, BOARD member, contractor, or other member of the HOSPITAL community shall be reported to the HOSPITAL pursuant to HOSPITAL policy governing conduct. The MEDICAL STAFF member shall be provided with a written acknowledgement of the complaint.

(2) Behavior by a MEDICAL STAFF member towards a HOSPITAL employee, BOARD member, contractor or other member of the HOSPITAL community may also be investigated in accordance with HOSPITAL policy. The EXECUTIVE COMMITTEE shall be advised of the process and all findings.
7.E  ABUSE OF PROCESS

Threats or actions directed against the complainant by the subject of the complaint will not be tolerated under any circumstance. Retaliation or attempted retaliation by members against complainants will give rise to corrective action pursuant to these BYLAWS. Individuals who submit a complaint or complaints which are determined to be false shall be subject to corrective action under these BYLAWS, if applicable, or HOSPITAL employment policies, whichever applies to the individual.

7.F  CONDUCT AWARENESS EFFORTS

The MEDICAL STAFF shall promote continuing awareness of the standards of appropriate behavior among the MEDICAL STAFF and the HOSPITAL community, including the following efforts:

(1) sponsoring or supporting educational programs on inappropriate behavior to be offered to MEDICAL STAFF members and HOSPITAL employees;

(2) disseminating this BYLAWS section to all current members upon its adoption and to all new members of the MEDICAL STAFF upon joining the STAFF;

(3) facilitating assistance by the MEDICAL STAFF Wellness Committee for members of the MEDICAL STAFF exhibiting inappropriate behavior to obtain education, behavior modification, or other treatment to prevent further violations.

ARTICLE 8 - PROFESSIONAL REVIEW PROCEDURES AND CORRECTIVE ACTION

8.A  NATURE OF PROFESSIONAL REVIEW PROCEDURES

Resolution of any request for an INVESTIGATION or controversy regarding the professional, ethical, or personal activities of any member of the STAFF, shall, if possible, be accomplished by an informal, intra-professional review procedure or monitoring by the appropriate MEDICAL STAFF member or committee.

8.B  INITIATION OF PROFESSIONAL REVIEW PROCEDURES

(1) Whenever a matter which cannot be resolved according to Section A above and which may merit INVESTIGATION, comes to the attention of any member of the STAFF, the CEO or the BOARD, a request for a professional review procedure shall be made to the appropriate department/committee.

(2) The chair of the department/committee shall arrange for review. If preliminary review indicates that the matter does not merit serious attention, the matter shall be dismissed with an appropriate notation made in the record. The chair may at any time refer a member to the MEDICAL STAFF Wellness Committee for evaluation and assistance as appropriate.

(3) If preliminary review indicates that the matter merits more detailed review, the department/committee shall promptly NOTIFY the RESPONDENT and arrange for a meeting between the RESPONDENT and the department/committee. If following this meeting, the matter can be resolved to the satisfaction of the department/committee it shall be dismissed with an appropriate notation made in the record. If the matter cannot be resolved in this manner, then the department/committee shall advise the EXECUTIVE COMMITTEE of such inability to reach a resolution or the department/committee may request the corrective actions set forth in Section C below.
(4) If the department/committee recommends that any of the corrective actions set forth in Section C below be initiated at any time during these procedures, it shall do so as provided in Section D of this Article.

8.C NATURE OF CORRECTIVE ACTION

The corrective action process provided by these BYLAWS shall consist of two different types: Level I corrective actions and Level II corrective actions.

(1) Level I corrective actions by the EXECUTIVE COMMITTEE shall include all actions or recommendations that do not involve a suspension, reduction or revocation of or a denial or failure to renew a member’s CLINICAL PRIVILEGES or MEDICAL STAFF membership. Such actions include but are not limited to issuance of a warning, letter of admonition, letter of reprimand, monitoring, and requests for physical or psychiatric evaluations or a referral to the MEDICAL STAFF Wellness Committee.

(2) Level II corrective actions by the EXECUTIVE COMMITTEE shall include but are not limited to the actions set forth in Article 9, Section A (1-11), or any action by the STAFF which could result in termination, suspension, limitation of membership or CLINICAL PRIVILEGES or a denial or failure to renew the CLINICAL PRIVILEGES or membership of a STAFF member. Grounds shall include, without limitation, any of the following:

(a) conviction of a felony;
(b) unethical conduct;
(c) incompetence;
(d) activities or professional conduct substantially below the standards of the STAFF;
(e) violation of these BYLAWS or the Rules and Regulations of the STAFF;
(f) falsification of a patient’s record, an application form to the STAFF or any credentialing information;
(g) consistent failure to keep adequate patient records; and
(h) any material misstatement or omission discovered in the credentialing process

8.D INITIATION OF CORRECTIVE ACTION

(1) Corrective action may be requested by any department/committee of the STAFF which has been unable to resolve a problem or controversy in a reasonable length of time by informal procedures, or any time the department/committee feels that a problem may be of major importance; by the CEO; by the EXECUTIVE COMMITTEE; or by the BOARD.

(2) All requests for corrective action shall be in writing, made through the CEO to the EXECUTIVE COMMITTEE, unless the EXECUTIVE COMMITTEE is the initiator of the action, and supported by reference to specific activities or conduct which constitutes the grounds for the request.

(3) The CEO shall promptly NOTIFY the RESPONDENT that a request for corrective action has been made regarding him/her, what the nature of the requested action is, and what his/her rights are as provided by these BYLAWS.

(4) Although, in appropriate cases, PRIVILEGES or membership, or both, may be suspended at any time during the INVESTIGATION, as provided in Section F of this Article, the mere fact that an INVESTIGATION is initiated shall not automatically cause any corrective action including suspension.
8.E PROCEDURE FOR CORRECTIVE ACTION

(1) The EXECUTIVE COMMITTEE shall review each request to determine whether the request is obviously specious. If it determines that INVESTIGATION is warranted, it shall forward the request to the Chair of the department or section wherein the RESPONDENT has PRIVILEGES, or to the Credentials Committee if deemed appropriate. Upon receipt of such request, the chair shall within ten (10) days, call a meeting of the department or section who shall act as an Investigating Committee to consider the matter. This Investigating Committee may request other members of the STAFF, and, if felt necessary, members of the profession or others who are not members of the STAFF, to assist in its INVESTIGATION. Members of the STAFF who have a formal business or professional association with the RESPONDENT or who may be otherwise biased shall be excused from serving on this committee.

(2) Within thirty (30) days after the Investigating Committee’s first meeting to investigate the request for corrective action, it shall make a report of its INVESTIGATION to the EXECUTIVE COMMITTEE. If the Investigating Committee is at the section level, the appropriate department shall review the Investigating Committee report and shall concur, disagree, or add to the report to be submitted to the EXECUTIVE COMMITTEE. Prior to the making of such report, the RESPONDENT shall have an opportunity for an interview with the Investigating Committee. At such interview, he/she shall be informed of the nature of the charges against him/her, and shall be invited to discuss, explain, or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these BYLAWS with respect to hearings shall apply thereto. A record of such interview shall be made by the Investigating Committee and included with its report to the EXECUTIVE COMMITTEE.

(3) Within sixty (60) days following the receipt of an Investigating Committee’s request for corrective action, the EXECUTIVE COMMITTEE shall take action upon the request. The RESPONDENT shall be permitted to make an appearance before the EXECUTIVE COMMITTEE prior to its taking action. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these BYLAWS with respect to a hearing shall apply thereto. A record of the actions taken or recommendations made by the EXECUTIVE COMMITTEE shall be kept. If the action contemplated by the EXECUTIVE COMMITTEE is any one of the actions identified in Article 9, Section A (1-11), then the RESPONDENT shall be entitled to the hearing and appellate review procedures set forth in Article 9.

(4) The action of the EXECUTIVE COMMITTEE on an Investigating Committee’s report requesting corrective action may be to:

(a) reject the request for corrective action,
(b) refer the RESPONDENT to the MEDICAL STAFF Wellness Committee,
(c) impose Level I corrective action or
(d) recommend Level II corrective action as defined in Section C of this Article.

(5) The Chief of Staff shall promptly NOTIFY the CEO of all requests for corrective action received by the EXECUTIVE COMMITTEE and shall keep the CEO fully informed of all action taken.

8.F SUMMARY SUSPENSION

(1) A summary suspension under this Section must be reported to the National Practitioner Data Bank if it is (a) in effect for more than thirty (30) days; (b) based on the professional competence or professional conduct of the health care practitioner that adversely affects, or could adversely affect, the health or welfare of a patient; and (c) is the result of a professional review activity taken by Hospital. In addition, summary suspension imposed for an indefinite length that have not lasted more than thirty (30) days but are expected to last more than thirty (30) days,
and that are otherwise reportable, may be reported to the NPDB. If the summary suspension ultimately does not last more than thirty (30) days, the report must be voided.

(2) Summary suspensions are treated differently from other professional review actions in that the procedural rights of the practitioner are provided AFTER the imposition of a suspension, as opposed to being afforded PRIOR TO the imposition of a suspension. A summary suspension is imposed by the Chief of Staff, CMO, the Chair of a department, or the EXECUTIVE COMMITTEE, whenever, in his/her/its judgment, action must be taken immediately, to summarily suspend all or any portion of the PRIVILEGES of a member to prevent imminent danger to the health of an individual. Such summary suspension shall become effective immediately upon imposition.

(3) An order for a summary suspension shall then be made in writing, signed by the originator, shall clearly delineate the PRIVILEGES which are suspended, shall include a brief statement of the reason for the suspension and shall be submitted to the CEO or his/her designee who shall take all administrative action necessary to carry out the orders of the suspension, promptly NOTIFY the RESPONDENT, and inform him of his/her rights under these BYLAWS.

(4) If either the Chief of Staff, the CMO, the Chair of a department, or the Executive Committee disagree that summary suspension is warranted, the matter shall be referred to the Joint Conference Committee, which shall meet within 48 hours and may summarily suspend by a majority vote if it determines that failure to take action may result in imminent danger to the health or safety of a patient, member, hospital employee, or any individual. If no summary suspension is imposed, the matter shall be immediately referred to the peer review committee for review, and action is warranted.

(5) Immediately upon the imposition of a summary suspension, the responsible department chair, or in his/her absence, the Chief of Staff or CMO shall have authority to provide for alternative coverage of the duties and assignments of a member, and to provide for alternative clinical coverage for the patients of a suspended PRACTITIONER remaining in the HOSPITAL at the time of such suspension. The wishes of the individual patients shall be considered in the selection of such alternative clinical coverage.

(6) If the suspension involves either the Chief of Staff or a Chair of a department, his/her immediate successor will act in his/her stead. All summary suspensions, whether continuing or not, shall be reported to the EXECUTIVE COMMITTEE at the next regular meeting under Closed Session. As soon as reasonably possible but no later than 14 days after the imposition of the suspension, or earlier if an accelerated review is requested in writing by the suspended staff member or practitioner, the EXECUTIVE COMMITTEE shall be convened to review and consider the appropriateness of action taken. The EXECUTIVE COMMITTEE may terminate the summary suspension, and as warranted shall recommend to the Governing Body modification or continuation, of the terms of the suspension, or other corrective action.

(7) Unless the EXECUTIVE COMMITTEE immediately terminates the suspension and recommends no further corrective action, a member shall be entitled to the hearing and appeals procedural rights as provided in these bylaws, in which case, the terms of the suspension as sustained by the EXECUTIVE COMMITTEE shall remain in effect pending a final decision by the Governing Body.

(8) A continuing summary suspension may vary from the original summary suspension and shall clearly delineate the PRIVILEGES which are suspended, and shall include a brief statement of the reason for the suspension.

(9) An order for a continuing summary suspension shall be automatically instituted as a request for corrective action by the CEO as provided in Section D, paragraph 2 of this Article.

(10) A continuing summary suspension shall remain in effect until all of the provisions of Sections D and E of this Article have been fulfilled.

(11) For purposes of reporting a summary suspension to the NPDB, if the summary suspension is confirmed by the review body, the action is considered to have taken effect when it was first imposed by the hospital official. If a summary suspension is in effect for more than 30 days before an action is taken by the authorized hospital committee or body, it must be reported to the NPDB. If the authorized hospital committee or body does not confirm
the initial action or takes a different professional review action, a Revision-to-Action Report must be submitted. If the authorized hospital committee or body vacates the summary suspension, the entity must void the previous report submitted to the NPDB. If the summary suspension subsequently is modified or revised as part of a final decision by the governing board or similar body, the health care entity must then submit a Revision-to-Action Report to supplement the Initial Report submitted to the NPDB. If the physician, dentist, or other health care practitioner surrenders his or her clinical privileges during a summary suspension, regardless of whether the suspension has been confirmed by a hospital review body, that action must be reported to the NPDB. The action must be reported because the practitioner is surrendering the privileges either while under investigation concerning professional conduct or professional competence that did or could affect the health or welfare of a patient, or in return for not conducting an investigation concerning the same.

8.G AUTOMATIC SUSPENSION/RELINQUISHMENT

(1) Automatic suspension shall be ordered by the CEO for reasons provided in this Section with notification of the Chief of Staff and the Chair of the appropriate department, who shall cooperate with the CEO in enforcing the suspension. The Member shall not be afforded fair hearing rights upon an automatic suspension. For violations of this Section, no report to the National Practitioner Data Bank shall be made.

(2) Delinquent Medical Records. A suspension of all of a Member’s Clinical Privileges, including the privilege of admitting patients to the Hospital, will be imposed automatically five (5) days after notification from the CEO or the Chair of the Medical Staff of failure to adhere to M.S. 17 (or other medical records completion standards as may be amended or modified from time-to-time). This subsection does not limit the ability of the Medical Staff or the Board to take other corrective action when a practitioner fails to properly or timely complete medical records or otherwise adhere to M.S. 17 and other medical records completion standards as may be amended or modified from time-to-time.

(3) Lack of Insurance. A suspension of all of a Member’s Clinical Privileges, including the privilege of admitting patients to the Hospital, shall be imposed automatically for failure to provide, to the satisfaction of the EXECUTIVE COMMITTEE and the CEO, continuing evidence of current malpractice insurance as required by these Bylaws, and the affected Practitioner shall be so notified.

(4) Action by State or Federal Agency to Limit a Professional License or Authority to Practice or to Limit or Terminate State or Federal Controlled Substances Prescribing Authority. Action by the State of Alaska or the federal government limiting a Member's license or authority to practice his or her profession, or limiting or terminating a Member’s authority to prescribe controlled substances shall to the same extent automatically limit the Member’s Clinical Privileges at the Hospital, which may require a complete suspension of the Member’s Clinical Privileges at the Hospital. This provision shall not be interpreted to prevent other appropriate corrective action proceedings in such a case.

(5) Conviction of Crimes. An automatic relinquishment of a Member’s Medical Staff membership and all Clinical Privileges shall be imposed in the event a Member is convicted of any felony related to the provision of health care; any crime related to health care fraud and abuse; any crime related to the Member’s treatment, discharge, billing, collection or utilization practices; or any crime that could form the basis for exclusion from participation in governmental health care programs. In the event a Member is charged with a felony, the EXECUTIVE COMMITTEE shall provide to the Board information available to enable determination of the Board’s need to suspend Clinical Privileges pending the outcome of said felony charge.

(6) Exclusion from Participation in Federal Health Care Programs. An automatic relinquishment of a Member’s Medical Staff membership and all Clinical Privileges shall be imposed in the event a Practitioner is excluded from participation in any federal health care program.
(7) **Other Grounds.** The Medical Staff Rules and Regulations may provide other grounds leading to automatic suspension of all or a part of a Member's Clinical Privileges.

(8) **Alternative Coverage.** In the event of an automatic suspension or relinquishment, alternative coverage for the patients of an affected Member in the Hospital will be arranged. The Chief of the Medical Staff will cooperate both in making arrangements for such coverage and in enforcing the automatic suspension.

(9) **Duration and Rights.** All automatic suspensions will continue until medical records are completed, where applicable, and in other cases of automatic suspensions, until the Practitioner documents to the satisfaction of the EXECUTIVE COMMITTEE and the CEO that the grounds for the automatic suspension no longer exist. No individual affected by automatic suspension or automatic revocation will be entitled to the hearing and appeal procedures set forth in these Bylaws, and no report of the automatic suspension shall be made to the National Practitioner Data Bank. The EXECUTIVE COMMITTEE and the CEO shall, upon request, meet with the individual to allow the individual to present any argument, explanation, documentation or other information suggesting that the grounds for the suspension no longer exist or that the grounds for the revocation do not exist. A Member on automatic suspension of all Privileges shall not be eligible during the period of suspension to vote or hold office.

(10) **Sickness or Disability.** Except when resulting from action of the State of Alaska or the federal government as described above, whenever automatic suspension is imposed for reasons beyond the control of the Practitioner due to sickness or disability, the Chief of the Medical Staff or the EXECUTIVE COMMITTEE may, in their discretion, revoke such suspension and place the Member on leave of absence, or take other action which they deem appropriate under the circumstances.

(11) **Permanent Termination.** Whenever automatic suspension of all Privileges continues for three (3) consecutive months, the individual's Medical Staff membership and clinical Privileges shall be deemed automatically terminated without the right to a hearing or appeal under these Medical Staff Bylaws, and may not be reinstated except pursuant to the procedures for an original application for membership or Privileges, unless this provision is expressly waived for good cause by the Board.

**ARTICLE 9 - HEARING AND APPELLATE REVIEW PROCEDURES**

As used in this Article, “Member” includes Members of the Medical Staff, as well as applicants for Medical Staff Membership and physicians, podiatrists and dentists who are temporary privileges holders. All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article. No action will be final or reported to any governmental agency unless and until the Member first has exercised or waived hearing rights under these bylaws or as otherwise required by law.

Further, as used in this Article, “Adverse Action” means an action proposed or taken by the Board or by the Medical Staff (which could be acting through the Executive Committee or a department), which is reportable to the National Practitioner Databank and/or to the Alaska Board of Medicine upon final action (i.e., upon final Board action as set forth in this section).

**9.A GROUNDS FOR HEARINGS**

Members are entitled to a hearing and appellate review upon the recommendation of an Adverse Action. Examples of these grounds include the following:

(1) Denial of MEDICAL STAFF membership

(2) Denial of requested advancement in MEDICAL STAFF membership

(3) Denial of MEDICAL STAFF membership renewal
(4) Recommendation to lower STAFF category

(5) Suspension of MEDICAL STAFF membership (except as provided in Article 8, Section F and G)

(6) Except as set forth in Article G, expulsion from MEDICAL STAFF membership

(7) Denial of requested PRIVILEGES

(8) Reduction in PRIVILEGES

(9) Suspension of PRIVILEGES which is in effect for longer than thirty (30) days

(10) Termination of PRIVILEGES

(11) Requirement of consultation or proctoring prior to exercising clinical privileges

No Member shall be entitled to a hearing as a result of any action recommended or taken that does not meet the definition of Adverse Action. Examples of matters which do NOT meet the definition of Adverse Action (and therefore do NOT give rise to a fair hearing) include, but are not limited to:

(1) Issuance of a letter of guidance, warning or reprimand;

(2) Imposition of a requirement for proctoring or consultation with no restriction on privileges;

(3) Failure to process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege;

(4) Requirement to appear for a special meeting under the provisions in the bylaws;

(5) Conducting an investigation into any matter or the appointment of an ad hoc investigation committee.

9.B NOTICE OF ACTION

The Chief of the Medical Staff or the President of the Board (depending upon which body recommended the proposed Adverse Action) shall notify the Member by written notice of the proposed Adverse Action including the acts/omissions for which the Member was reviewed, the findings of the EXECUTIVE COMMITTEE or the Board (depending upon which body recommended the proposed Adverse Action), and the reasons for its recommendation. The notice shall state that the Member has a right to a hearing pursuant to this Article 9, and shall provide a summary of the hearing rights granted under these bylaws or attach a copy of this Article 9. The letter will inform the Member that he or she has the right to request a hearing on the proposed Adverse Action by providing the CEO a written request within 30 days of the date of the notice of Adverse Action. The written notice shall state that, if adopted, the action will be reported to the Alaska Board of Medicine and the NPDB as required by state and federal law.

9.C WAIVER OF HEARING AND APPEAL RIGHTS

If an Adverse Action occurs, the Member must exhaust the appeal rights and remedies set forth herein before resorting to formal legal action challenging the Adverse Action, the procedures used to arrive at such Adverse Action or asserting any claim related to the Adverse Action.

If the Member fails to request a hearing in accordance with these bylaws, such failure shall be deemed an irrevocable waiver of the right to such hearing and any appellate review. Waiver of hearing and appeals rights is deemed an acceptance of the recommendation or actions of the EXECUTIVE COMMITTEE or the Board (depending upon which
body recommended the proposed Adverse Action). In such case, the matter shall be reviewed by the Governing Body for final action, in which case, the Governing Body shall consider the recommendation for Adverse Action at its next regular meeting following the waiver by the Member.

9.D PRE-HEARING PROCESS

(1) Notice of Time and Place of Hearing. Upon receipt of a timely request for hearing, the Chief Executive Officer shall notify the Member by written notice of the time, place and date of the hearing (or the proposed time and date for the Member to select from). The hearing will be held not sooner than 30 days and no later than 60 days after the date of the notice of hearing unless holding the hearing sooner than 60 days from the date of the notice is impractical, or unless the parties otherwise agree. The notice shall also include a copy of the EXECUTIVE COMMITTEE’s or the Board’s (depending upon which body recommended the proposed Adverse Action) basis for the hearing, list of witnesses, as well as whether the EXECUTIVE COMMITTEE or Board (depending upon which body recommended the proposed Adverse Action) will be represented by legal counsel.

(2) Witnesses. Within 15 days of receipt of the notice of the hearing, the Member shall provide the Chief Executive Officer with a list of witnesses expected to testify at the hearing on behalf of the Member, as well as whether the member will be represented by legal counsel at the hearing and the name and contact information of the legal counsel. If dates and times for the hearing were offered, the Member will also select a date and time for the hearing in the response. Both parties may revise their witness lists with notice to the other party no later than two (2) business days prior to the hearing.

(3) Appointment of Review Panel

(a) Composition of Review Panel. The Chief of the Medical Staff (or the President of the Board if the Board was the body which recommended the proposed Adverse Action), in agreement with the CEO, shall appoint a review panel comprised of at least 3 persons, and will select a chairperson from the appointed Members (“Review Panel”). The Review Panel should be comprised of three Members of the Hospital Medical Staff. However, if it is not possible to identify any or enough Members of the Medical Staff to serve on the Review Panel, the Medical Staff Chief of Staff, in agreement with the CEO, may appoint up to three physicians from outside the Medical Staff in order to obtain a three-person Review Panel to hear the matter at issue.

(b) Eligibility for Review Panel. Consistent with the Conflict of Interest Policy of these bylaws, no Medical Staff Member who has participated in the initiation of or participated significantly in the case at issue shall serve on the Review Panel, nor shall any individual who is in direct economic competition with the Member serve on the Review Panel. However, the Review Panel may call as a witness Members of the same medical specialty or subspecialty as the Member in issue (who shall be subject to cross-examination by either party), and any Member of the Medical Staff or other practitioner may appear before the Review Panel as a witness if requested by either party. A Medical Staff Member shall not be disqualified from serving on a review panel because he/she has heard of the case or has a basic knowledge of the facts involved in the case.

(4) Appointment of Hearing Officer. The Chief of the Medical Staff (or President of the Board if the Board was the body who made the recommended Adverse Action), in agreement with the CEO, may select the chairperson of the Review Panel as the Hearing Officer. Alternatively, in the discretion of the Chief of the Medical Staff (or the President of the Board if the Board was the body who made the recommended Adverse Action), in agreement with the CEO, a separate Hearing Officer may be selected. The Hearing Officer shall be an attorney-at-law, but shall not be in economic competition with the Member, and shall not currently represent, or within the prior twelve month period have represented, the Hospital, the Medical Staff or the Member, or be selected from within a law firm that currently represents, or within the prior twelve month period has represented, the Hospital, the Medical Staff or the Member.
9.E  CONDUCT OF HEARING

(1) **Presiding Officer (Hearing Officer).** The Hearing Officer shall preside over the hearing to determine the order of procedure during the hearing, to maintain decorum and to ensure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and shall also be referred to as the Presiding Officer. The Presiding Officer shall make all rulings on matters of procedure, and the admissibility of evidence. If the Presiding Officer is the chairperson of the Review Panel, service as the Presiding Officer shall not prevent such individual from voting. However, if the Presiding Officer is not a Member of the Review Panel, such individual shall not vote. Prior to the hearing, the Presiding Officer shall hold one or more scheduling conference(s) with both parties to establish deadlines for pre-hearing disclosures of witnesses lists, evidence, exhibits, and other matters which will be addressed at the hearing, as determined appropriate by the Presiding Officer. All witness lists, evidence and exhibits to be used at the hearing shall be exchanged at least two (2) business days prior to the hearing.

(2) **Quorum.** A simple majority of the Review Panel shall constitute a quorum. Action is taken by the affirmative vote of at least two of the three members of the Review Panel present during a meeting or hearing at which a quorum exists. No Member of a Review Panel may vote by proxy.

(3) **Record of Hearing.** A permanent record of the hearing shall be made by court reporter or electronic means, as determined by the Presiding Officer. A copy of the transcript shall be provided to both parties upon request. Additional copies can be requested at the cost of the party making the request.

(4) **Personal Appearance.** The personal appearance of the Member requesting the hearing is required. However, if both the Member and the Medical Staff Chief of Staff (or Board President if the Board is the body that recommended the Adverse Action) agree, the hearing could be held by electronic means with audio and video capability which permits simultaneous auditory and visual display and interaction of all participants. A Member who fails without good cause to appear and proceed at the hearing is deemed to have waived his or her rights to all hearing and appellate review protections under these bylaws, with the same consequences as Article 9, Section C (Waiver of Hearing and Appeal Rights), above.

(5) **Postponement.** The hearing may be postponed by the Presiding Officer upon request, but only upon a showing of good cause.

(6) **Representation.** The Member who requested the hearing is entitled to be represented at the hearing by an attorney, a Member of the Medical Staff in good standing, or another person of the Member’s choice. However, the Member may only be represented by one individual. The EXECUTIVE COMMITTEE, or Board, depending upon which body took the action or made the recommendation giving rise to the request for hearing, shall appoint one of its Members, or in the case of the EXECUTIVE COMMITTEE, any Medical Staff Member who is not a member of the Review Panel, to represent it at the hearing, and also may be represented by an attorney at the hearing. Additionally, the Review Panel may be advised by legal counsel (in addition to the Hearing Officer). However, legal counsel may not influence the Review Panel’s substantive review, other than to clarify its responsibilities. While legal counsel may attend and assist the respective parties in proceedings provided herein, due to the professional nature of the review proceedings, it is intended that the proceedings will not be judicial in form but rather a forum for professional evaluation and discussion between peers. Accordingly, the Presiding Officer, and/or appellate review body, as applicable, may impose reasonable limits on the time allowed for legal counsel cross-examination and oral arguments, as well as reasonable limits on the number of witnesses called. Any Member who incurs legal fees in his/her behalf shall be solely responsible for payment thereof.

(7) **Rights of Parties.** During a hearing, each of the parties shall have a right to take the following actions, all subject to the reasonable limits on time imposed by the Presiding Officer:

(a) Present evidence deemed relevant by the Presiding Officer, and
(b) Call, examine and cross-examine witnesses.

(8) If the Member who requested the hearing does not testify in his/her own behalf, he/she may be called and examined.

(9) **Procedure and Evidence.** Except as hereinafter provided, no right exists to discovery of documents or other evidence in advance of a hearing, but the Presiding Officer may confer with both parties in advance of the hearing in order to encourage and advance mutual exchange of documents relevant to the issues to be presented at the hearing. It shall be the duty of the Member and the EXECUTIVE COMMITTEE or Board (depending upon which body recommended the proposed Adverse Action), or its designee, to exercise reasonable diligence in notifying the Presiding Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, so that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be made at the hearing. The hearing shall not be conducted strictly according to rules of evidence relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely on in the conduct of their serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. The focus of the Review Panel’s deliberation and review shall be on the Adverse Action prompting the Member’s request for a hearing. However, the Review Panel shall be entitled to consider evidence of prior events and/or actions to the extent they are relevant to the Adverse Action under review, such as any pertinent material contained on file in the Hospital and all other information that can be considered, pursuant to the Medical Staff Bylaws and Policies, in connection with applications for appointment or reappointment to the Medical Staff and for Clinical Privileges; provided however, that the Member under review shall be given notice of the evidence being considered prior to the hearing. The Presiding Officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by the Presiding Officer and entitled to notarize documents. The Review Panel may allow the parties to submit written statements of the matter to the Review Panel prior to the hearing, and shall permit the parties to submit a written statement at the close of the hearing. The Review Panel shall establish the deadlines and page limits associated with the submission of such written statements.

(10) **Burden of Proof.** The body whose recommendation gave rise to the request for hearing shall have the initial obligation to present evidence in support thereof. The Member shall thereafter be responsible for supporting a challenge to the recommended Adverse Action by a preponderance of the evidence that the grounds therefor lack any factual basis or that such basis or the conclusions drawn therefrom are either arbitrary, unreasonable or capricious.

(11) **Recesses and Adjournment.** The Review Panel may recess the hearing and reconvene the same, without written notice, for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Review Panel shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of its deliberations, the hearing shall be declared officially adjourned.

(12) **Review Panel Report.** Within 30 days after final adjournment, the Review Panel shall make a written report of its findings and recommendations in the matter, stating the reasons for each recommendation, and shall forward the report, together with the hearing record, all other documentation considered by the Review Panel and a description of the process for appealing the decision, to the Member and to the EXECUTIVE COMMITTEE or Board, depending upon whose recommendation gave rise to the request for hearing.

### 9.F REQUEST FOR APPELLATE REVIEW

(1) The affected Member or the EXECUTIVE COMMITTEE or Board, depending upon which body’s action gave rise to the request for hearing, may, within 7 days after the date the appealing party receives notice of the Review Panel’s recommendation, request appellate review. A request for appellate review must be in writing to the CEO and must include a statement regarding the reason(s) for the appeal. The CEO will forward the request to the chairperson of the Board. If appellate review is not requested within 7 days after the date of the notification, the
parties shall be deemed to have waived all rights to the same and the Review Panel’s recommendation shall be forwarded to the Board for final action.

(2) Upon receiving notice of request for appellate review, the Board shall, within 7 days set a date, time and place for the meeting to conduct the appellate review, and shall promptly notify the Member of the date, time and place for the review. The Member will be notified of the appellate review meeting at least fifteen (15) days prior to the date set for such meeting. The date of the appellate review shall not be less than fifteen (15) nor more than sixty (60) days from the date of receipt of the request for appellate review. However, such deadline may be extended for good cause by the Board or in agreement with the Member.

9.G PROCEDURE FOR APPELLATE REVIEW

(1) The appellate review shall be conducted before an Appellate Review Committee comprised of a committee of three (3) members of the Board selected by the Board, and one Member of the Appellate Review Committee shall be designated as Chair. The Chair shall determine the order of procedure during the appellate review, make all required rulings, and maintain decorum. The Appellate Review Committee shall have all powers granted to the Review Panel as well as such additional powers as are reasonably appropriate to discharge its responsibilities.

(2) No Member of the EXECUTIVE COMMITTEE or Board who participated on the Review Panel or the hearing on the matter in issue shall be a Member of the Appellate Review Committee, and no Member of the Appellate Review Committee may be in direct economic competition with the Member. However, knowledge of the matters under consideration do not preclude any person from serving on the Appellate Review Committee.

(3) NATURE OF PROCEEDINGS: The proceedings by the Appellate Review Committee shall be in the nature of an appellate review based upon the hearing record, the Ad Hoc hearing committee’s report, all subsequent results and action, the written statements, if any, provided at the hearing below and any other material that may be presented and accepted by the Appellate Review Committee. The proceedings shall be restricted to reviewing whether the BYLAWS were followed and whether there is substantial evidence to support the recommendations.

(4) The appealing party shall, upon written request, be afforded access to such records and documents which have been considered by the Review Panel hearing the matter. The appealing party may submit a written statement covering any matters raised at any step in the procedure to which the appeal is related. The written statement shall be submitted to the CEO for transmittal to the Appellate Review Committee and the other party by written notice at least seven (7) days prior to the appellate review meeting. The other party may also submit a written statement responding to the written statement submitted by the appealing party, and such responsive written statement shall be submitted to the CEO for transmittal to the Appellate Review Committee at least three (3) days prior to the appellate review meeting. The Chair of the Appellate Review Committee may impose page limits to any written statements submitted in appellate review.

(5) Neither party is required to personally attend the appellate review meeting. However, if the parties personally attend, the appealing party shall be afforded reasonable time for oral argument, if desired, which time shall not exceed thirty (30) minutes including questions, and in the course of the oral argument, shall be required to answer questions asked by any Member of the Appellate Review Committee. The other party shall also be permitted oral argument in favor of any adverse recommendation or decision, and shall also be required to answer questions asked by any Member of the Appellate Review Committee. The non-appealing party’s time for oral argument, if desired, shall not exceed thirty (30) minutes including questions.

(6) The parties may be represented by an attorney or one other person of their choice before the Appellate Review Committee. The Appellate Review Committee may also be represented by legal counsel to the Hospital, however, legal counsel may not influence the Appellate Review Committee’s substantive review, other than to clarify its responsibilities.
(7) The Appellate Review Committee shall review the record created in the proceedings, including the written statements submitted and the oral arguments, if any. New or additional matters or evidence not raised or presented during the original hearing and not otherwise reflected in the record may be introduced at the appellate review only in the discretion of the Appellate Review Committee and as the Appellate Review Committee deems appropriate. The party requesting consideration of the matter of evidence must show that it could not have been discovered with reasonable diligence in time of the initial hearing and that the new or additional matters or evidence would have reasonable likelihood of changing the result. The requesting party shall provide, through the CEO, a written, substantive description of any new or additional matters or evidence to the Appellate Review Committee and the other party at least ten (10) days prior to the scheduled date of the review.

(8) The Appellate Review Committee may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of oral arguments, if any, the appellate review shall be closed. The Appellate Review Committee shall then, at a time convenient to itself, conduct deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared finally adjourned.

(9) The Appellate Review Committee shall submit a written report to the Board with a recommendation that the Board affirm, modify, or reject the Review Panel’s recommendation. The Board shall then render its final decision in the matter in writing, including an explanation of the reasons for its decision. The written report will be provided to the EXECUTIVE COMMITTEE, if the EXECUTIVE COMMITTEE is the body whose recommendation resulted in the request for a hearing and to the affected Member by written notice.

(10) The Board’s decision shall be final and shall be effective immediately and not subject to further review. No Member is entitled to more than one hearing and one appellate review on any matter.

ARTICLE 10—MEDICAL STAFF LEADERS

10.A OFFICERS OF THE STAFF

The officers of the STAFF shall include:

(1) Chief of Staff
(2) Chief of Staff Elect
(3) Secretary/Treasurer
(4) Member-at-Large (Foundation Rep 1)
(5) Immediate Past Chief of Staff

10.B TERM OF OFFICE

Officers will serve two-year terms.

10.C QUALIFICATIONS

To be eligible for a leadership position, MEDICAL STAFF members must satisfy the criteria set forth in this section initially and continuously throughout their term. Exceptions may be granted to these qualification requirements if recommended by the Leadership Council and approved by the Board.

The MEDICAL STAFF member must:
(1) Be an Active STAFF member in Good Standing as defined in these Bylaws;
(2) Have no pending or past adverse actions regarding appointment or privileges;
(3) Demonstrate an ability to work well with others;
(4) Be committed to perform duties and responsibilities of the position;
(5) Have leadership experience or participation in performance improvement committees;
(6) Participate in leadership training as determined by the Leadership Council; and
(7) Disclose any conflicts of interest related to the position.

10.D NOMINATION AND ELECTION OF OFFICERS

(1) NOMINATIONS
   (a) The Leadership Council will submit a list of qualified, as outlined in Section C, candidates for each vacant position to the EXECUTIVE COMMITTEE at least 60 days prior to an election. Any voting member of the MEDICAL STAFF may submit additional nominations to the EXECUTIVE COMMITTEE at least 45 days prior to the election.
   (b) The EXECUTIVE COMMITTEE will review and determine if the candidates meet the eligibility criteria to hold a leadership position as outlined in this Section.
   (c) All eligible nominees must accept the nomination to be placed on the ballot.
   (d) No nominations will be considered after the EXECUTIVE COMMITTEE approves the ballot.
   (e) The MEDICAL STAFF will receive a list of candidates at least 30 days prior to the election.

(2) ELECTION PROCESS
   (a) The election will take place 30 days after the candidate list has been sent to the voting members of the MEDICAL STAFF for review.
   (b) The EXECUTIVE COMMITTEE will determine the method of voting which may include an electronic or written ballot.
      (i) If the EXECUTIVE COMMITTEE elects to vote at a meeting of the MEDICAL STAFF by written ballot, voting members unable to attend a meeting shall be allowed to vote by submitting an absentee ballot directly to MEDICAL STAFF office no later than noon on the day of the election. No proxy ballots will be accepted.
      (ii) If the EXECUTIVE COMMITTEE elects to vote via an electronic or written method, absent of a meeting, then ballots must be returned to the MEDICAL STAFF office by the established time and date determined by the EXECUTIVE COMMITTEE. Written ballots may be returned to the MEDICAL STAFF office by facsimile, mail, email, or other electronic means that have been authorized by the EXECUTIVE COMMITTEE.
   (c) Candidates that receive the majority of the votes cast will be elected to their position pending Board approval. If no candidate receives a majority vote on the initial ballot, a second vote will be held by the MEDICAL STAFF in which the candidate receiving the most votes will be elected.
10.E REMOVALS, RESIGNATIONS, AND VACANCIES

10.E.1 REMOVAL

(a) MEDICAL STAFF Officers and members of the EXECUTIVE COMMITTEE may be removed from their position by a three-fourths vote of the EXECUTIVE COMMITTEE, a two-thirds vote of the voting STAFF, or by the Board. Grounds for removal will be:

(i) Failure to perform the duties of the position;

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

(iii) Failure to continue to meet the qualification requirements set forth in Section C;

(iv) A medical condition that prohibits the leader from fulfilling the function of the position held; or

(v) Conduct that undermines a culture of safety or is detrimental to the MEDICAL STAFF and/or Hospital.

(b) Written notice of the meeting date in which the removal action will occur will be given to the individual at least 10 days in advance. The individual will be given the opportunity to address the EXECUTIVE COMMITTEE, the voting STAFF, or the Board (as applicable) prior to the vote of removal. Removal will become effective upon approval by the Board.

10.E.2 RESIGNATION

Any leader may resign his/her position by providing written notice to the EXECUTIVE COMMITTEE. The resignation will take effect upon the receipt of the notice, when a successor is elected, or a later date specified.

10.E.3 VACANCIES

(a) If there is a vacancy in the office of the Chief of Staff, the Chief of Staff Elect shall serve as Chief of Staff for the remainder of that term.

(b) If there is a vacancy in any other elected officer position, it shall remain vacant until a special election can be held. The Chief of Staff will determine the date of the special election but no sooner than 14 days after the vacancy occurs.

10.F DUTIES OF OFFICERS

10.F.1 CHIEF OF STAFF

The Chief of Staff will:

(a) Act in coordination with the CEO in all matters of mutual concern within the Hospital;

(b) Represent the views, policies, needs and grievances of the STAFF to Administration and the Board;

(c) Call, preside over and be responsible for the agenda of all regular and special Executive Committee and MEDICAL STAFF meetings;

(d) Serve as the Chair of the EXECUTIVE COMMITTEE, with vote if necessary, and as an ex-officio member of all other STAFF committees;

(e) Serve as the Chair of the Leadership Council;

(f) Serve as an ex officio member of the Professional Affairs-Joint Conference Committee of the Board;

(g) Serve as a signatory on the Hospital’s MEDICAL STAFF account;
(h) Serve as the spokesperson for the STAFF, or assign a designee, for all external professional and public relations;

(i) Promote adherence by the STAFF to the Bylaws, Rules and Regulations, and policies and the policies and procedures of the Hospital;

(j) Be accountable to Administration and the Board, in conjunction with the EXECUTIVE COMMITTEE, for the performance and maintenance of quality with respect to the STAFF’s delegated responsibility to provide care; and

(k) Perform all functions authorized in these Bylaws and applicable policies, including interventions regarding professional performance.

(2) **CHIEF OF STAFF ELECT**

The Chief of Staff Elect will:

(a) In absence of the Chief of Staff, assume all duties and act with full authority of the Chief of Staff;

(b) Serve as a voting member of the EXECUTIVE COMMITTEE;

(c) Serve as a member of the Leadership Council;

(d) Serve as ex officio member of the Professional Affairs-Joint Conference Committee of the Board;

(e) Perform all functions authorized in these Bylaws and applicable policies, including interventions regarding professional performance;

(f) Automatically succeed the Chief of Staff at the end of his/her term or if the office should become vacated for any reason during the Chief of Staff’s term; and

(g) Perform any duties assigned by the Chief of Staff, the EXECUTIVE COMMITTEE, or the Board.

(3) **SECRETARY/TREASURER**

The Secretary/Treasurer will:

(a) Serve as a voting member of the EXECUTIVE COMMITTEE;

(b) Serve as a member on the Leadership Council;

(c) Be a signatory of the Hospital’s MEDICAL STAFF account;

(d) Serve as an ex officio member of the Professional Affairs-Joint Conference Committee of the Board;

(e) Perform all functions authorized in these Bylaws and applicable policies, including interventions regarding professional performance; and

(f) Perform any duties assigned by the Chief of Staff, the EXECUTIVE COMMITTEE, or the Board.

(4) **MEMBER-AT-LARGE**

The member-at-large will:

(a) Serve as a voting member of the EXECUTIVE COMMITTEE;

(b) Serve as a member of the Leadership Council;

(c) Serve as an ex officio member of the Professional Affairs-Joint Conference Committee of the Board;

(d) Perform all functions authorized in these Bylaws and applicable policies, including interventions regarding professional performance; and
(e) Perform any duties assigned by the Chief of Staff, the EXECUTIVE COMMITTEE, or the Board.

(5) IMMEDIATE PAST CHIEF OF STAFF

The Immediate Past Chief of Staff will:

(a) Serve as a voting member of the EXECUTIVE COMMITTEE;

(b) Serve as a member of the Leadership Council;

(c) Serve as a mentor for the Chief of Staff and other MEDICAL STAFF Leaders;

(d) Perform all functions authorized in these Bylaws and applicable policies, including interventions regarding professional performance; and

(e) Perform any duties assigned by the Chief of Staff, the EXECUTIVE COMMITTEE, or the Board.

ARTICLE 11 - DEPARTMENTALIZATION OF THE STAFF

11.A ORGANIZATION OF DEPARTMENTS AND SECTIONS

(1) The MEDICAL STAFF shall be organized into departments and sections as follows:

(a) CLINICAL DEPARTMENTS

(i) ANESTHESIOLOGY

(ii) EMERGENCY MEDICINE

(iii) FAMILY MEDICINE

(iv) INTERNAL MEDICINE

(v) OBSTETRICS AND GYNECOLOGY

(vi) ORTHOPEDIC SURGERY

(vii) PATHOLOGY

(viii) PEDIATRICS

(ix) RADIOLOGY

(x) SURGERY

(b) SECTIONS

(i) PSYCHIATRY (of the Department of Internal Medicine)

(ii) DENTAL (of the Department of Surgery)

(iii) CARDIOLOGY (of the Department of Internal Medicine)

(2) The EXECUTIVE COMMITTEE may create, eliminate, or reorganize departments and sections if approved by the Board.

(3) The purpose of organizing the MEDICAL STAFF into departments is to:

(a) Provide a mechanism of oversight regarding the department’s quality and appropriateness of services rendered to patients;

(b) Recommend policies and procedures related to the services supplied by the department;

(c) Monitor the professional practices of department members with clinical privileges; and

(d) Provide appropriate specialty coverage for the Emergency Department and consultations as outlined in the Bylaws, Rules and Regulations, and applicable policies.
11.B ASSIGNMENT TO DEPARTMENT

Each provider appointed to the MEDICAL STAFF will be assigned to a clinical department. Assignment to a particular department does not prohibit an individual from seeking and being granted clinical privileges associated with another department. If an individual has a change in practice, the individual may request a change in his/her department assignment as appropriate.

11.C ORGANIZATION OF SECTIONS

When members within an established Department, with special clinical interests such as surgical or medical specialties, wish to be organized for the purposes of self-governance, peer review and education, they may form a Section within the Department. Each Department may contain none, one, or more than one Section. All members of a Section understand that their primary representation on the EXECUTIVE COMMITTEE is through the Department in which they are a standing member. For a Section to be formed it must complete the following:

1. Two or more members of a Department, with similar clinical interests petition the Department, in writing, of their interest in forming a Section within the Department. Along with this information the petitioners will also explain the purposes of the proposed Section.

2. If the proposal to form a Section is approved by the Department, the petition to form the Section shall be submitted to the EXECUTIVE COMMITTEE for approval. The EXECUTIVE COMMITTEE shall be the final authority which decides if a new Section of the MEDICAL STAFF will be formed.

11.D QUALIFICATIONS, SELECTION, AND TENURE OF DEPARTMENT AND SECTION CHAIRS

1. QUALIFICATIONS

   Each chair will:

   (a) Be a member of the Active STAFF and indicate a willingness to serve;

   (b) Be certified by the appropriate specialty board, or acceptable comparable competence, as determined by the credentialing process; and

   (c) Meet the eligibility for leadership outlined in Article 10, Section C.

2. SELECTION AND TENURE

   When there is a vacancy in the department or section chair position, or a new department is created, the Active STAFF of the department will elect the department or section chair.

   (a) The election will be held at the last meeting prior to the beginning of the new MEDICAL STAFF year.

   (b) Vacancies before the end of the designated term will be filled by an election of the Active STAFF members of the department or section at their next meeting and approved by the EXECUTIVE COMMITTEE and Board.

   (c) The candidate with the majority of votes will be elected. If no candidate receives a majority on the initial vote, a second vote will be held in which the candidate receiving the most votes will be elected. In the event the second vote results in a tie, the EXECUTIVE COMMITTEE will vote to determine the chair or section position.
(d) The department or section chair will serve a two-year term and may be appointed for additional terms. The term of the chair begins at the start of the new MEDICAL STAFF year.

(3) **REMOVAL**

(a) Department and Section chairs may be removed during his/her term by a three-fourths vote of the Active STAFF of the department or section, three-fourths vote of the full EXECUTIVE COMMITTEE, or by the Board. Grounds for removal will be:

(i) Failure to perform the duties of the position;

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

(iii) Failure to continue to meet the qualification requirements set forth in Article 10, Section C of these Bylaws;

(iv) A medical condition that prohibits the leader from fulfilling the function of the position held; or

(v) Conduct that undermines a culture of safety or is detrimental to the MEDICAL STAFF and/or Hospital.

(b) Before a meeting is scheduled to vote on removal, a member of the EXECUTIVE COMMITTEE, as applicable, will meet with and inform the individual of the reasons for the proposed removal. Written notice of the meeting date in which the removal action will occur will be given to the individual at least 10 days in advance. The individual will be given the opportunity to address the department or section, the EXECUTIVE COMMITTEE, or the Board, as applicable, prior to the vote of removal. Removal will become effective upon approval by the Board.

**11.E DUTIES OF THE DEPARTMENT CHAIR**

Department chairs are responsible for the following functions, either individually or in collaboration with Hospital personnel:

(1) Being accountable to the EXECUTIVE COMMITTEE for all clinically and administratively related activities of the department and/or section;

(2) Monitoring professional performance of individuals in the department who have clinical privileges, including performing ongoing and focused professional practice evaluations and performance improvement interventions.

(3) Assessing and recommending criteria for clinical privileges that are relevant to the department and/or section;

(4) Evaluating and recommending clinical privileges for members of the department

(5) Assessing and recommending to the Hospital off-site sources for needed patient care, treatment, and services not provided by the department or organization;

(6) Integrating the department or service line into the primary functions of the organization;

(7) Coordinating and integrating interdepartmental and intradepartmental services;

(8) Developing and implementing policies and procedures that guide and support the provision of care, treatment, and services;

(9) Providing recommendations regarding the sufficient number of qualified and competent persons to provide care, treatment, and services;
(10) Determining the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

(11) Continuously assessing and improving the quality of care, treatment, and services;

(12) Maintaining quality control programs, as appropriate;

(13) Orienting and providing continuing education to all persons in the department or service;

(14) Recommending space and other resources needed by the department or service;

(15) Serving as a voting member of the EXECUTIVE COMMITTEE;

(16) Promoting adherence to the MEDICAL STAFF Bylaws, Rules and Regulations, and policies and the policies and procedures of the Hospital within the department;

(17) Ensuring appropriate coverage by cooperating in the preparation of Emergency Department on-call rosters;

(18) Performing all functions authorized in these Bylaws and applicable policies; and

(19) Performing any duties assigned by the Chief of Staff or the EXECUTIVE COMMITTEE.

11.F VICE CHAIRS OF DEPARTMENTS AND SECTIONS

The qualifications, selection and tenure of a department or section Vice Chair are as stated in Section E of this Article. The Vice Chair shall assume all of the duties of the Chair in his/her absence. He or she may also perform such other duties as may be assigned to assist the Chair.

ARTICLE 12 - COMMITTEES

12.A GENERAL PROVISIONS

(1) MEDICAL STAFF COMMITTEES AND FUNCTIONS

This Article outlines the MEDICAL STAFF committees that carry out performance improvement activities, including ongoing and professional practice evaluations that are delegated to the MEDICAL STAFF by the Board.

(2) APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS

(a) The Leadership Council will appoint all committee chairs and members, unless otherwise stated. When possible, the Leadership Council will avoid appointing any member to dual service on Medical Staff or Hospital peer review or quality improvement committees. Any exception to this guideline regarding dual service must be approved by the Medical Executive Committee.

(b) Hospital and administrative representatives on the committees, will be non-voting members, and will be appointed by the CEO, unless otherwise stated.

(c) The Chief of Staff, CMO, and CEO (or his/her designee) will be ex officio members, without vote, on all committees.

(3) TENURE AND REMOVAL OF COMMITTEE CHAIRS AND MEMBERS

(a) The initial term of a committee chair and member will be two-years, but the member may be appointed for additional terms.

(b) At its discretion, the Leadership Council may remove and fill vacancies of committee chairs and members.
(4) MEETINGS, REPORTS, AND RECOMMENDATIONS

Each committee outlined in these Bylaws will meet as necessary to fulfill its functions. Committees will make a permanent record of its meetings that contain its findings, proceedings, and actions. This report will be forwarded to the EXECUTIVE COMMITTEE and other groups as applicable.

12.B THE EXECUTIVE COMMITTEE

(1) COMPOSITION

The EXECUTIVE COMMITTEE will consist of the officers and department chairs of the STAFF. Administrative ex officio members, without vote, will be the CEO, CMO, and the Chief Nursing Officer (CNO). Other individuals or groups may be invited as guests, without vote, to an EXECUTIVE COMMITTEE meeting to assist in discussion on agenda items. Guests will remain for the designated topic discussion only and will be excused for the remainder of the meeting. All individuals who participate in the EXECUTIVE COMMITTEE meetings, as a standing or ex officio member, or as a guest, are bound to confidentiality requirements. The EXECUTIVE COMMITTEE shall be divided into members who attend open EXECUTIVE COMMITTEE meetings, and members who may attend both open and closed sessions of the EXECUTIVE COMMITTEE. The officers of the STAFF, the CEO, and CMO are the only members who are permitted to attend closed sessions of the EXECUTIVE COMMITTEE, unless ad-hoc members are invited to such closed sessions of the EXECUTIVE COMMITTEE as described below. The Chief of Staff shall be the Chair of all meetings.

(2) DUTIES OF THE EXECUTIVE COMMITTEE

The EXECUTIVE COMMITTEE is delegated the primary authority over activities related to the functions of the MEDICAL STAFF and for performance improvement of the professional services provided by individuals with clinical privileges. This authority may be removed by amending these Bylaws and related policies. The duties of the EXECUTIVE COMMITTEE shall include:

(a) representing and acting on behalf of the MEDICAL STAFF in the intervals between MEDICAL STAFF meetings (the officers are empowered to act in urgent situations between EXECUTIVE COMMITTEE meetings);

(b) recommending directly to the Board on at least the following:

   (i) the membership of the MEDICAL STAFF;
   (ii) the structure of the MEDICAL STAFF;
   (iii) the process for review of credentials and delineation of individual clinical privileges and scope of practice;
   (iv) applications for MEDICAL STAFF appointment and reappointment;
   (v) delineation of clinical privileges and scope of practice for each individual who meets eligibility criteria;
   (vi) the process by which MEDICAL STAFF appointment may be terminated;
   (vii) hearing procedures;
   (viii) activities related to patient safety;
(ix) quality indicators to promote uniformity regarding patient care services;

(x) participation of MEDICAL STAFF in Hospital performance improvement activities and the quality of professional services being provided by the MEDICAL STAFF;

(xi) the process of analyzing and improving patient satisfaction; and

(xii) reports and recommendations from MEDICAL STAFF committees, departments, and other groups, as appropriate;

(c) providing oversight and guidance with respect to continuing medical education activities;

(d) consulting with administration on quality-related aspects of contracts for patient care services;

(e) reviewing and approving all standing orders for consistency with nationally recognized and evidence-based guidelines;

(f) providing liaison among the MEDICAL STAFF, Administration, and the Board;

(g) performing any other functions as are assigned to it by these Bylaws or other applicable policies; and

(h) ensuring the Bylaws, Rules and Regulations, policies, and associated documents of the MEDICAL STAFF are reviewed, at least every five years, and updated as needed.

(3) CLOSED EXECUTIVE SESSION

All matters requiring peer review protection, including but not limited to all credentialing matters, will be held in a closed executive session. The EXECUTIVE COMMITTEE will receive a report of the closed executive session findings or actions. The Leadership Council may invite ad-hoc members to the closed executive session as needed per the agenda.

(4) MEETINGS

The EXECUTIVE COMMITTEE will meet monthly and will maintain a permanent record of its proceedings and actions.

12.C STANDING COMMITTEES

(1) CREATION OF STANDING COMMITTEES

The EXECUTIVE COMMITTEE may, upon approval of the Board and without amendment of these Bylaws, establish additional committees to perform one or more STAFF functions. In the same manner, the EXECUTIVE COMMITTEE may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish MEDICAL STAFF functions. Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special committee will be performed by the EXECUTIVE COMMITTEE.

(2) SPECIAL COMMITTEES

The EXECUTIVE COMMITTEE may create special committees for a specific purpose as needed. The chair and members of the committee will be appointed by the Chief of Staff and/or the EXECUTIVE COMMITTEE. Special Committees will report to the EXECUTIVE COMMITTEE its findings, proceedings, recommendations, and/or actions based on the nature of the committee’s function.

(3) BYLAWS COMMITTEE

(a) COMPOSITION: The Bylaws Committee shall be composed of the chair, the Secretary/Treasurer, and at least three (3) other members of the STAFF.
(b) DUTIES: The Bylaws Committee shall be responsible for a continuing review of the BYLAWS and Rules and Regulations of the STAFF, and for making recommendations relating to their revision and updating.

(4) PEER REVIEW COMMITTEE (PRC)

(a) COMPOSITION: Each Department, which may be the subject of peer review by this Committee, shall have the opportunity to have a voting member on the PRC. The PRC shall be composed of Active members of the STAFF in GOOD STANDING. PRC membership shall consist of at least seven (7) voting members of the STAFF along with the CMO as a non-voting, ex-officio member. Officers of the STAFF should not serve on this committee unless approved by the Medical Executive Committee.

(b) DUTIES: The duties and responsibilities of the PRC shall be as delineated in the current FMH MEDICAL STAFF approved Peer Review Policy.

(5) CREDENTIALS COMMITTEE

(a) COMPOSITION: The Credentials Committee shall consist of a minimum of five (5) members of the Active STAFF in GOOD STANDING. Officers of the STAFF may not serve on this committee.

(b) DUTIES: The duties of the Credentials Committee shall be:

(i) to thoroughly and objectively review the credentials of all applicants for membership, all applicants for reclassification of category or change in PRIVILEGES, and, on a biennial basis, all membership renewals;

(ii) to make recommendations to the EXECUTIVE COMMITTEE, based on such reviews, and considering the recommendations of the department or sections, for the designation of category, the granting of PRIVILEGES, and the assignment of applicants and members to the various departments and sections as provided in Articles 5 and 6 of these BYLAWS; and

(iii) to conduct any professional review procedure on any matter referred to it by the EXECUTIVE COMMITTEE.

(6) MEDICAL STAFF WELLNESS COMMITTEE

(a) COMPOSITION: The MEDICAL STAFF Wellness Committee shall be comprised of no less than three Active MEDICAL STAFF members in GOOD STANDING, a majority of which, including the chair, shall be PHYSICIANS. Members of this committee shall not serve as active participants on any MEDICAL STAFF or HOSPITAL peer review or quality management, assessment and improvement committees while actively involved in a matter referred to this committee.

(b) DUTIES:

(i) Evaluation. To assist members referred to this Committee and thereby further the quality and safety of patient care, the MEDICAL STAFF Wellness Committee may receive reports related to the health, well-being, or perceived impairment of individual MEDICAL STAFF members and, as it deems appropriate, shall evaluate the veracity of such reports, gather additional data and make recommendations regarding such reports to the EXECUTIVE COMMITTEE. The Committee shall also facilitate self-referral by MEDICAL STAFF members seeking assistance with known or suspected physical, mental or emotional impairment. The Committee may refer the member to appropriate sources of treatment and assistance.

(ii) Monitoring. With respect to matters involving individual MEDICAL STAFF members, the Committee shall, as it may deem appropriate, provide advice, counseling, or monitoring, or coordinate services
with outside treatment and assistance sources. Such activities shall be confidential; however, in the event information received by the Committee clearly demonstrates that the health or known impairment of a MEDICAL STAFF member poses an unreasonable risk of harm to hospitalized patients, or that the member is refusing to obtain assistance or failing to comply with treatment or assistance plans, that information may be referred for corrective action.

(iii) Education. The Committee shall also consider general matters related to the health and well-being of the MEDICAL STAFF and HOSPITAL staff, and, with the approval of the EXECUTIVE COMMITTEE, and in collaboration with the HOSPITAL Education department, develop educational programs on recognizing behavioral problems, illness and impairment in healthcare professionals. The Committee may also develop recommendations for the EXECUTIVE COMMITTEE regarding assisting MEDICAL STAFF members with their health-related problems.

(7) INFECTION PREVENTION COMMITTEE

(a) COMPOSITION: The Infection Prevention Committee shall be a joint MEDICAL STAFF and Hospital Committee. It shall consist of at least 3 members of the MEDICAL STAFF, one of whom is a member of one of the Surgical Departments. This Committee shall be co-chaired by a member of the STAFF as appointed by the Leadership Council and a HOSPITAL employee as appointed by the CEO.

(b) DUTIES: The duties of the Infection Prevention Committee shall be to develop and monitor a Hospital-wide infection control program as defined in the Infection Prevention Plan currently in use at Fairbanks Memorial Hospital.

(8) BIOETHICS COMMITTEE

(a) COMPOSITION: The Bioethics Committee shall consist of physicians and such other staff as the Medical Executive Committee may deem appropriate. It may include a palliative care provider, nurses, lay representatives, social workers, clergy, ethicists, attorneys, administration and board members. The Chair of the Committee shall be a member of the Active STAFF in GOOD STANDING appointed by the Leadership Council.

(b) DUTIES: The Bioethics Committee at the HOSPITAL provides recommendations relating to ethical dilemmas that may arise during the provision of care. The Bioethics Committee is an interdisciplinary group that offers consultative services for ethical issues, questions, or dilemmas related to patient care, and is available to consult with families, patients, health care professionals, and HOSPITAL employees desiring assistance with ethical decision making. Additional duties of this Committee may include:

(i) participating in development of guidelines for consideration of cases having bioethical implications;

(ii) developing and implementing procedures for the review of such cases;

(iii) developing and/or reviewing institutional policies regarding care and treatment of such cases;

(iv) retrospectively reviewing cases for the evaluation of bioethical policies;

(v) consulting with concerned parties to facilitate communication and aid conflict resolution; and

(vi) educating the HOSPITAL staff and MEDICAL STAFF on bioethical matters.

(9) JOINT CONFERENCE COMMITTEE

(a) COMPOSITION: The Joint Conference Committee shall be composed of the EXECUTIVE COMMITTEE of the MEDICAL STAFF, representing the STAFF, representatives of the BOARD, representing the BOARD and the HOSPITAL CEO. It shall meet annually or more often if necessary.

(b) DUTIES: The Joint Conference Committee shall:
(i) provide medical-administrative liaison between the STAFF, the BOARD, and the CEO;
(ii) conduct itself as a forum for discussion of items of mutual interest and concern, especially those pertaining to patient care; and
(iii) act as a conflict resolution committee as defined in Article 14.

(c) RELATIONSHIP TO GOVERNING BODY: Subject to its ultimate authority, the Board of Directors of Foundation Health or its successors shall have a duty to rely on the output of this Committee in medical administrative matters not reserved to be the responsibility of the MEDICAL STAFF (see Preamble). This reliance shall be exercised in a manner similar to the BOARD’s reliance on the MEDICAL STAFF’s recommendations in those areas in which clinical judgment, evaluation of professional competence, and ethical conduct are involved.

(10) PHARMACY AND THERAPEUTICS COMMITTEE

(a) COMPOSITION: This committee shall consist of at least five (5) members of the STAFF, the Pharmacy Director or his/her designee, and an ex-officio member from Nursing Administration.

(b) DUTIES: The duties of the Pharmacy and Therapeutics Committee shall include:

(i) assisting in the formation of professional practices, policies, and criteria regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the HOSPITAL, including antibiotic usage, in order that the quality of medical care provided in the HOSPITAL may be improved;

(ii) advising the STAFF and the pharmaceutical service on matters pertaining to the choice of available drugs;

(iii) making recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

(iv) periodically developing and reviewing a formulary or drug list for use in the HOSPITAL;

(v) evaluating clinical data concerning new drugs or preparations requested for use in the HOSPITAL;

(vi) establishing standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;

(vii) reviewing drug reactions;

(viii) reviewing and approving a manual of policies and procedures for the HOSPITAL pharmaceutical service; and

(ix) making recommendations to the CEO regarding other matters pertaining to the Pharmacy Department.

(11) QUALITY IMPROVEMENT COMMITTEE

(a) COMPOSITION: The Quality Improvement Committee shall consist of at least one member of each clinical department, all of whom are voting members, and may also include such administrative members, appointed jointly by the Leadership Council and the CEO.

(b) DUTIES: The Quality Improvement Committee shall perform the following performance improvement functions or shall delegate them to the appropriate department(s) or committees:

(i) Monitor and evaluate the quality and appropriateness of patient care, the clinical performance of all individuals with CLINICAL PRIVILEGES and the quality of the documentation in the medical record.

(ii) Measure, assess and improve MEDICAL STAFF processes related to:
- Cases referred by Peer Review Committee for system issues
- Code Blue
- Core Measures
- Documentation
- Falls
- Infection Prevention
- Medication management / Pharmacy & Therapeutics
- Moderate Sedation
- Morbidity and Mortality Data
- Ongoing Professional Performance Evaluation (OPPE)
- Operative and other procedures
- Restraints
- Resuscitation and its outcomes
- Sentinel Events / Patient Safety Data
- The use of developed criteria for autopsy
- Thermal Injuries
- Use of blood and blood components
- Utilization Management

(iii) Review and assess sentinel event and patient safety data and monitor actions taken.

(iv) Establish objective criteria for screening that reflects current knowledge in clinical experience. Criteria shall be developed by each department and approved by the EXECUTIVE COMMITTEE.

(v) Communicate information among departments when problems or opportunities to improve patient care involve more than one department and track the status of identified problems to assure improvements or resolutions.

(vi) Utilization Review: Evaluate the medical necessity of continued HOSPITAL services for selected patients and conduct reviews of admission or continued stay denials, when appropriate;

(vii) Medical Records:

1. Assure that documentation in the medical record by the MEDICAL STAFF contains sufficient information to:
   - identify the patient;
   - support the diagnosis/condition and justify the care, treatment, and services;
   - document the course and results of care treatment and services; and
   - promote continuity of care among providers.

2. Review and make recommendations on all forms to be used in the medical record requiring PHYSICIAN signature;

(viii) Make recommendations to departments and sections, the EXECUTIVE COMMITTEE and Administration regarding corrective action in matters pertaining to records.

ARTICLE 13 - STAFF MEETINGS

13.A MEETINGS OF THE MEDICAL STAFF
(1) The MEDICAL STAFF shall hold at least quarterly meetings for the purpose of updating members on department and committee reports and recommendations; electing MEDICAL STAFF Officers and department chairs, if necessary; and or acting on any other matters placed on the agenda by the Chief of Staff.

(2) The meeting date, time, and location shall be determined by the Chief of Staff.

(3) Special meetings of the MEDICAL STAFF may be called by the Chief of Staff, the CMO, the MEC, or by a petition signed by at least 25% of the voting STAFF.

13.B DEPARTMENT AND COMMITTEE MEETINGS

(1) Each department and committee will meet as often as necessary to accomplish their functions, at times set by the chair.

(2) Special meetings of any department or committee may be called by or at the request of the Chair, the Chief of Staff, the MEC, or by a petition signed by not less than 25% of the voting STAFF members of the department or committee (but not fewer than three members).

13.C PROVISIONS COMMON TO ALL MEETINGS

(1) PREROGATIVES OF THE CHAIR

(a) The Chair of a MEDICAL STAFF, department, or committee meeting is responsible for:

(i) setting the agenda of the meeting;

(ii) determining the meeting format, which may include telephone or video conference options; and

(iii) using his/her authority to rule definitely on all matters of procedures. Robert’s Rules of Order may be used for reference at the Chair’s discretion, however it will not be binding. Specific provisions of these Bylaws and MEDICAL STAFF, department, and committee custom will prevail at all meetings and elections.

(2) NOTICE OF MEETINGS

(a) MEDICAL STAFF will be given advance notice of all regular meetings of the MEDICAL STAFF and regular meetings of departments and committees. At least two weeks prior to the meetings, notice may be provided via written and/or electronic communication and shall contain the date, time, and place of the meeting.

(b) When a special meeting of the MEDICAL STAFF, a department, or a committee is called, the notice period will be reduced to 48 hours (i.e., must be given at least 48 hours prior to the special meeting). Furthermore, posted written communication may not be the sole means for notification of a special meeting.

(c) Attendance of an individual at a meeting will constitute a relinquishment of that individual’s objection to the notice given for the meeting.

(3) QUORUM AND VOTING

(a) The voting members present, but not less than three, at the meeting will constitute a quorum for all regular or special meetings of the MEDICAL STAFF, departments, or committees. Exceptions to this general rule are as follows:

(i) For meetings of the MEC, Credentials Committee, and Peer Review Committee, the presence of at least 50% of the voting members of the committee will constitute a quorum; and
(ii) For amendments to these MEDICAL STAFF Bylaws, at least 25% of the voting STAFF will constitute a quorum.

(b) MEDICAL STAFF, department, and committee recommendations and actions will be by consensus. In the event a vote is necessary on an issue, a majority of the votes cast by the eligible members present will determine the outcome.

(c) Alternative methods for voting may be used, at the discretion of the Chair, for matters requiring a vote. The MEDICAL STAFF, department, or committee may be presented with a question by mail, facsimile, e-mail, hand delivery, telephone, or other technology approved by the Chair. Voting members must return their vote by the method designated in the notice. A quorum when using an alternative voting method will be the number of responses returned by the date indicated (but not fewer than three) with the exception of amendments to these Bylaws and actions by the MEC, the Credentials Committee, and the Peer Review Committee (as noted in (a)). The question raised will be determined in the affirmative and will be binding if a majority of the responses returned has so indicated.

(4) MINUTES, REPORTS, AND RECOMMENDATION

(a) All meetings of the MEDICAL STAFF, departments, and committees will have Minutes prepared that include the attendance of members, recommendations made, and the votes taken on each issue. The Chair will authenticate the minutes of the meeting.

(b) The MEC shall receive a summary of all recommendations and actions of the MEDICAL STAFF, departments, and committees and shall keep the Board apprised of such.

(5) CONFIDENTIALITY

Business conducted by the MEDICAL STAFF, and its departments or committees, is considered confidential and proprietary and should be treated as such. Furthermore, members of the MEDICAL STAFF who have access to, or are the subject of, professional review activities including credentialing and/or peer review information understand that this information is subject to heightened sensitivity and, as such, agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by these Bylaws, or applicable MEDICAL STAFF or Hospital policy. A breach of confidentiality with regard to any MEDICAL STAFF information may result in the imposition of disciplinary action.

(6) ATTENDANCE REQUIREMENTS

(a) Each Active STAFF member is expected to attend and participate in all MEDICAL STAFF meetings and applicable department and committee meetings each year. Attendance may be in person or via electronic means as long as real-time audio allows for interaction with meeting members.

(b) Members of the Active STAFF are required to attend at least 25% of department and committee meetings during each two-year reappointment cycle. Meetings, for this purpose, include all regular and special meetings of the MEDICAL STAFF, department, or committees.

(c) Failure to meet this attendance requirement will not constitute grounds for non-reappointment to the STAFF. However, failure to meet this attendance requirement will result in a fine of One Hundred Dollars ($100), payable to the Hospital MEDICAL STAFF account. Any reappointment application will be considered incomplete and will not be processed unless the applicant is current with respect to the payment of any fines. Excuses will not be considered when compliance with this attendance requirement is reviewed.

(D) Attendance at any meeting in which a member has been given notice that his/her attendance is mandatory requires the member attend in order to avoid potential corrective action. Medical Staff leaders may be willing to postpone or reschedule a meeting if the required Staff member puts in a written request, with explanation, regarding the need to change the established meeting time and/or date.
ARTICLE 14 - CONFLICT RESOLUTION

14.A APPLICABILITY

This Article shall apply in the following circumstances:

(1) When the STAFF and the GOVERNING BOARD (the “Parties”) are unable to agree on any issue of mutual interest and concern except those issues which fall within the purview of Article 8 and Article 9 of these BYLAWS. By adopting or approving these BYLAWS, the STAFF and the GOVERNING BODY are deemed to agree to follow the procedures set forth in this Article in an attempt to resolve disputed matters prior to initiating any court action.

(2) When a conflict arises between the EXECUTIVE COMMITTEE and the STAFF regarding a proposed or adopted rule or policy, or other issue of significance to the STAFF.

14.B IMPLEMENTATION

Whenever disagreement exists between the STAFF and the GOVERNING BOARD as to any issue described in Section A above, either the Chief of Staff, the CEO shall be entitled to refer the matter to the Joint Conference Committee for discussion and interaction. Such referral shall be accomplished by the delivery of a written request to each of the three parties for a meeting of the Joint Conference Committee.

When a disagreement exists between the EXECUTIVE COMMITTEE and the STAFF, the conflict management process under Section E of this Article shall be followed.

14.C GENERAL PROCESS DEFINITIONS

(1) The time limitations of individual steps in the conflict resolution process may be extended only with the unanimous written agreement of the involved parties. The entire process as defined in this Article shall not exceed six (6) months’ duration. After that period of time, the conflict is considered unresolved.

(2) The STAFF and the GOVERNING BOARD shall each have one vote. All decisions, including the selection of the mediator or arbitrator(s), made by the Joint Conference Committee requires a majority vote.

(3) No statement made or action taken in connection with the Joint Conference Committee’s proceedings or any mediation shall be admissible in any court action.

14.D JOINT CONFERENCE COMMITTEE ACTIONS

(1) INITIAL EFFORT TO RESOLVE DISPUTE. Upon the referral of any matter to the Joint Conference Committee, the Committee shall meet at least once each week until the issue is resolved, but not longer than three (3) weeks, and shall make a good faith effort to resolve the dispute. If the issue is resolved by vote of the Joint Conference Committee, a written statement of the resolution shall be issued by the Committee to the GOVERNING BOARD Joint Conference Committee for approval.
(2) **MEDIATION.** In the event the Joint Conference Committee is unable to reach a resolution of the dispute during its initial three week effort, the parties shall each designate a representative to enter into mediation.

The representatives shall choose a qualified, neutral mediator, who shall meet with them in order to assist in developing options and formulating alternatives for resolving the issue. The mediation process shall be conducted promptly and in good faith, over a period not to exceed three (3) weeks. The representatives may also meet, without the mediator, in an effort to reach a resolution of the dispute which is agreeable to each side. If the mediation process results in a proposed resolution acceptable to the Joint Conference Committee, the proposed resolution shall be reduced to writing by the Joint Conference Committee and submitted to all parties and the GOVERNING BOARD Joint Conference Committee for final approval.

(3) **COST OF MEDIATION.** The cost and expenses of the mediator and/or arbitrator shall be borne by the HOSPITAL.

14.E **EXECUTIVE COMMITTEE AND STAFF CONFLICT MANAGEMENT**

(1) In the event of conflict between the EXECUTIVE COMMITTEE and the STAFF (as represented by written petition signed by at least twenty-five (25) members of the Active STAFF) regarding a proposed or adopted rule or policy, or other issue of significance to the STAFF, the Chief of Staff shall convene a meeting with the petitioners’ representative(s).

(2) The foregoing petition shall clearly state the basis of the disagreement and include a designation of up to five Active members of the STAFF who shall serve as the petitioners’ representative(s). The EXECUTIVE COMMITTEE shall be represented by an equal number of EXECUTIVE COMMITTEE members appointed by the Chief of Staff. Such EXECUTIVE COMMITTEE members shall not be a party to the petition.

(3) The EXECUTIVE COMMITTEE’s and the petitioners’ representative(s) shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the STAFF, the leadership responsibilities of the EXECUTIVE COMMITTEE, and the safety and quality of patient care at the HOSPITAL. Resolution at this level requires a majority vote of the EXECUTIVE COMMITTEE’s representatives at the meeting and a majority vote of the petitioners’ representative(s).

(4) If the EXECUTIVE COMMITTEE and the petitioners’ representative(s) are able to resolve the conflict, the resolution shall be submitted to the Active members of the STAFF. If the Active members of the STAFF approve the proposed resolution, the proposal will be forwarded to the GOVERNING BOARD for its review and consideration.

(5) Should the EXECUTIVE COMMITTEE and the petitioners’ representative(s) fail to reach resolution, or the Active members of the STAFF do not approve the resolution, the petition and all relative material shall be submitted to the GOVERNING BOARD for its review and consideration. The decision of the GOVERNING BOARD shall be final and shall not serve as a basis for conflict resolution as described under Sections C and D of this Article.

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ARTICLE 15 – CHIEF MEDICAL OFFICER

5.A **APPOINTMENT**

The Chief Medical Officer must be eligible to be a member of the MEDICAL STAFF. The position will be appointed by, and report to, the CEO of the Hospital.

5.B **DUTIES**

The CMO will perform such duties and functions as may be delegated from time to time by the CEO, which may include but not be limited to the following:
(1) Assisting the CEO in the implementation of the hospital’s performance improvement program;
(2) Serving as an ex officio, non-voting, member of all departments and MEDICAL STAFF committees;
(3) Serving as an advisor to the MEDICAL STAFF and the Chief of Staff regarding matters arising related to the MEDICAL STAFF Bylaws, Rules and Regulation, and applicable policies.
(4) Acting as the liaison between Administration and the MEDICAL STAFF, as well as a liaison between the Board and the MEDICAL STAFF;
(5) Assisting MEDICAL STAFF Leaders, including officers, and department and committee chairs, in the performance of their duties;
(6) Supervising MEDICAL STAFF library resources;
(7) Acting as the Hospital’s medical liaison, after consultation with the CEO, to local, state and federal agencies
(8) Performing functions authorized in all applicable policies, including the collegial intervention steps;
(9) Assisting the CEO as the liaison to hospital-based physicians; and
(10) Assisting in maintaining hospital accreditation.

ARTICLE 16 - IMMUNITY FROM LIABILITY AND INDEMNIFICATION

(1) Immunity from Liability. Any member of the MEDICAL STAFF shall be entitled to immunity from liability as set forth in Appendix D of these BYLAWS.
(2) Indemnification. Any member of the MEDICAL STAFF shall be entitled to legal defense and indemnification as set forth in Appendix D of these BYLAWS.

ARTICLE 17 – AMENDMENTS

17.A GENERAL

Neither the MEC, the MEDICAL STAFF, nor the Board will unilaterally amend these Bylaws.

17.B PROCESS FOR SUBMITTING AND PRESENTING PROPOSED BYLAWS AMENDMENTS

(1) Amendments to these Bylaws may be proposed by the MEC or a petition signed by at least 25% of the voting members of the MEDICAL STAFF.
(2) The MEC must review any proposed amendments prior to a vote by the MEDICAL STAFF. Notice of proposed amendments, after incorporating such changes as may have been agreed upon by the MEC if the amendment was submitted by the MEDICAL STAFF, shall be distributed to the MEDICAL STAFF for review at least 14 days prior to a vote.

17.C PROCESS OF ADOPTING PROPOSED BYLAWS AMENDMENTS

(1) The MEC will determine the method of voting on proposed amendments by the MEDICAL STAFF, which may include at a meeting of the MEDICAL STAFF or through use of alternative methods.
(a) Prior to any meeting, where proposed amendments may be voted upon, the MEDICAL STAFF will be given notice of the meeting details, including the date and time as determined by the MEC. At the meeting of the MEDICAL STAFF, or a special meeting called specifically for such purpose, the MEC shall state its position regarding the proposed amendments. For a proposed amendment to be passed, the amendment must receive the majority of votes cast by at least 25% of the voting STAFF present at the meeting.

(b) The MEC may elect to present proposed amendments to the MEDICAL STAFF using alternative methods such as written or electronic ballots. In these instances, ballots must be returned to the MEDICAL STAFF office by the date indicated by the MEC. Along with the proposed amendments, the MEC may provide a written statement of their position, favorably or unfavorably. For a proposed amendment to be adopted, an amendment must receive a majority of the votes cast, so long as the applicable quorum requirement is met.

(2) If an amendment is adopted by the MEDICAL STAFF, the amendments will be effective only after approval by the Board.

(3) If the Board determines to not accept a recommendation submitted to it by the MEC or the MEDICAL STAFF, this will be resolved using the conflict resolution process outlined in Article 14 of these BYLAWS.

(4) The MEC will have the authority to adopt revisions to these Bylaws and Appendices that are required because of reorganization, renumbering, or punctuation, spelling, or other errors of grammar and are technical, non-substantive amendments.

ARTICLE 18 – OTHER MEDICAL STAFF DOCUMENTS

18.A GENERAL

The MEDICAL STAFF shall maintain Rules and Regulations, policies, and procedures that are applicable to members of the STAFF and those providers who have been granted clinical privileges or scope of practice by the Board.

18.B AMENDMENTS TO THE MEDICAL STAFF RULES AND REGULATIONS

(1) Amendments to the MEDICAL STAFF Rules and Regulations may be proposed by the MEC or voting members of the MEDICAL STAFF.

(a) Proposed amendments by the MEC may be made at any meeting in which a quorum is met and by a majority vote of members present.

(b) Proposed amendments by the MEDICAL STAFF may be made by submitting a petition signed by at least 25% of the voting STAFF to the MEC.

(2) The MEC must review any proposed amendments prior to a vote by the MEDICAL STAFF. Notice of proposed amendments to the Rules and Regulations, after incorporating such changes as may have been agreed upon by the MEC if the amendment was submitted by the MEDICAL STAFF, shall be distributed to the MEDICAL STAFF for review at least 14 days prior to a vote.

(3) The process for adopting proposed amendments to the Rules and Regulations are set forth in Article 17, Section C of these Bylaws.

(4) The MEC and the Board may adopt such provisional urgent amendments to the Rules and Regulations that are deemed necessary for legal or regulatory compliance, without providing prior notice of the proposed amendments to the MEDICAL STAFF. After adoption, these provisional amendments to the Rules and Regulations will be communicated each member of the MEDICAL STAFF for their review. The MEDICAL STAFF will have 30 days
to provide comments on the provisional amendments to the MEC. If the STAFF approves of the provisional amendment, the amendment shall stand. If the STAFF does not approve of the provisional amendment, this will be resolved using the conflict resolution process as outlined in Article 14 of these BYLAWS.

18.C AMENDMENTS TO MEDICAL STAFF POLICIES AND PROCEDURES

(1) Other policies of the MEDICAL STAFF may be adopted and amended by a majority vote of the MEC. No prior notice is required.

(2) Any amendment or revision to the MEDICAL STAFF Rules and Regulations and other MEDICAL STAFF policies will become effective only when approved by the Board.

18.D NOTIFICATION OF AMENDMENTS TO MEDICAL STAFF DOCUMENTS

The MEDICAL STAFF will be informed of any amendments or revisions to the MEDICAL STAFF Rules and Regulations, policies, and procedures in a timely manner. The amended documents shall be available in electronic form to all members of the MEDICAL STAFF and providers who hold clinical privileges or scope of practice granted by the Board.

ARTICLE 19 - ADOPTION AND IMPLEMENTATION OF BYLAWS

Once adopted as provided in Article 17 at any regular or special meeting of the Active MEDICAL STAFF, these BYLAWS, together with the appended Rules and Regulations, shall replace any previous BYLAWS, Rules and Regulations, and shall become effective when approved by the BOARD. The BYLAWS shall, when adopted and approved, be equally binding on the MEDICAL STAFF, the HOSPITAL, and their successors in interest. The HOSPITAL’S affiliation with other hospitals, health care systems or similar entities shall not in and of itself affect these BYLAWS.

______________________________
Chief of Staff - Terry Conklin, M.D.

______________________________
Secretary/Treasurer – Jessica Panko, M.D.

APPROVED BY THE GOVERNING BODY ON:

______________________________
Foundation Health Partners
APPENDIX A – BASSETT ARMY COMMUNITY HOSPITAL RESOURCE SHARING AGREEMENT
Complete copy on file in the Medical Staff Office

APPENDIX B – RESOURCE SHARING AGREEMENT BETWEEN EIELSON'S 354TH MEDICAL GROUP, FAIRBANKS MEMORIAL HOSPITAL AND THE MEDICAL STAFF OF FAIRBANKS MEMORIAL HOSPITAL
Complete copy on file in the Medical Staff Office

APPENDIX C - RULES AND REGULATIONS

1. STAFF PRIVILEGES

A. Medical Staff

Initial Applications for Appointment

Each application for MEDICAL STAFF appointment to Fairbanks Memorial Hospital must be accompanied by an application fee outlined in the MS-06 Credentialing, Initial Appointment and Renewal Policy. This requirement applies to the categories of Active staff, Courtesy staff, Consulting staff, Community-Based and Temporary (such as locum tenens privileges).

Initial applications for Advanced Practice Providers must be accompanied by an application fee equivalent to one-half the MEDICAL STAFF application fee.

Biennial Renewal

Each application for biennial membership renewal to the MEDICAL STAFF of Fairbanks Memorial Hospital must be accompanied by an application fee as outlined in the MS-06 Credentialing, Initial Appointment and Renewal Policy. This applies to Active, Courtesy, Consulting and Community-Based STAFF. Advanced Practice Providers’ membership renewal fees shall be equivalent to one-half the MEDICAL STAFF renewal fee.

All fees collected from initial and biennial reappointment to the MEDICAL STAFF shall be promptly deposited in the MEDICAL STAFF hospital account. The Secretary-Treasurer of the MEDICAL STAFF will report quarterly on the status of this account, and all disbursement of these funds are subject to the approval of the MEDICAL STAFF Executive Committee.

Fifty percent (50%) of collected fees will be designated for educational expenses. The Chief of Staff may authorize the use of up to a maximum of $100 per month (non-accumulative) for miscellaneous expenses. Any expenditure above that amount will require approval of the Executive Committee.
Ethical Practice. In signing the pledge to abide by the MEDICAL STAFF Bylaws, each applicant for STAFF membership is committed to the ethical practice of his/her profession. This includes, but is not limited to:

1. Refraining from fee splitting or other inducements relating to patient referral.
2. Providing for continuous care of his/her patients.
3. Refraining from delegating the responsibility for diagnosis or care of hospitalized patients to a medical or dental practitioner who is not qualified to undertake this responsibility and who is not adequately supervised.
4. Seeking consultation whenever necessary.
5. Refraining from providing “ghost” surgical and medical services

Primary Responsibility for Care. Every patient will have a physician primarily responsible for their care. Only physicians who have been duly appointed to membership on the MEDICAL and have been granted clinical privileges may be primarily responsible for the care of a patient.

The admitting physician shall be the patient’s primary physician unless he/she appoints another physician in the orders.

Physicians taking call in the emergency room shall do an emergency room workup on the patient through the use of medical record. The emergency room physician is to advise the patient’s physician as soon as possible of the patient’s admission and if the physician cannot be notified, the emergency room physician is responsible for the patient’s care until such time that the patient’s physician can be informed of the patient’s admission.

When the patient returns from surgery, the physician writing the post-op orders shall be the primary physician unless he/she designates another physician.

In the event several physicians write post-op orders, the general surgeon shall be considered the primary physician.

If confusion persists as to who the primary physician is despite the above guidelines, the unit nurse shall contact the physicians concerned and request that they specifically designate a primary physician.

The attending practitioner or his/her designee must see the inpatient at least once every twenty-four (24) hours until the patient is discharged from the hospital, unless the physician has made the decision, and documented the decision in the chart, that the patient is stable enough to be transferred to a less acute setting.

Continuing Education. All members of the MEDICAL STAFF will be required to participate in continuing education. Requirements shall be in accordance with those established by the State Board of Medical Examiners.

Impaired STAFF. If an incident occurs that is thought by a professional to be due to impairment of a STAFF member’s judgment by disease, drugs or alcohol, following appropriate notification, a written report shall be made of the incident and submitted to the Chief of Staff or his/her designee (or, in their absence, the chief of the clinical department or his/her designee) or the CEO. Within one working day of receipt of said report, the Chief of Staff or his/her designee shall interview the STAFF member involved in the incident and immediately take whatever action is thought appropriate. This action may include, but is not restricted to, referral to the MEDICAL STAFF Wellness Committee, further investigation, reprimand, or suspension as outlined in the Bylaws. The Chief of Staff then must report the action taken at the next regular Executive Committee meeting.
B. Advanced Practice Providers

In the hospital, Advanced Practice Providers may exercise only those privileges within the scope of practice authorized by the Board upon recommendation of the MEDICAL STAFF. The clinical privileges extended to Advanced Practice Providers shall be dependent on the practitioner’s experience, training, and demonstrated competence as verified during the credentialing and privileging process, in addition to the ongoing monitoring of professional performance by the MEDICAL STAFF and HOSPITAL. Advanced Practice Professionals must adhere to all requirements and responsibilities set forth in the Allied Health Policy, Medical Staff Bylaws, Rules and Regulations, and applicable Medical Staff and Hospital policies, procedures, protocols or guidelines.

2. DEPARTMENTS AND COMMITTEES OF THE MEDICAL STAFF

A. It is the intent that Active STAFF membership carries with it committee assignments and every attempt shall be made to equalize committee membership among the STAFF.

B. A member who wishes to change from one department to another shall channel his/her request through the Credentials Committee for referral to the department involved.

C. The meetings of the MEDICAL STAFF shall be held as provided in Article 13 of the Bylaws.

D. The MEDICAL STAFF discussions at general staff meetings, department meetings, and special committee meetings shall constitute a thorough review and analysis of the clinical work done in the hospital and shall include an analysis of clinical reports from each department and the reports of the committees of the Active MEDICAL STAFF.

E. In order to ensure effective communication between the MEDICAL STAFF and the Governing Body concerning quality of care, reports of all studies concerning quality and appropriateness of care (i.e., patient care audits) will be presented to the Governing Body for review.

Mass Casualty Assignments - All physicians shall be assigned to posts, in the hospital, in the auxiliary hospital, or in mobile casualty stations and it is their responsibility to report to their assigned stations. No physician shall perform any duties other than those assigned. The chief of the (disaster emergency) medical and surgical services in the hospital and the CEO of the hospital will work as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the hospital to another or evacuation from the hospital premises, the chief of the medical and surgical services during the disaster will authorize the movement of patients by direction of the CEO of the hospital and the chief of medical and surgical services. All policies concerning patient care will be a joint responsibility of the chief of the medical and surgical services and the CEO of the hospital. In their absence, the deputy chief and alternate in administration are next in line of authority respectively. All physicians on the MEDICAL STAFF of the hospital specifically agree to relinquish direction of the professional care of their patients to the chief of the (disaster emergency) medical and surgical services in case of such emergency.

3. ADMITTING PRACTICES

The hospital shall admit patients suffering all types of diseases.

Patients admitted to the hospital may be admitted only by STAFF who have submitted proper credentials and have been granted privileges.

Every infant born at Fairbanks Memorial Hospital must be admitted to the newborn service. All infants admitted to the newborn nursery must be seen daily by a physician.

Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever. Every admission shall
have an admission note on the chart stating the reasons for admission, the important physical findings, and the plan of treatment. This note shall be written by the admitting physician at the time of admission, but shall not be necessary if the history and physical examination has been done and recorded on the chart at the time of admission. An admission note is not a substitute for the history and physical. A complete history and physical examination shall in all cases be written within twenty-four (24) hours after admission of the patient.

Except in emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated and the consent of the CEO or his/her delegate has been secured. In case of emergency, the provisional diagnosis shall be stated as soon after the admission as possible.

Standing orders for the patient admitted to the hospital shall be: blood pressure, pulse, respiration, and weight. These may be changed only by mutual consent of the MEDICAL STAFF and CEO, and the latter shall notify all personnel concerned. These orders shall be signed by the attending physician.

4. THE MEDICAL RECORD

The attending physician shall be held responsible for the preparation of a complete medical record for each patient. This record shall include identification data; complaint; personal history; family history; history of present illness; physical examinations; special reports such as consultations, clinical laboratory, x-ray and others; provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; summary or discharge note; follow-up; and autopsy when available.

All entries made in the medical record must be dated and signed with the name and the title of the individual making the entry. Entries may be made only by members of the STAFF and nursing and allied professionals designated in patient care policy.

In accordance with patient care policy, only registered nurses and allied professionals as defined in patient care policy may take verbal orders within their scope of practice. All verbal orders must be countersigned by the physician within 72 hours.

Exceptions to this are orders for radiology prep-procedures which are recorded in the medical record by the radiological technician. These must be countersigned by the radiologist within eight (8) hours.

Symbols and abbreviations may only be used in the medical record when they have been approved by the MEDICAL STAFF. Each must have an explanatory legend.

The patient shall be discharged only on the order of the attending physician or dentist.

The patient’s medical records shall be complete at the time of discharge. When this is not possible, the patient’s record will be available for completion in the HIRS Department after discharge. Records with any *key deficiencies (as defined below) remaining after the limit defined by Stated regulations (not greater than 15 days) post discharge, will be considered delinquent. A weekly incomplete charts status shall be provided by Medical Records to physician offices for their information.

Key Deficiency is defined as any of the following remaining incomplete, or absent, after discharge:

1. History and Physical (including an update if required);
2. Discharge Summary;
3. Final Progress Note on those patients hospitalized less than 48 ours whose problems are of a minor nature, normal newborns, and uncomplicated deliveries; or
4. Operative Report
Corrective action shall occur as outlined in the Policy for Monitoring Provider’s Chart Completion.

Free access to all medical record of all patients, including computerized Health Care Information Network data of Fairbanks Memorial Hospital, shall be afforded to STAFF physicians in good standing for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. Access to the Health Care Information Network of Fairbanks Memorial Hospital carries with it all of the confidentiality requirements and responsibilities of access to the written medical records. Misuse of the Network will be considered a violation of the MEDICAL STAFF policy concerning medical records and will subject the member to disciplinary action under the Bylaws. Subject to the discretion of the CEO, former members of the MEDICAL STAFF shall be permitted free access to information from the medical records of their patients, covering all periods during which they attended such patients in the hospital.

The medical record is the property of the hospital and is maintained for the benefit of the patient, the MEDICAL STAFF, and the hospital. It is the hospital’s responsibility to safeguard both the record and its informational content against loss, defacement, tampering, or use by an unauthorized individual.

Written consent of the patient or his/her legal qualified representative is required for release of medical information to persons not otherwise authorized to receive this information. This shall not be construed to require written consent for use of the medical record for automated data processing or designated information for use in patient care evaluation studies such as retrospective audit and MEDICAL STAFF monitoring functions for departmental review of work performance or official surveys for hospital compliance for accreditation, regulatory, and licensing standards or for educational purposes and research programs.

The original medical record may be removed from the hospital’s jurisdiction and safekeeping only in accordance with a court order, or as may be otherwise required by applicable law. In the case of admission of a patient, all previous records shall be available for the use of the attending physician. This shall apply whenever the patient may be attended by the same physician or by another.

5. CONSULTATIONS

The patient’s physician is responsible for requesting consultations when indicated. It is the duty of the hospital staff through its chiefs of departments and Executive Committee to make sure that members of the staff do not fail in the matter of calling consultations as needed.

A consultant must be qualified to give an opinion in the field in which his/her opinion is sought. The status of the consultant is determined by the MEDICAL STAFF on the basis of an individual’s training, experience, and competence.

A satisfactory consultation includes examination of the patient and the record. A written opinion signed by the consultant must be included in the medical record. When operative procedures are involved, the consultation note, except in emergency, shall be recorded prior to the operation.

6. PATHOLOGY

Every member of the MEDICAL STAFF is expected to be actively interested in securing autopsies. No autopsy shall be performed without proper written consent. All autopsies shall be performed by the hospital pathologist or by a physician delegated the responsibility. Request for autopsy shall be accompanied by a written statement of brief clinical history, provisional cause of death, and questions to be answered by post-mortem examination.

Pathology materials in which the diagnosis of cancer was reported at an external institution must be reviewed by the HOSPITAL Pathology Department prior to the patient receiving first course therapy at the HOSPITAL.
7. PHARMACY

Only drugs listed on the hospital formulary which has been approved by the Pharmacy and Therapeutics Committee shall be used in the hospital. Exception can be made for drugs for bona fide clinical investigations. Exceptions to these rules shall be well justified.

Narcotics, sedatives, anticoagulant drugs that are ordered without time limitation of dosage shall be automatically discontinued according to the following schedule:

1. Narcotics and sedatives after five (5) days.
2. Antibiotics after seven (7) days.
3. Anticoagulants after seventy-two (72) hours.

Drugs should not be discontinued without notifying the physician. If the order expired during the night, it should be called to the attention of the physician the following morning.

8. SURGERY

A surgical operation shall be performed only with written consent of the patient or his/her legal representative, except in emergencies.

A history and physical examination must be recorded before the time stated for the operation, or the operation shall be canceled. The nursing service shall notify the operating room supervisor of such cancellation if there is not written history and physical on the patient’s chart ten minutes (10) prior to the scheduled surgery. If a patient is in the hospital the night prior to the scheduled surgery without a history and physical on the chart, the physician shall be notified and reminded of the above stated rules. The only exception would be an emergency, in which case the physician shall state in writing that such delay would constitute a hazard to the patient.

Surgeons must be in the operating room and ready to commence operation at the time scheduled; and, in no case will the operating room be held longer than fifteen (15) minutes after the time scheduled. If the case be “on call”, the physician shall be notified forty-five (45) minutes following notification by the operating supervisor that his/her case is being readied; if the physician cannot arrive within the forty-five minutes, his/her case will be postponed to the end of the operating schedule.

All operations performed shall be fully described in written form by the operating surgeon within the twenty-four (24) hours after the surgery.

All tissues removed at operation are to be submitted for pathologic examination in accordance with hospital policies and TJC guidelines. Some normal tissues, removed incidentally at the time of operation and having no direct relevance to the disease process being treated, may be exempted from pathologic review when in the opinion of the responsible surgeon it is unlikely that pathologic examination will be useful. All tissues removed for disease or having direct relevance to the disease or condition being treated must be submitted for pathologic examination.

Tissues exempt from being sent to pathology for examination (at the discretion of the responsible surgeon) are:

1. Cataracts
2. Foreskins
3. Hernia sacs
4. Knee cartilage
5. Nail fragments
6. Nasal cartilage and bone from deviated septums
7. Orthopedic hardware
8. Placentas
9. Product of conception less than 20 weeks gestational age
10. Segments of ribs, bones or soft tissue removed only to enhance the surgical procedure
11. Skin and tissue from debridement of burn and frostbite patients
12. Skin scars from repeat surgeries in non-cancer patients
13. Teeth
14. Traumatic amputations
15. Bone and cartilage removed as part of corrective or reconstructive orthopedic procedure unless clinically suspicious for neoplasm or infection.
16. Fat removed by liposuction
17. Intrauterine contraceptive devices without attached soft tissue
18. Skin or other normal tissue removed during a cosmetic or reconstructive procedure (e.g., blepharoplasty, cleft palate repair, abdominoplasty, rhytidectomy, syndactyly repair), provided it is not contiguous with a lesion and the patient does not have a history of malignancy (excluded are reduction mammoplasties).
19. Peritoneal washings (in non-cancer patients without an ovarian mass or a clinical suspicion of neoplasm).
20. Urinary tract stones
21. Urinary stents, catheters, implants
22. Cord lipomas
23. Vasectomy segments

9. SPECIAL CATEGORIES OF PATIENTS

Patients who are emotionally ill or who become emotionally ill while in the hospital, as well as those who suffer the results of alcohol or drug use disorders, shall be treated with empathy and dignity, and referrals shall be made as appropriate.

Emotionally Ill Patients. Patients who are emotionally ill and come to the emergency room will be treated in accordance with Fairbanks Memorial Hospital Emergency Room Policy for Emotionally Ill Patients.

Patients who are emotionally ill, and are hospitalized for this reason, shall be hospitalized in the psychiatric unit, unless, at the physician’s discretion, this is not feasible.

Patients who become emotionally ill while in the hospital may, at the physician’s discretion, be transferred to the psychiatric unit and/or be offered psychiatric consultation and treatment. When a patient, in the physician’s opinion, is actively suicidal, he/she will be transferred to the psychiatric unit unless this is not medically feasible. Psychiatric consultation and treatment will be requested and offered before discharge to all patients who remain actively suicidal.

Alcohol Use Disorder Patients. Patients who come to the emergency room in an inebriated state, and do not require hospitalization, shall be examined for the possibility of other illness and/or trauma and may be referred, according to emergency room procedures, to the detoxification center.
At the earliest appropriate time during hospitalization, patients who suffer results from alcohol use disorder shall be informed of community resources for counseling and rehabilitation. Such resources shall be contacted for referral by the hospital social worker, if the patient requests. Referrals to the patient educator for the patient to participate in the program on alcohol use disorder may be made at the physician’s discretion.

Substance Use Disorder Patients. Patients with substance use disorders, who are treated in the emergency room and do not require hospitalization, shall be treated in accordance with emergency room procedures for people with substance abuse disorders.

Patients who have substance use disorders and are hospitalized shall be informed, at the earliest appropriate time during their hospitalization, of the community resources available to them. At the patient’s request, the hospital social worker will contact the agency for initial referral. If a patient is a participant in the Methadone Program and is requiring assistance, the medical director of that program should be contacted. At all times, the patient who suffers from substance use disorders will be treated with dignity and empathy. The above applies to terminally ill patients who may have developed a physical dependency on drugs used for pain relief.

Patients of concern in the infection prevention policies of the hospital.

If the recent results of the following tests are unknown on patients who are the source of a serious exposure to blood and body fluid pathogens within the hospital, then these patients shall have the following tests ordered at no cost to the patient: Hepatitis B surface antigen, Hepatitis C antibody, and HIV antibody. Pre and post-test counseling will be provided by the hospital if requested by the physician. The patient’s attending physician will be notified of the incident and action taken.

Laboring Patients. The obstetrical patient, laboring and non-laboring presenting to the Emergency Department (ED) or to Obstetrical (OB) Triage will be assessed and guided to the appropriate service based on their immediate medical needs as outlined in the Laboring and Non Laboring Obstetrical Patient Triage Assessment and Disposition: Presenting to the Emergency Department or OB Triage policy.

10.  STANDING ORDERS

Standing orders may be initiated by a physician or dentist member of the active or courtesy STAFF, in cooperation with the appropriate department head responsible for the supervision of the personnel who will be implementing such orders (i.e. Administrative Representative of Nursing, dietitian, physical therapist). When this department head is the Administrative Representative of Nursing, and the orders apply to one clinical area, he/she may delegate this cooperative responsibility to the head nurse of that area or to the patient educator with regard to patient teaching materials.

All standing orders must be approved and signed annually by the Medical Executive Committee. A signed updated copy of all standing orders will be accessible on the facility intranet.

11.  STANDARDIZED PATIENT INSTRUCTION SHEETS

Standardized patient instruction sheets routinely given to patients without specific doctor’s orders must be initially approved by the appropriate department/committee of the MEDICAL. These instruction sheets must be reviewed annually by the chair of the appropriate medical department/committee before the February meeting of that department/committee, signed, and dated. These may be brought to the department or the committee meeting for discussion at the discretion of the chair, or he/she may approve, sign, and update them him or herself.

Upon annual review, if the department/committee chair determines instructions need revision, the revisions may be made only with the approval of the department.
A copy of the standardized patient instruction sheets, signed and updated annually, will be kept in the medical records department. The above does not apply to diet instruction sheets which are adapted from the approved hospital diet manual.

APPENDIX D – IMMUNITY FROM LIABILITY AND INDEMNIFICATION POLICY AND PROCEDURE

IMMUNITY FROM LIABILITY.

The following shall be express conditions to any applicant or member’s application for, or exercise of, PRIVILEGES at the HOSPITAL:

A. Any act, communication, report, recommendation, or disclosure, with respect to any such applicant or member, performed or made in good faith and without malice at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by laws.

B. Such privilege shall extend to members of the STAFF, HOSPITAL personnel, the CEO and his/her representative, and to third parties, who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article 16, the term “third parties” means both individuals and organizations from whom information has been requested by an authorized representative of the BOARD or of the STAFF.

C. There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

D. Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution’s activities related to, but not limited to:
   1. applications for appointment or PRIVILEGES;
   2. periodic reappraisals for membership renewal or PRIVILEGES;
   3. corrective action, including summary suspension, hearings and appellate reviews;
   4. patient care evaluations;
   5. utilization reviews; and
   6. other HOSPITAL, departmental, section or committee activities related to quality patient care and interprofessional conduct.

E. The acts, communications, reports, recommendations and disclosures referred to in this APPENDIX D may relate to a member’s professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

F. In furtherance of the foregoing, each member shall, upon request of the HOSPITAL execute releases in accordance with the tenor and import of this APPENDIX D in favor of the individuals and organizations specified in paragraph 2, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State.

G. The consents, authorizations, releases, rights, privileges and immunities provided by Article 5, Section A and B of these BYLAWS for the protection of this HOSPITAL’S members, other appropriate HOSPITAL officials and
personnel and third parties in connection with applications for initial membership shall also be fully applicable to the activities and procedures covered by this Article 16.

INDEMNIFICATION POLICY AND PROCEDURE.

The Alaska Department of Health and Social Services has adopted regulations requiring the governing body of the HOSPITAL to maintain an organized MEDICAL STAFF responsible for investigating, reviewing and analyzing factors which may contribute to any occurrence resulting in patient injuries, keeping records of any corrective actions taken against a member of the MEDICAL STAFF, and making annual recommendations to the governing body regarding the membership of and PRIVILEGES for each member of the MEDICAL STAFF. Pursuant to these MEDICAL STAFF Bylaws, the MEDICAL STAFF performs professional peer review of PHYSICIANS with CLINICAL PRIVILEGES at HOSPITAL. FHP and the Medical Staff recognize that it is important to the citizens of the State of Alaska, the HOSPITAL, FHP and the MEDICAL STAFF that professional peer review be responsible and effectively performed at HOSPITAL. This Indemnification Policy and Procedure ("Policy") sets forth the scope of such indemnification.

As used herein, the term “member of the MEDICAL STAFF” means all PRACTITIONERS duly licensed in the State of Alaska who are privileged to attend patients at the HOSPITAL as provided in the MEDICAL STAFF BYLAWS and includes any partnership of which such a PRACTITIONER is a partner, any corporation with respect to which such PRACTITIONER is a shareholder, and any association in which such PRACTITIONER is a member.

1. **FHP Undertaking to Defend and Indemnify.** FHP will indemnify any member of the MEDICAL STAFF of the HOSPITAL against whom a claim is made by any person who claims a legal remedy based upon an assertion that the claimant is or will be damaged in whole or in part by an act or omission of a member of the MEDICAL STAFF or any committee of the MEDICAL STAFF of the HOSPITAL arising from participation by the member of the MEDICAL STAFF or the committee of the MEDICAL STAFF in professional peer review activities within the purview of the MEDICAL STAFF BYLAWS of the HOSPITAL.

2. **FHP Remedy for Wrongful Conduct.** In any case where FHP is called upon to indemnify and does indemnify a member of the MEDICAL STAFF, FHP will have the right to seek to avoid that obligation as to any particular member of the MEDICAL STAFF by commencing and prosecuting to conclusion an arbitration or judicial proceeding at which it shall have the burden of proving by a preponderance of the evidence that the claim from which defense and indemnity is being provided under paragraph 1 was the result of intentional misuse of the professional peer review process (including any willful violation of any law, statute, rule, or bylaw) with improper motives by the particular member of the MEDICAL STAFF.

If FHP is successful in such proceeding, the member of the MEDICAL STAFF shall reimburse FHP forthwith for all costs incurred, including attorney’s fees, in defending such member, and any payment made on behalf of such member, and FHP shall be under no further obligation to defend or indemnify such member.

The proceeding authorized under this paragraph may not be joined with the legal proceeding against the member of the MEDICAL STAFF which gives rise to the obligation under paragraph 1 of this Agreement.

No decision or judgment rendered in any legal proceeding against the MEDICAL STAFF member which gives rise to the obligation of paragraph 1 of this Agreement shall have collateral estoppel or res judicata effect in any proceeding authorized by this paragraph.

3. **Cooperation.** In providing the defense required by paragraph 1 of this Agreement, FHP shall be solely responsible for the selection of defense counsel and the member of the MEDICAL STAFF for whom the defense is being provided shall fully and completely cooperate with the selected defense counsel in defending the claims. When, in
the opinion of defense counsel, a member of the MEDICAL STAFF fails to fully and completely cooperate with defense counsel in a manner prejudicial to the defense of the claim, FHP shall be immediately relieved from all further obligations to the member of the MEDICAL STAFF under this Agreement, including the obligation to indemnify such member.

4. **Arbitration.** If under paragraph 2 hereof, FHP seeks to determine such wrongful conduct by arbitration, the following procedure shall apply: If the parties are able to agree upon a single arbitrator, the dispute shall be submitted to him or her for resolution. If not, each party to the dispute shall select a qualified arbitrator, and the two arbitrators will in turn select a third qualified arbitrator. In the event the arbitrators selected by each party are unable to agree upon a third arbitrator within thirty (30) days of their appointment, then such third arbitrator shall be selected by the Chief Judge of the United States District Court for the District of Alaska, or, if such Judge is unable or unwilling to select such third arbitrator, then by the presiding Judge of the Superior Court for the State of Alaska, 4th Judicial District. Any decision made by the single arbitrator or a majority of the three arbitrators, as the case may be, shall be final, binding, and conclusive upon parties to the proceeding for all purposes; and judgment may be entered thereon in any court having jurisdiction.

If any dispute arises concerning the applicability of the obligation of FHP, under paragraph 1 hereof as to any particular claim, such dispute shall be resolved by arbitration under the procedure set forth above. FHP will be obligated to provide indemnity and defense pending the outcome of the arbitration proceeding, but shall be entitled to be reimbursed forthwith by the members defended for all costs, fees and amounts advanced should FHP prevail in the proceeding.