BARTLETT REGIONAL HOSPITAL

MEDICAL STAFF BYLAWS

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BARTLETT REGIONAL HOSPITAL

RESTATED MEDICAL STAFF BYLAWS

PREAMBLE.

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

WHEREAS, the Bartlett Regional Hospital Medical Staff is responsible for the provision of medical care in the Hospital according to applicable standards of care, and accepts this responsibility, subject to the ultimate authority of the Hospital Board; and

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

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

DEFINITIONS.

1. *Hospital* means Bartlett Regional Hospital of Juneau, Alaska.
2. *Board* or *Hospital Board* means the City and Borough of Juneau Hospital Board, which is the governing body of the Hospital.
3. *Chief Executive Officer* means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.
4. *Medical Staff* or *Staff* means the Medical Staff of Bartlett Regional Hospital, including all duly licensed doctors (MDs), doctors of osteopathic medicine (DOs), oral and maxillofacial surgeons (OMSs), podiatrists (DPMs) and dentists (DMDs, DDSs) who have been appointed to the Medical Staff.
5. *Medical Staff Executive Committee* or *Executive Committee* means the executive committee of the Medical Staff unless specific reference is made to the executive committee of the Hospital Board.
6. *Physician* means an individual with an MD, DO, OMS or DPM degree who is licensed or authorized to practice medicine in Alaska.
7. *Practitioner* means, unless otherwise expressly qualified, any physician, dentist or allied health professional applying for or exercising privileges in the Hospital.
8. *Medical Staff Year* means the period from January 1st through December 31st.
9. *Attending Physician* means a physician staff member with appropriate privileges who admits, discharges and has primary responsibility for a patient during the course of hospitalization.
10. *Inpatient Admission* means the formal acceptance by the hospital of a patient who is to be provided with room, board and continuous nursing service in an area of the hospital where patients generally stay at least overnight.

11. *Joint Conference Committee.* The Joint Conference Committee is composed of the Medical Staff Executive Committee, the Administrator and the Executive Committee of the Hospital Board.

12. *Allied Health Professional* or *AHP* means a licensed independent health care practitioner other than a licensed physician, podiatrist or dentist who is licensed or certified by state or federal law to provide health care to patients, satisfies the qualification requirements of these Bylaws, and has been granted privileges to provide or order specified services in the Hospital.

14. *Clinical privileges* or *privileges* means permission granted to a practitioner by the Board to render or order specific professional, diagnostic, therapeutic, medical, dental, podiatric or surgical services.

15. *Special notice* means written notification sent by certified or registered mail, return receipt requested.

ACRONYMS – Yet To Be Developed

ARTICLE I: NAME

1.1 The name of this organization is the Bartlett Regional Hospital Medical Staff.

ARTICLE II: PURPOSES AND RESPONSIBILITIES

2.1 Purposes.

The purposes of the Medical Staff are:

a. To serve as the collegial body through which individual practitioners may be appointed and so obtain clinical privileges at the Hospital;

b. To provide a mechanism for accountability to the Hospital Board for the appropriateness of the performance of each individual practitioner appointed to the Medical Staff with the goal of providing patient care at that level of quality recognized as the professional standard of care;

c. To assist the Hospital in providing accessible emergency medical services consistent with generally recognized professional standards;

d. To provide all patients admitted to or treated in Bartlett Regional Hospital with care consistent with generally recognized professional standards, regardless of race, gender, ethnicity, age, religion, color, cultural identification, sexual orientation, national origin, physical or mental disability or method of payment;

e. To maintain a level of professional performance consistent with generally recognized professional standards with respect to all practitioners authorized to practice in the Hospital through the appropriate delineation of the clinical privileges that each practitioner may exercise in the Hospital and through an ongoing review and evaluation of each practitioner's performance in the Hospital;

f. To provide an appropriate setting for professional review and continuing education, thereby seeking to maintain scientific standards and to advance professional knowledge and skill;

g. To initiate, maintain and improve Bylaws and Rules and Regulations for self governance of the Medical Staff; and

h. To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Hospital Board and the Chief Executive Officer.

2.2 Basic Obligations Accompanying Staff Appointment.

Each practitioner, regardless of his assigned staff category, and whether exercising permanent or temporary privileges, is expected to:

a. Provide patient care at the level that meets or exceeds the applicable standard of care;

b. Abide by the Bylaws, Rules and Regulations, and policies and procedures of the Medical Staff and Hospital;

c. Discharge staff, committee and Hospital functions for which he is responsible by staff category assignment, appointment, election or otherwise, and participate in quality review activities;

d. Prepare and complete medical records in a timely fashion, as required by the Bylaws, Rules and Regulations and other applicable policies and procedures of the Medical Staff or Hospital, including a medical history and physical examination completed no more than thirty (30) days before or within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services that is completed and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual and contains the information specified in the rules and regulations;

e. Provide or arrange for appropriate and timely medical coverage and care for patients for whom the provider is responsible;

f. Participate in the Hospital on-call schedule, if a member of the active Medical Staff; and

g. Participate in quality review activities, including chart review as indicated.

Failure to satisfy any of these basic obligations is grounds, as warranted by the circumstances, for corrective action or denial of reappointment.

ARTICLE III: STAFF MEMBERSHIP

3.1 Nature of Staff Membership.

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

3.2 Basic Qualifications for Membership.

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

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

b. provides patient care in accordance with the following general competencies, as those may be updated and revised from time to time:

1. technical quality of care: effective skill and judgment; appropriate performance of clinical privileges;

2. quality of service: ability to meet the customer service needs of patients and other caregivers;

3. relationships: positive and constructive interpersonal interactions with colleagues, hospital staff and patients;

4. citizenship: participation and cooperation with medical staff responsibilities;

5. patient safety and patient rights: cooperation with rules and procedures that protect patient safety and rights; and

6. resource utilization: effective and efficient use of the Hospital's clinical resources.

c. are qualified to provide a needed service within the hospital;

d. adhere to generally recognized standards of professional ethics;

e. have documented the capability to work cooperatively with other practitioners, and are willing to participate in the discharge of Medical Staff responsibilities; and

f. provide proof of, and maintain at all times, professional liability insurance in not less than the minimum amounts required for the practitioner's specialty by the Hospital Board after consultation with the Medical Staff Executive Committee.

No practitioner shall be automatically entitled to membership on the Medical Staff or to the exercise of particular clinical privileges merely because the practitioner is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board or had, or presently has, staff membership or privileges at this Hospital or at another health care facility or in another practice setting.

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

3.3 Conditions of Appointment.

The following conditions apply to all members of the Medical Staff:

a. The member shall not deceive a patient as to the identity of a practitioner providing treatment or service or delegate the responsibility for diagnosis or care of hospitalized patients to another person who is not qualified to undertake such responsibility.

b. Acceptance of membership on the Medical Staff shall constitute the member's agreement to abide by the Medical Staff Bylaws and Rules and Regulations, other applicable policies and procedures of the Medical Staff and Hospital, and the principles of medical ethics applicable to the member's branch of health care or specialty.

c. Each member of the Medical Staff is responsible to:

1. provide for continuous care for his or her patients at the Hospital;
2. meet standards of professional performance and utilization established by the Medical Staff;
3. appropriately document patient illness and care in a timely manner;
4. assist in the medical care evaluation and utilization programs;
5. accept committee assignments;
6. participate in continuing education programs;
7. work cooperatively, professionally and constructively with other practitioners at the Hospital; and
8. participate in on-call, emergency services and other special care units, as required by staff category.

d. The member shall promptly notify the Chief Executive Officer of the revocation, suspension or lapse of his professional license, or the imposition of terms of probation or limitation of practice by any licensing agency; his loss of staff membership or loss, curtailment or restriction of privileges at any hospital or health care institution; the cancellation or restriction of his professional liability coverage or DEA registration; the commencement of a formal investigation by the Department of Health and Human Services or any agency of the United States or the State of Alaska, or any other state; or the member's knowledge of a claim or potential claim relating to or arising out of care provided by the member at the Hospital.

e. The member shall promptly notify the Chief Executive Officer of any federal or state, investigations, charges or sanctions that may debar, disqualify, preclude or exclude the member from participation in Medicare, Medicaid, or any other publically funded health care program, or that otherwise may disqualify the member from treating patients at the Hospital. A practitioner shall not render care to any patient at the Hospital while subject to any such sanction.

3.4 Duration of Appointment.

a. A practitioner's initial appointment shall be provisional for one (1) year of focused professional practice evaluation (FPPE) and observation of clinical competence and ethical conduct under conditions of supervision as determined by the Credentials Committee.

b. Reappointment and reassignment of privileges shall be for a period not to exceed two (2) years.

c. Failure of a provisional appointee to the Medical Staff to qualify for reappointment shall result in termination of the practitioner's membership and privileges. However,

an extension of the provisional appointment period may be granted if the practitioner, for reasons beyond the practitioner's control, has not had a sufficient number of cases to facilitate a fair evaluation of his or her performance. A provisional appointee whose membership is terminated under this section shall have the rights provided in Article VII of these Bylaws.

ARTICLE IV: APPOINTMENT, REAPPOINTMENT, CLINICAL PRIVILEGES, AND LEAVES OF ABSENCE

4.1 Application for Appointment, Reappointment and Clinical Privileges.

a. Contents of application. Each application for appointment, reappointment or clinical privileges shall be presented in writing on the prescribed form and signed by the applicant. The applicant is responsible for the contents of the form. The applicant has the burden of producing all information requested in the application form and any additional information that would reasonably be material to the Medical Staff's decision on the application. It is the responsibility of the applicant to complete the application and any requests for additional information to the satisfaction of the Credentials Committee. The application form shall require detailed information that may include, but is not limited to:

1. The applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current DEA registration, continuing medical education and information related to the clinical privileges to be exercised by the applicant;
2. An account of the applicant's professional activities with respect to each year since completion of medical, podiatric or dental education;
3. References from peers familiar with the applicant's current professional competence and ethical character, medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism, together with names and contact information for the applicant's supervisor or department head and other individuals with whom the applicant has worked directly and substantially;
4. Requests for membership categories and clinical privileges;
5. Past or pending disciplinary actions; voluntary resignations from a medical staff during the process of an investigation or to avoid an investigation; license and clinical privilege limitations; formal collegial interventions; termination of health care employment or resignation in lieu of termination of health care employment; substance abuse evaluations and treatments required by any licensing agency, medical staff or employer; and similar matters;
6. Physical and mental health status, including any particular matters relevant to the specific clinical privileges requested;
7. Pending or potential claims, suits or settlements involving allegations of abuse, malpractice or professional liability;
8. Written evidence that the applicant meets Alaska State Medical Board requirements for continuing medical education (CME); and

9. Written evidence that the applicant is covered by professional liability insurance in the amount established for the applicant's specialty by the Board after consultation with the Medical Staff, including information regarding pending and previous malpractice claims. For each malpractice claim, the applicant must provide the name of the claimant; the county and state where the claim arose; the approximate date the claim was made; the status of the claim; the amount of any judgment or settlement against the applicant; and an objective statement of the claim against the applicant and the applicant's response.

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

1. agrees to appear for interviews with regard to the application;
2. authorizes the Hospital to consult with members of other hospital medical staffs with which the applicant has been associated and with others who may have information bearing on competence, character and ethical qualifications, substance abuse, disciplinary actions, criminal record, and other relevant information;
3. consents to query by the Hospital to the National Practitioner Data Bank regarding the applicant or member and submission of any resulting information to the Credentials Committee for inclusion in the applicant's credentials file;
4. consents to inspection by the Hospital and Medical Staff of all records and documents that may be material to an evaluation of professional and ethical qualifications and competence for staff membership, and to the exercise of the clinical privileges requested;
5. agrees to refrain from fee-splitting;
6. releases from liability, to the fullest extent allowed by law, all representatives of the Board, Hospital and Medical Staff for their acts performed in good faith and without malice in connection with evaluating the application;
7. releases from liability, to the fullest extent allowed by law, all individuals and organizations who provide information to the Hospital concerning the applicant's competence, ethics, character, past employment, past medical staff memberships, clinical history and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information; and
8. attests to the correctness and completeness of all information furnished and acknowledges that any material misstatement in or omission from the application constitutes grounds for denial of the application or for automatic revocation of staff membership or clinical privileges. For purposes of this paragraph, "material" means that the misstated or omitted information would be considered by a reasonable person to be relevant to the evaluation of the application. .

c. **Information and Documentation**. An applicant for appointment, reappointment or clinical privileges has the burden of providing clear and convincing information and documentation concerning the applicant's experience, background, training, demonstrated ability, current competence, emotional stability, availability, and physical and mental health status, with sufficient adequacy to demonstrate to the satisfaction of the Credentials Committee, the Medical Staff, and the Hospital Board that the applicant is capable of providing care to patients in conformance with generally recognized professional standards, taking into account patients' needs, the available Hospital facilities and resources, and utilization standards in effect at the Hospital. Failure to meet this burden shall result in denial of the application.

d. **Complete Application**. The Medical Staff will not take action on an incomplete application. An application for appointment, reappointment or clinical privileges is not complete unless and until the Credentials Committee is satisfied that the requirements of this section are met.

1. The applicant must submit a signed written application, using the prescribed form, in which all of the requested information is provided. All entries and attachments must be legible, understandable, and substantively responsive on every point of inquiry. It shall be the applicant's responsibility to promptly provide updated information on any changes or additions to the application after it is submitted.

2. The applicant must respond to all further requests from the Medical Staff, through its authorized representatives, for clarifying information or for submission of additional information. This may include, but not necessarily be limited to, (i) personal interviews with the applicant and (ii) submission to a medical or psychiatric evaluation, at the applicant's expense, by a physician selected by the Credentials Committee, if deemed appropriate by the Executive Committee to resolve questions about the applicant's fitness to perform the physical and/or mental functions associated with requested clinical privileges. If the requested information is in the exclusive possession of another person or entity, the applicant shall take such measures as are necessary to obtain that information or to arrange for it to be submitted to the Medical Staff directly by the source.

3. The applicant's credentials must be verified from primary sources, including educational institutions, training programs, federal and state license, certification and law enforcement agencies, the Drug Enforcement Administration, CMS, the OIG and the National Practitioner Data Bank, as appropriate.

4. The Credentials Committee must receive written evaluations from the applicant's references and directed references from other potential sources of relevant information.

5. The applicant's identity must be verified through government-issued photo identification.

6. The applicant must certify that he or she has received, read and agrees to be bound by the terms the Medical Staff Bylaws and Rules and Regulations.

e. **Application for Privileges**. An application for new or additional clinical privileges by a practitioner in good standing, for which there may not be a prescribed form, is not complete unless and until:

1. The applicant submits a written request for the privileges, supported by a complete description of the applicant's training, experience, and other qualifications for the requested privileges, with all additional requested information.

2. The applicant's current licensure, certifications and National Data Bank reports have been verified from primary sources.

3. In the case of new privilege categories, the Credentials Committee verifies that the Hospital has adequate equipment and facilities to support the requested privileges.

f. **Incomplete Application**. An application for appointment, reappointment or clinical privileges that is found to be incomplete by the Credentials Committee does not qualify the applicant for an appointment, reappointment or credentialing recommendation, regardless of any assessment or determination that may have been made as to its completeness at an earlier stage in the process. Should the applicant fail to make the application complete after a reasonable time (normally 180 days), the application will be deemed withdrawn and the credentialing process will be terminated. Termination of the credentialing process under this provision is not considered an adverse action and does not entitle the applicant to the rights provided in Article VII of these Bylaws; provided that, if the applicant disagrees that the application is incomplete, on request the applicant may attend the next regular Credentials Committee meeting and explain why, in the applicant's view, the application should be considered complete or why the applicant should be granted additional time to complete the application.

g. Assembly of Information. The application for appointment, reappointment or clinical privileges shall be presented to the Chief Executive Officer for assembly of the necessary information and a preliminary determination of the completeness of the application. If the application appears to be complete, the Chief Executive Officer shall transmit the application and all other pertinent information to the Credentials Committee.

4.2 Appointment Process.

a. The Credentials Committee shall examine the application for completeness and determine whether the applicant must provide additional documentation or other information. When the application is complete, the Credentials Committee shall evaluate the application on its merits and determine whether the applicant meets the qualifications for the category of staff membership and the clinical privileges requested.

b. Within ninety (90) days after receipt of a complete application for membership, the Credentials Committee shall transmit to the Medical Staff Executive Committee the application and all other information it considered in arriving at its recommendation. The Credentials Committee will recommend that the applicant be appointed to the

Medical Staff, rejected for Medical Staff appointment, or that action on the application be deferred. Where rejection or deferment is recommended, the reasons for the recommendation shall be stated.

c. Within ninety (90) days after receipt of an application from the Credentials Committee, the Medical Staff Executive Committee shall evaluate the application on its merits, and shall forward to the Hospital Board a written report and recommendations as to staff appointment and, if appointment is recommended, as to staff category, clinical privileges, and any special conditions to be attached to the appointment. The Medical Staff Executive Committee may in its discretion defer a decision and refer the application back to the Credentials Committee for further consideration or to obtain additional information. The reasons for each recommendation shall be noted in the application file.

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

2. Favorable Recommendation: When the recommendation of the Medical Staff Executive Committee is favorable to the applicant, the Medical Staff Executive Committee shall promptly forward the application, together with all supporting information, to the Hospital Board. For the purposes of this provision, "all supporting information" includes the application and all other information considered by the Medical Staff Executive Committee, the reports and recommendations of the Credentials Committee and minority views.

3. Adverse Recommendation: When the recommendation of the Medical Staff Executive Committee is adverse to the applicant, the Chief Executive Officer shall promptly notify the practitioner in writing, including notice that the applicant is entitled to the rights provided in Article VII. For the purposes of this provision an "adverse recommendation" by the Executive Committee means any action that constitutes grounds for a hearing pursuant these Bylaws.

d. The Hospital Board shall either accept the recommendation of the Medical Staff Executive Committee or reject it.

e. If the Hospital Board accepts the recommendation of the Medical Staff Executive Committee, the Chief Executive Officer shall transmit the decision in writing to the applicant.

f. If the Hospital Board does not accept the recommendation of the Medical Staff Executive Committee, the Hospital Board shall refer the application to the Joint Conference Committee. The Joint Conference Committee shall meet promptly (normally within 30 days) after referral from the Hospital Board to address the differences in the recommendation of the Medical Staff Executive Committee and the decision by the Hospital Board. The Joint Conference Committee may invite the Credentials Committee Chair to participate. The Joint Conference Committee meeting shall be held in executive session.

g. The Joint Conference Committee will prepare a recommendation in writing. The recommendation will be delivered to the applicant and the Hospital Board by the Joint Conference Committee Chair. The Hospital Board shall either accept the recommendation or reject it. If the Hospital Board's decision is adverse to the applicant, the applicant shall be entitled to request a hearing as provided in Article VII. If the applicant does not request a hearing, the decision shall be the Hospital Board's final administrative decision on the application.

h. An applicant who has received a final adverse decision regarding appointment or clinical privileges, or who has withdrawn an application for appointment of privileges after being informed of an adverse recommendation by the Credentials Committee, the Medical Staff Executive Committee, the Joint Conference Committee or the Hospital Board, shall not be eligible to reapply for such appointment or privileges for a period of twenty-four (24) months, unless expressly allowed to reapply by the Medical Staff Executive Committee for good cause shown. Any such re-application shall be processed as an initial application. The applicant shall submit such additional information as the Medical Staff Executive Committee may require demonstrating that the basis of the earlier adverse action no longer exists. The applicant shall be entitled to the rights provided in Article VII in the event the Medical Staff Executive Committee denies the request to allow the applicant to reapply.

4.3 Reappointment Process.

a. At least ninety (90) days prior to the expiration of each medical staff member's appointment, the member may reapply for membership in writing, on the prescribed form. In accordance with Section 4.1(h) of these Bylaws, the application shall be presented to the Chief Executive Officer for assembly of the necessary information, a preliminary determination of the completeness of the application, and transmittal to the Credentials Committee. Reappointment and renewal of privileges are not a matter of right. The burden of proof is on the member to demonstrate competence for reappointment and reassignment of privileges.

b. The reappointment application form shall request information necessary to update the medical staff file on the member's health care related activities relevant to reappointment and the renewal of privileges as requested. This form may include, by way of example and not by limitation, requests for information about any continuing training, education and experience relating to the member's qualifications for reappointment; the applicant's requests for reappointment, change in staff status or renewal or modification of clinical privileges; current physical and mental health status with reference to the specific clinical privileges to be renewed; proof of current licensure and DEA registration; the name and address of any other health care organization or practice where the member provided services during the preceding period; membership, awards, or other recognition conferred or granted by any professional society; sanctions of any kind imposed or contemplated by any other health care organization or licensing authority; professional liability insurance coverage; and pending or potential claims, suits, or settlements involving the member's professional ethics and qualifications that may bear on his ability to provide

good patient care in the hospital. One peer recommendation is required for reappointment.

c. The reappointment process will follow the process of initial appointment. Only complete applications for reappointment will be considered. The applicant has the burden of completing the application and establishing his or her qualifications for reappointment and the clinical privileges requested.

d. Each recommendation concerning the reappointment of a Medical Staff member and the granting of clinical privileges upon reappointment shall be based on the member's professional competence and clinical judgment in the treatment of patients, professional ethics and conduct, attendance at Medical Staff meetings and participation in staff affairs, compliance with the Hospital's policies regarding matters affecting patient care and with the Medical Staff Bylaws and Rules and Regulations, cooperation with Hospital personnel and colleagues in matters affecting patient care, and other factors relevant to the applicant's quality of care and treatment of patients in the Hospital.

e. Reappointments to the Medical Staff shall be for a period not to exceed two (2) years.

f. Applications for reappointment and renewal of privileges shall be considered in a timely manner by all persons and committees required to act on them. It is anticipated that an application will be fully processed prior to the expiration date of the member's current term of appointment.

4.4 Limitation of Clinical Privileges.

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

4.5 Modification of Staff Category or Clinical Privileges.

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

4.6 Leave of Absence.

a. A Medical Staff member may, upon written request, be given a leave of absence by the Medical Staff Executive Committee. A leave of absence may be granted for a period of not less than ninety (90) days or more than two (2) years.

1. A request for leave of absence shall state the approximate period of absence. The request must be submitted at least 60 days in advance of the beginning date for the leave of absence requested.

2. During the leave of absence, the member may not exercise clinical privileges at the Hospital, and membership rights and responsibilities shall be inactive.

3. Before returning from the leave of absence, the member must submit an application for reinstatement of privileges. The application must be in writing, and provide information pertinent to the leave of absence, including a written report or documentation of professional or other activities during the absence.

b. Failure, without good cause, to request reinstatement as provided above shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of Medical Staff membership and privileges. A practitioner whose membership and privileges are so terminated may request to be heard on the good cause issue at a meeting of the Medical Staff Executive Committee. A request for membership and privileges subsequently received from a practitioner so terminated shall be submitted and processed in the manner specified for applications for initial appointment.

ARTICLE V: CLINICAL PRIVILEGES

5.1 Exercise of Clinical Privileges.

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

5.2 Criteria for Delineation of Privileges.

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

5.3 Temporary Privileges While Awaiting Approval.

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

a. Temporary privileges may not be used at the time of reappointment to accommodate administrative delays.

b. Temporary privileges may only be granted when the application is complete and the applicant’s credentials file contains verified information establishing the practitioner's qualifications, ability and judgment to exercise the privileges requested, including:

1. current licensure;

2. relevant training and experience;

3. current competence;

4. ability to perform the privileges requested;

5. National Practitioners Data Bank reports;

6. no current or previously successful challenges to licensure, registration, certification, or involuntary staff membership or privilege discipline action at another hospital or medical organization.

c. An initial FPPE plan is required as a condition of temporary privileges under this section.

5.4 Temporary Privileges For Specific Purposes. Temporary privileges for specific purposes may be granted to a practitioner by the Chief Executive Officer upon presentation of satisfactory proof to the Chief Executive Officer and to the Chief of Staff that the practitioner is appropriately licensed and qualified.

a. Temporary privileges may be granted for the care of one or more specific patients by a practitioner who is not an applicant for staff appointment, but who is otherwise fully qualified for appointment and has specific expertise, skills or knowledge needed for the patient's or patients' care.

b. Any patient cared for by a practitioner granted temporary privileges under this section will be assigned to the care of a member of the Active Medical Staff who will be responsible to supervise and coordinate the patient's care. Practitioners granted temporary privileges under this section may not be granted admitting privileges.

c. Temporary privileges may be granted to a practitioner with similar privileges at another hospital for the purpose of obtaining or providing training under the supervision of a member of the Active Medical Staff.

5.5 Termination of Temporary Privileges. The Chief of Staff or the Chief Executive Officer may immediately terminate any temporary privileges upon discovery of any information or the occurrence of any event that raises questions about the practitioner's professional qualifications, ability or suitability for temporary privileges. The practitioner's patients will be assigned to another practitioner by the Chief of Staff. The practitioner may request a hearing on the termination of temporary privileges.

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

5.7 Dental Privileges.

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

5.7 Podiatry Privileges.

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

ARTICLE VI: PROFESSIONAL REVIEW ACTIONS

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

a. Professional review may be requested when there are concerns that action in the furtherance of quality health care at the Hospital may be necessary because the activities, conduct, skills, currency or physical or mental health of any practitioner:

1. are detrimental to patient or staff safety;
2. do not meet the ethical or professional standards of the Medical Staff;
3. are contrary to or fail to meet the requirements of the Medical Staff Bylaws, Rules and Regulations or Policies:
4. are contrary to the Hospital's policies or procedures;
5. are disruptive, inappropriate or unprofessional;
6. have resulted in a criminal charge or conviction;
7. have led to an adverse action by a professional association, licensing board or administrative agency; or
8. have otherwise called into question the practitioner's credentials or qualifications for Medical Staff membership or privileges.

b. A request for professional review must be in writing and include copies of any readily available relevant documents, charts and other information.

c. The Medical Staff Executive Committee shall review the request and determine whether there is a reasonable basis to believe that professional review in the furtherance of quality health care may be necessary. If so, the Medical Staff Executive Committee will promptly investigate the matter.

d. During its investigation, the Medical Staff Executive Committee may collect and review medical records, committee minutes and other documents, and may consult with or interview witnesses, Hospital administration and staff, experts, counsel, members of the medical staff or other individuals, as it deems appropriate.

e. The Medical Staff Executive Committee will notify the practitioner that an investigation is being conducted and the nature of the concerns. The practitioner may submit a written statement and any pertinent documents to the Medical Staff Executive Committee. The practitioner shall be provided an opportunity for an interview with the Medical Staff Executive Committee.

f. If the practitioner against whom an investigation or professional review has been requested is a member of the Medical Staff Executive Committee, the practitioner shall not participate in the investigation of, or deliberation on, the request.

g. At the conclusion of its investigation, the Medical Staff Executive Committee shall decide, in writing:

1. that no professional review action is necessary;
2. to defer action for a reasonable time when circumstances warrant;
3. to issue a letter of admonition, censure, reprimand or warning;
4. to refer the practitioner for focused professional practice evaluation (FPPE);
5. to impose probation or limitations on the practitioner's medical staff membership;
6. to reduce, modify, suspend or revoke the practitioner's clinical privileges;
7. to impose summary suspension;
8. to suspend or revoke the practitioner's medical staff membership; or
9. to take any other action appropriate under the circumstances.

h. The Medical Staff Executive Committee Chair shall promptly notify the Chief Executive Officer and the Quality Director of all requests for professional review and its decisions on those requests.

6.2 Right to Hearing, Notice and Request for Hearing. A practitioner may request a hearing whenever these Bylaws provide for a right to a hearing or when the Medical Staff Executive Committee, for reasons of competency or conduct and for a period of more than fourteen (14) days:

a. imposes probation or limitations on the practitioner's medical staff membership or clinical privileges,

b. reduces, modifies, suspends or revokes the practitioner's clinical privileges,

c. imposes summary suspension, or

d. suspends or revokes the practitioner's medical staff membership.

e. In those instances, the Chief Executive Officer shall promptly provide written notice to the practitioner of the Medical Staff Executive Committee's decision by first class mail

with a copy by electronic mail to the practitioner's most current addresses on file with the Hospital. The notice will state:

1. that a professional review action has been proposed to be taken against the practitioner;

2. describing the proposed action and stating the reasons for the proposed action;

3. that the practitioner has the right to request a hearing on the proposed action by delivering a written request for hearing to the Chief Executive Officer within thirty (30) days after the date the notice was sent to the practitioner; and

4. a summary of the practitioner's hearing rights.

6.3 No Hearing Requested. If the practitioner does not timely and properly request a hearing, the Chief Executive Officer will transmit the Medical Staff Executive Committee's decision to the Hospital Board for its review and approval together with the information gathered in the investigation. The Hospital Board will, in writing:

a. approve the decision, if it is supported by substantial evidence in the investigative record, or remand to the Medical Staff Executive Committee for additional investigation or reconsideration of the decision, with a statement of reasons.

b. The Chief Executive Officer will promptly provide a copy of the Hospital Board's decision to the practitioner by first class mail with a copy by electronic mail to the practitioner's most current address on file with the Hospital.

c. If the Medical Staff Executive Committee fails to investigate a request for professional review, the Hospital Board, after consultation with the Medical Staff Executive Committee, may direct the Medical Staff Executive Committee to conduct an investigation and to issue a written decision on the matter.

6.4 Authority and Confidentiality.

a. At all times the Executive Committee, the Chief Executive Officer and the Chief of Staff retain their full authority and complete discretion to take whatever action may be warranted by the circumstances and in the furtherance of quality health care, including summary suspension of a practitioner's clinical privileges as provided in Section 6.4.

b. All aspects of the professional review process are confidential to the fullest extent allowed by law.

6.5 Collegial Intervention.

a. The Medical Staff encourages collegial intervention to address and, where possible, resolve concerns relating to a practitioner's clinical practice or professional conduct.

The goal of collegial intervention is to arrive at voluntary, responsive actions by the practitioner to resolve concerns before the professional review process is initiated.

b. Collegial intervention may be initiated by the Executive Committee, the Chief of Staff, the Quality Review Committee or any department head.

c. Collegial intervention may include counseling, sharing of comparative data, monitoring, proctoring, focused professional practice evaluation (FPPE), arranging additional training or education, or any other method reasonably expected to resolve the concerns.

d. The Chief of Staff may request that one or more members of the Medical Staff conduct a collegial intervention.

e. Collegial intervention is encouraged but is not mandatory. It is not a prerequisite to an investigation, a professional review, a corrective action or the summary suspension of a practitioner's clinical privileges.

f. Collegial intervention is a professional review activity and confidential to the fullest extent allowed by law.

6.6 Summary Suspension for Reasons of Competency or Conduct.

a. The Chief of Staff or the Chief Executive Officer or, in their absence from the Hospital, their designees, have authority to summarily suspend or restrict a practitioner's clinical privileges for reasons of competency or conduct. Summary suspension may be imposed whenever there is a reasonable basis to believe that failure to take such an action may result in an imminent danger to the health or safety of any individual.

b. The Chief of Staff or Chief Executive Officer, whichever imposed the suspension, shall promptly provide the practitioner and the Executive Committee written notice of the suspension and a brief statement of reasons.

c. A summary suspension or restriction under this section may be for an initial period of no longer than seven days.

d. During the initial period the Medical Staff Executive Committee shall conduct a preliminary investigation limited solely to determining whether there is a reasonable basis to continue the suspension or restriction the practitioner's clinical privileges pending a professional review.

e. If the Medical Staff Executive Committee determines that there is no reasonable basis to believe that there may be an imminent danger to the health of any individual if the practitioner exercises the clinical privileges in question during the professional review process, the Medical Staff Executive Committee may lift the suspension or restriction. Otherwise, the Medical Staff Executive Committee will continue the suspension or restriction during the professional review process.

f. The Medical Staff Executive Committee will issue a short written decision explaining its reasons for continuing or lifting the summary suspension or restriction. The matter will then proceed as a request for professional review.

g. If the suspension remains in effect the professional review process will proceed as expeditiously as practicable:

(i) the Medical Staff Executive Committee's decision on whether there is a reasonable basis to continue the suspension pending a professional review will normally be issued within 7 days of the date the summary suspension or restriction was imposed;

(ii) the hearing, if requested, will normally take place within 90 days of the date the hearing is requested; and

(iii) the time frames for decision and hearing may be extended by the Medical Staff Executive Committee for the convenience of the parties or to obtain additional information or consultation relating to the suspension.

6.7 Administrative Suspension.

a. The Chief of Staff or the Chief Executive Officer shall administratively suspend or restrict the clinical privileges of a practitioner if the practitioner's license, certificate, eligibility or registration has been suspended or revoked by the issuing license agency, including any:

(i) state or provincial medical board or medical board of examiners;

(ii) state or provincial dental board or board of dental examiners;

(iii) state or provincial board of nursing;

(iv) other federal, state or provincial health care licensing agency;

(iv) federal or state controlled substance agency; or

(v) federal or state health care program, such as Medicaid or Medicare.

b. The Chief of Staff or the Chief Executive Officer shall administratively suspend the clinical privileges of a practitioner upon finding that the practitioner's medical staff membership or clinical privileges at any other Hospital or medical institution have been revoked or suspended for reasons of competency or conduct.

c. The Chief of Staff or the Chief Executive Officer shall administratively suspend the privileges of any practitioner upon finding that there has been a lapse or reduction in a provider's professional liability insurance coverage below the minimum amounts required by these Bylaws. The provider may request reinstatement of appointment and appropriate privileges by sending a written notice to the Chief of Staff and Chief Executive Officer, along with

(i) documentation of new or renewed insurance coverage in the required amounts and a written statement explaining the circumstances and any limitations on the new or renewed coverage; and

(ii) a written summary of the practitioner's activities at the Hospital during the period of coverage lapse or reduction.

d. The Chief of Staff or the Chief Executive Officer may reinstate clinical privileges that have been administratively suspended once the practitioner shows, to the Chief of Staff or Chief Executive Officer's satisfaction, that reinstatement is appropriate.

e. If it appears from the circumstances of the administrative suspension that there is a reasonable basis to believe that professional review in the furtherance of quality health care may be necessary, the Chief of Staff or the Chief Executive Officer will refer the matter to the Executive Committee. The matter will then proceed as a request for professional review.

ARTICLE VII: HEARINGS AND APPELLATE REVIEW

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

a. adverse decisions on an application for appointment or reappointment to the medical staff;

b. adverse decisions on an application for clinical privileges;

c. proposed professional review actions;

d. terminations of temporary privileges for reasons of competency or conduct;

e. termination of a contract between the Hospital and a practitioner for reasons of competency or conduct and resulting in a restriction or termination of Medical Staff membership or clinical privileges; and

e. summary suspensions due to a reason of competency or conduct that are longer than seven (7) days duration.

7.2 Hearing Panel. Per CBJ Code 40.15.110, a professional review hearing shall be held before a panel comprised of two physicians and one independent hearing officer. The panel shall be appointed by the Hospital Board.

a. The hearing officer shall conduct the hearing.

b. The hearing officer's fees and costs and administrative costs of the hearing, if any, shall be paid by the Hospital. Each party shall pay their own costs and attorney's fees, if any.

c. The hearing officer shall be a neutral and unbiased individual who was not involved in the investigation of the request for professional review or the Executive Committee's investigation, does not represent any individual or entity involved, is not in economic competition with the practitioner, is admitted to practice law in Alaska and is:

(i) a retired judicial officer; or

(ii) an attorney licensed to practice in the State of Alaska with a minimum of ten years' experience in health care matters; or

(iii) an attorney on the American Health Lawyer's Association's list of dispute resolvers.

e. The physician panelists may not be in direct economic competition with the physician involved and may not have a financial or personal interest in the outcome of the hearing. If two qualified physician panelists do not agree to serve on the panel within 30 days of the practitioner's request for a hearing, the matter shall be heard by the hearing officer alone.

d. The hearing officer shall participate in the panel's deliberations but shall not vote on the decision unless the two physician members disagree, in which case the hearing officer may vote. If the hearing officer hears the matter alone, the hearing officer will make the decision.

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

a. the place, time, and date of the hearing, which shall not be less than 30 days after the date of the notice; and

b. a list of the witnesses (if any) expected to testify at the hearing in favor of the adverse action.

7.4 Failure of Practitioner to Appear. If the affected practitioner fails to personally appear at the hearing without good cause, the practitioner's right to a hearing will be forfeited, and the decision being appealed will be final.

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

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

a. to be represented by an attorney or other person;

b. to have a record made of the proceedings, upon payment of any reasonable charges associated with the preparation of the record;

c. to call, examine, and cross-examine witnesses;

d. to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law; and

e. to submit a written statement at the close of the hearing.

7.7 Duties of the Hearing Officer. Per CBJ Code 40.15.110, the hearing officer shall have authority to conduct the hearing.

a. The hearing shall be conducted as informally and expeditiously as is consistent with the interests of fairness.

b. The hearing officer shall rule on pre-hearing matters and all questions of procedure, discovery and evidence, and shall admit any relevant evidence presented that a reasonably prudent person would rely upon in the conduct of serious affairs, regardless of admissibility in a court of law.

c. The hearing officer may contact the parties directly (*ex parte*) on procedural matters, but shall not have discussions or other communications on any substantive matter relating to the hearing unless both parties are present. The physician panel members shall not discuss the matter with the parties or with any other medical staff member or third party.

d. The panel shall deliberate outside of the parties' presence. The parties and any representatives of the parties or the administration shall not be present during, participate in, or attempt to influence the hearing officer's deliberations.

e. The panel shall decide the matter and shall promptly issue a written recommended decision. The recommended decision shall contain findings of fact, conclusions of law, and any recommended professional review action.

f. The hearing officer shall file the decision with the Chief Executive Officer, together with the recordings or transcript and the exhibits, pleadings and other documents or materials that were considered during the hearing process. These documents and materials shall constitute the administrative record.

7.8 Confidentiality. The hearing is a confidential professional review matter. Per CBJ Code 40.15.120, the hearing will be held in executive session. All documents, testimony and argument presented during the hearing shall be confidential to the fullest extent of the law.

7.9 Notice of the Decision. The Chief Executive Officer will promptly forward copies of the decision to the practitioner and the Chief of Staff. The Chief Executive Officer shall retain the administrative record until the matter is final.

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

7.11 **No Appeal Filed**. Per CBJ Code 40.15.080, if neither party appeals the decision, the Chief of Staff will forward the administrative record to the Hospital Board for review and action under Section 7.13, except that appeal statements and oral argument will not be required.

7.12 **Appeal Filed.** Per CBJ Code 40.15.080, if the practitioner or the Chief of Staff files a timely notice of appeal, the Hospital Board will review the matter and issue a final administrative decision on the merits.

a. The Hospital Board will review the decision and, to the extent it deems appropriate and necessary, the administrative record.

b. The Hospital Board will hear receive written appeal statements from the parties or their representatives and hear oral argument before taking action on the appeal. No new or additional evidence or testimony will be heard by the board. The Hospital Board will be represented by the Hospital's counsel.

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

a. approve the decision if it is supported by substantial evidence in the administrative record, in which case the decision will be the Hospital Board's final decision; or

b. remand for the taking of additional evidence, or reconsideration of the decision, with a statement of reasons and directions. If the decision is remanded, the panel (or the hearing officer if the matter was decided by a hearing officer alone) will follow the Board's direction and prepare a revised decision, which will be distributed to the parties by the Chief Executive Officer under Section 7.9. The revised decision will be considered by the Hospital Board pursuant to Sections 7.10 – 7.12 and, if adopted, will be the Hospital Board's final decision.

7.14 **Effective Date; Notice**. The Hospital Board's final decision shall be effective on the date it is issued. The Chief Executive Officer will promptly deliver copies of the Hospital Board's decision to the Medical Executive Committee, to the practitioner, and to the panel or to the hearing officer if the matter was decided by a hearing officer alone. Per CBJ Code 40.15.080, the decision will be sent to the practitioner by first class mail within ten (10) days of the date it is issued, with a copy by electronic mail to the practitioner's most current address on file with the Hospital.

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

a. If the practitioner or the Medical Executive Committee is not satisfied with the Hospital Board's final decision, the party may appeal that decision to the City and Borough of Juneau Assembly within twenty days of the date of the Board's decision, per § 3.16 of the Charter of the City and Borough of Juneau and the Administrative Appeal Procedures of the City and Borough of Juneau Code, Chapter 01.50.

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

ARTICLE VIII: CATEGORIES OF THE MEDICAL STAFF

8.1 The Medical Staff.

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

8.2 The Active Medical Staff.

The Active Medical Staff consists of physicians, dentists and podiatrists who admit, consult or are actively involved in the medical affairs of the hospital, have their principal practice location in Juneau, and are able to provide continuous care to their patients at the Hospital. The Active Medical Staff performs all organizational and administrative functions of the Medical Staff and are responsible for seeking to maintain the quality of all medical care in the Hospital. Active Staff members are eligible to vote and to hold Medical Staff office. Active staff members serve on Medical Staff committees, attend Medical Staff meetings, and participate in on-call medical coverage at the hospital.

8.3 The Courtesy Medical Staff.

The Courtesy Medical Staff consists of physicians and dentists, including specialists, who are qualified for Medical Staff membership, may or may not have a principal practice location in Juneau, exercise clinical privileges intermittently or infrequently, and for whom the responsibilities associated with Active Medical Staff membership would be unreasonably burdensome.

a. Courtesy Medical Staff members may admit, or exercise clinical privileges in the Hospital for, no more than twenty-four (24) patients or twenty-four (24) short stay surgical procedure patients, or any combination not exceeding a total of twenty-four (24) patients per calendar year.

b. Courtesy Medical Staff members may admit, or exercise clinical privileges in the Hospital for more than (24) patients or twenty-four (24) short stay surgical procedure patients only upon a showing of good cause, and with the prior approval of the MSEC.

c. Courtesy Medical Staff members are invited to participate in Medical Staff meetings, committees or other functions when present at the Hospital. Courtesy Medical Staff members are not required to attend Medical Staff meetings and may not vote or hold Medical Staff office.

8.4 The Consulting Medical Staff.

The Consulting Medical Staff consists of physicians and dentists who are recognized specialists, who meet all of the prerequisites for Medical Staff membership, and who come to the Hospital on a schedule or by request.

a. Consulting Medical Staff members may not admit patients to the Hospital.

b. Consulting Medical Staff members may consult on the care of patients in the Hospital in person, by telephone or electronically, and may write or give telephonic or electronic orders on a patient at the request of the patient's attending physician.

c. Consulting Medical Staff members are invited to participate in Medical Staff meetings, committees or other functions when present at the Hospital. Courtesy Medical Staff members are not required to attend Medical Staff meetings, do not count towards quorum and are not eligible to vote or hold Medical Staff office.

8.5 The Honorary Medical Staff.

The Honorary Medical Staff consists of Medical Staff members of any category who have served the Hospital meritoriously or are of outstanding reputation, including physicians and dentists who have retired from active practice. Honorary Staff members are relieved of Medical Staff duties and attendance requirements, do not have clinical privileges, do not count towards quorum, and are not eligible to vote or hold Medical Staff office. Honorary Staff members may serve on committees.

8.6 The Allied Medical Staff.

The Allied Medical Staff consists of licensed independent practitioners other than physicians, dentists and podiatrists, including physician assistants, advanced nurse practitioners, nurse midwives, nurse anesthetists, psychologists, optometrists and doctors of chiropractic who are properly licensed, qualified and credentialed, who are located within the community, and who provide care to patients at the Hospital.

a. Allied Medical Staff members may, but are not required to, attend Medical Staff meetings. Allied Medical Staff members do not count toward quorum, and are not eligible to vote or hold Medical Staff office.

b. Allied Medical Staff members may be appointed to Medical Staff committees and are expected to actively participate in Medical Staff quality assurance activities.

c. Allied Medical Staff members' clinical privileges shall be no greater than the scope of their licensure or certifications. Allied Medical Staff members must have an Active Medical Staff physician sponsor or supervisor unless the Credentials Committee grants an exception. The Credentials Committee may set conditions for the sponsorship or supervision.

d. Other practitioners may be allowed to access hospital services without being appointed to the Allied Medical Staff and without being granted privileges, by approval of the Credentials Committee, and on such conditions as the Credentials Committee believes appropriate.

ARTICLE IX: OFFICERS

9.1 Officers of the Medical Staff.

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

9.2 Qualifications of Officers.

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

9.3 Election of Officers. Medical Staff Officers are nominated and elected to fill vacancies on the MSEC by the Active Medical Staff at the annual meeting. Each candidate must consent to nomination.

a. The nominee for each office receiving the most votes shall be elected. Tie votes are resolved by a coin toss.

b. A quorum for the election shall be the number of Active Medical Staff members present and voting at the annual meeting.

9.4 Term of Office.

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

9.5 Vacancies in Office.

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

9.6 Removal of Officers.

Any Medical Staff officer may be removed from office at any time, for any reason, by a two-thirds (2/3) majority vote of the Active Medical Staff present at a Medical Staff meeting.

9.7 Duties of Officers.

a. The Chief of Staff is the chief administrative officer of the Medical Staff, and shall:

1. Act in coordination and cooperation with the Chief Executive Officer and Hospital Board in all matters of mutual concern within the Hospital;

2. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;

3. Serve as chair of the Medical Staff Executive Committee;

4. Be responsible for the enforcement of the Medical Staff Bylaws and Rules and Regulations; implementation of sanctions where indicated; and for the Medical Staff's compliance with the procedural safeguards in all instances where corrective action has been requested against a Medical Staff member;

5. Appoint, unless otherwise provided in these Bylaws or the Rules and Regulations, the Medical Staff members of all Medical Staff committees except the Executive Committee, and be an *ex officio* member of all Medical Staff Committees;

6. Represent the views, policies, needs and grievances of the Medical Staff to the Hospital Board, the Hospital Board President, and the Chief Executive Officer;

7. Receive and interpret the policies of the Hospital Board to the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;

8. Be responsible for the quality improvement and educational activities of the Medical Staff;

9. Be the spokesman for the Medical Staff in its external professional and public relations; and

10. Attend all Board meetings and attend other Hospital Board subcommittee meetings as assigned.

b. In the absence of the Chief of Staff, the Immediate Past Chief of Staff shall assume all the Chief of Staff's duties and authority. In the absence of both, the Secretary/Treasurer shall assume all the Chief of Staff's duties and authority.

c. The Chief of Staff-Elect shall perform such duties as may be assigned by the Chief of Staff.

ARTICLE X: COMMITTEES OF THE MEDICAL STAFF

10.1 Composition of Committees.

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

10.2 Term of Service.

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

10.3 Removal and Vacancies.

Except for the Medical Staff Executive Committee, a Medical Staff committee member may be removed by the Chief of Staff, and a Hospital committee member may be removed by the Chief Executive Officer, at any time and for any reason. A committee vacancy shall be filled in the same manner in which appointments to the committee are ordinarily made.

10.4 Quorum.

Quorum for a committee meeting is two members.

10.5 Manner of Action.

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

electronic mail by a majority of committee members. The committee chair will tabulate the votes.

10.6 Ex officio Members.

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

10.7 Attendance by Active Medical Staff Members.

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

10.8 Meetings.

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

10.9 Special Committee Meetings.

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

10.10 Minutes.

The committee chair or designee shall prepare minutes of all regular and special committee meetings, including a record of the attendance of committee members and votes taken. The minutes shall be submitted for approval at the next regular meeting of the committee and, after such approval is obtained, shall be forwarded to the Medical Staff Executive Committee. Each committee shall maintain a permanent file of all meeting minutes.

ARTICLE XI: MEETINGS OF THE MEDICAL STAFF

11.1 Regular Medical Staff Meetings.

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

11.2 Annual Medical Staff Meeting.

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

11.3 Special Medical Staff Meetings.

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

11.4 Attendance by Active, Courtesy, Consulting, Honorary and Allied Medical Staff Members.

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

a. The Chief of Staff may excuse a member due to illness, attending a patient in an emergency, on-call status or other extenuating circumstances. The Medical Staff member must notify the Chief of Staff before the meeting for an absence to be excused.

b. An Active Medical Staff member who fails to meet attendance requirements may be assessed a fine by the Chief of Staff. Persistent and unexcused failure to attend Medical Staff Meetings may result in corrective action.

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

11.6 Quorum.

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

11.7 Minutes.

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

ARTICLE XII: CONFIDENTIALITY, IMMUNITY AND RELEASES

12.1 Confidentiality of Information.

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

12.2 Authorization and Conditions.

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

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

b. Agrees to be bound by the provisions of these Bylaws and the Medical Staff's Rules, Regulations and Policies , to the maximum extent allowed by law; and

c. Acknowledges that the provisions of these Bylaws are express conditions precedent to the practitioner's application for or acceptance of Medical Staff appointment and clinical privileges, and to the continuation of such appointment and exercise of clinical privileges at the Hospital.

12.3 Waiver and Full Release of Liability.

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

12.4 Release of Information.

Each practitioner shall execute general and specific releases to allow access to information pertinent to the practitioner's application for appointment, reappointment or clinical privileges, or in connection with a disciplinary or corrective action. Failure to execute such releases shall be deemed a voluntary withdrawal of such application; or, if in connection with a disciplinary or corrective action, shall result in a presumption that the facts or circumstances that are the subject matter of the releases reflect adversely on the practitioner, and such presumption shall stand unless the practitioner presents verifiable facts to the contrary. "Information" as used in this section means any oral or written reference, record or communication of any kind about a practitioner that is created, received or maintained

concerning a practitioner's professional licensure or certification, education, training, clinical ability, judgment, utilization practices, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect the quality or efficiency of patient care. Each practitioner irrevocably forever waives, releases and renounces any claim or cause of action whatsoever against any person or entity providing information to the Hospital or the Medical Staff pursuant to this section, to the fullest extent permitted by federal and state law.

ARTICLE XIII: ACCESS TO MEDICAL STAFF RECORDS

13.1 Access by Persons within the Hospital or Medical Staff.

a. All requests for Medical Staff records by persons described below shall be made to and recorded by the Medical Staff Office, which shall be responsible for preserving the confidentiality of the records. Requests by other persons must be made to the Chief of Staff. Unless authorized by the Chief of Staff, a person permitted to inspect Medical Staff records shall be given a reasonable opportunity to inspect the records and to make notes, but not to remove the records or make copies of them. Removal or copying shall only be upon the express written permission of the Chief of Staff or designee.

b. Medical Staff officers, Medical Staff committee members, Hospital Board members, the Medical Staff Coordinator, the Chief Executive Officer, the Chief Executive Officer's designee and the Quality Director shall have access to Medical Staff records to the extent necessary to perform their official functions.

c. General Access by Practitioners to Medical Staff Records

1. A practitioner shall have access to the credentials and professional review files of other practitioners only as set out above.

2. A practitioner shall have the right to review and copy any documents in his own credentials and professional review file which he submitted (e.g., application, re-application, privileges list or correspondence) or which were addressed or sent as copies to him. A practitioner shall not be allowed access to professional references or professional review records except in a corrective action proceeding, or as required by law.

3. A practitioner shall be allowed access to Medical Staff and committee files only with the MSEC's written permission and in accordance with the Medical Staff's Rules, Regulations and Policies.

13.2 Access by Persons or Organizations Outside of the Hospital or Medical Staff.

a. An outside agency or organization that has authority pursuant to federal or state law to review the performance of the Hospital or Medical Staff in fulfilling its functions, including accreditation agencies, will be permitted to inspect Medical Staff records to the extent that the Chief of Staff and the Chief Executive Officer agree that disclosure is appropriate. Records shall not be copied or removed from the Hospital's premises without the permission of the Chief of Staff and the concurrence of the Chief Executive Officer.

b. Information contained in a practitioner's credentials and professional review files may be released in response to a properly authorized, written request from another hospital or its Medical Staff. Such requests must include notification that the practitioner is a member of the requesting hospital's Medical Staff or is an applicant for Medical Staff membership there. The request must be accompanied by a release of information and a release of liability from the practitioner in a form acceptable to the Chief of Staff and Chief Executive Officer. Disclosure shall be limited to the information requested. All responses to such requests shall be reviewed and concurred in by the Chief of Staff and the Chief Executive Officer.

c. In deciding whether to release any information, the Chief of Staff and the Chief Executive Officer may consult the Hospital's legal counsel.

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

ARTICLE XIV: RULES AND REGULATIONS

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

ARTICLE XV: PROFESSIONAL REVIEW

15.1. Professional Review.

The Medical Staff has delegated to the Medical Staff Quality Improvement Committee (MSQIC) primary authority to ensure that Medical Staff maintains the highest professional standards of practice. The MSQIC assesses individual matters and trends referred to it that meet the approved indicators and routinely evaluates the Ongoing Professional Practice Evaluations (OPPE) of all individuals granted clinical privileges and the Focused Professional Practice Evaluations (FPPE) other than the initial FPPE. The MSQIC recommends professional improvement opportunities for individual practitioners, and reports on individual case reviews to the Credentials Committee and to the MSEC, as appropriate.

15.2 Professional Performance Analysis.

For purposes of defining expectations of performance, the MSQIC uses the current Joint Commission General Competencies (MS 06.01.03), as amended from time to time.

15.3. Professional Review Management.

The MSQIC manages BRH's on-going professional practice evaluation process (OPPE and FPPE), consulting as appropriate with the Credentials Committee and the MSEC. The Credentials Committee manages focused professional practice evaluation of newly privileged practitioners (FPPE).

a. Cases may be referred to the MSQIC for professional review by the MSEC, the Credentials Committee, the Wellness Committee, the Quality Director or the CEO. The MSQIC may also, at its own initiative, open cases based on OPPE indicators.

b. The MSQIC may consult with an external reviewer as part of the professional review process. The external reviewer will report findings and recommendations back to the MSQIC. Circumstances indicating external consultation include, but are not limited to:

1. Lack of internal expertise: when no one on the MSQIC has adequate expertise in the specialty under review; including new procedures or technology.

2. Ambiguity: when dealing with vague or conflicting recommendations from reviewers, medical staff committees or administration.

3. Credibility: when the only practitioners on the medical staff with the needed expertise were involved in the case or have a conflict of interest.

4. Benchmarking: when the MSQIC is concerned about the care provided by its physicians relative to best practices and wishes to better define its expectations and as future quality monitoring to determine whether improvement has been achieved.

5. Lack of internal resources: when the medical staff has the expertise but lacks sufficient time to perform the needed Professional review.

15.4 Professional Review Procedures: Professional review will be conducted by the MSQIC members present at the meeting when a case is reviewed. MSQIC meetings will be conducted informally and expeditiously. The MSQIC members will seek consensus on cases.

a. The MSQIC Chair will assign a lead reviewer to each case. The lead reviewer will perform an initial assessment of the case.

b. If the lead reviewer has no questions or concerns about the care provided, the reviewer will recommend that the MSQIC close the case. If the MSQIC agrees, a "care appropriate or exemplary" form will be placed in the provider's quality file, with copies to the provider.

c. If the lead reviewer has questions or concerns about the care provided, the MSQIC will send a letter to the involved practitioner. The letter will identify the questions and concerns, and invite the practitioner to submit a response in writing.

d. The MSQIC may review charts, notes or any other materials that it deems useful, may request the assistance and expertise of other medical staff members, may interview hospital staff or medical staff members, and may consult with an external reviewer if it deems these actions appropriate.

e. The MSQIC will apply the analysis framework described above when reviewing and reporting on a case. The MSQIC will report its findings as follows:

1. Normally the lead reviewer will report case findings on a MSQIC report form and will evaluate the cases as "care appropriate," "care inappropriate" or "care controversial."

2. MSQIC reports of cases deemed "care appropriate" will be placed in the practitioner's quality file, with a copy to the practitioner.

3. Confidential reports of cases that are deemed "care inappropriate" or "care controversial" will be forwarded to the practitioner as a short narrative letter describing the MSQIC's concerns.

(i) The narrative letter will identify performance improvement opportunities.

(ii) The MSQIC Chair will discuss the case and performance improvement opportunities with the practitioner.

(iii) The narrative letter will be placed in the involved practitioner's quality file, with a copy to the practitioner. The practitioner may place a written response in the quality file.

(iv) The MSQIC will report instances of "care controversial" or "care inappropriate" to the Credentials Committee, and may report any reports of care to the MSEC as it deems appropriate.

f. MSQIC reviews and other activities are not considered investigations or corrective action and are not reportable to the National Practitioner Data Bank, to the State Medical Board or to other licensing boards or agencies.

g. MSQIC reports, narrative letters, responses and any other MSQIC materials will be retained in the practitioner's quality file for six years, after which they will be destroyed by the Quality Director.

h. Portions of MSQIC meetings relating to professional review of individual practitioners will not be recorded. Minutes will not be taken of those discussions other than reflecting the time the discussion began, the names of those present, and the list of cases reviewed.

1. Only MSQIC members and individuals invited by the MSQIC may be present or participate in MSQIC meetings.

2. All notes or other documents created at the MSQIC meeting or by the MSQIC members relating to a case are considered confidential working notes and will be kept in a secure file or destroyed.

15.5 Use of Professional Review Information for System Improvements.
The MSEC and the MSQIC may use both aggregate and practitioner-specific MSQIC information, including Professional Review reports and practitioner responses, to identify system issues and recommend system improvements to the appropriate BRH department(s) or outside organizations.

15.6 Use of Professional Review Information for Credentialing.
The Credentialing Committee and the MSEC may use aggregate and practitioner-specific MSQIC information, including Professional Review reports and practitioner responses, in making recommendations regarding credentialing, privileging and performance improvement opportunities.

15.7 Practitioner Feedback Report.
The MSQIC will develop OPPE measures and regularly provide practitioners with their own data though a Practitioner Feedback Report (PFR).

a. PFRs will be distributed at a minimum annually to practitioners with significant clinical activity.

b. PFRs are a starting point for identifying improvement opportunities and are not considered definitive until further evaluation is conducted, including OPPE and FPPE, if appropriate.

c. PFRs are confidential and may only be distributed to the individual practitioner, the MSQIC, the Credentials Committee and the MSEC.

d. The MSQIC will regularly evaluate the OPPE measures used in the PFR, including rate or rule indicators, and will consult with the Credentials Committee on ways to implement and improve the PFR system, including adding or changing PFR criteria.

    1. The PFR may contain indicators for feedback purposes only that will not be used in reappointment decisions (e.g., length of stay).

    2. The MSQIC will assure that the medical staff has sufficient lead time to adapt its practices before new or changed PFR indicators are used in credentialing and privileging decisions.

e. The MSQIC will determine acceptable thresholds for PFR indicators. When these criteria are exceeded, the MSQIC Chair will advise the Credentials Committee and the MSEC that the practitioner should be considered for OPPE or FPPE.

15.8 MSQIC Information is Confidential.
Professional review information is strictly confidential to the maximum extent allowed by federal and state law, and is to be treated as strictly confidential by the MSQIC and any other individual or body

that is involved in the Professional review process. Practitioner-specific professional review information, including the information in a practitioner's quality file, may be reviewed only by authorized individuals who have a legitimate need to know the information.

a. The following individuals are authorized to access individual practitioner quality files. The files must be reviewed under the supervision of the Quality Director. The authorized individuals are:

    1. The involved practitioner;

    2. MSEC officers, the Credentials Committee Chair and the MSQIC Chair;

    3. Medical staff services professionals and quality staff supporting the MSQIC and the professional review process, strictly for administrative assistance; and

    4. Accreditation surveyors with appropriate jurisdiction (e.g., Joint Commission or CLIA) and federal or state agency officials authorized by law to review the quality files.

b. Other individuals requesting access to a practitioner's quality file must make a request in writing to the MSEC, and will only be permitted access if authorized by law and for good cause shown.

c. Subpoenas pertaining to MSQIC records and individual practitioner quality files shall be referred to the Compliance Officer, who shall consult with the Quality Director and the CEO and, if appropriate, the Hospital Attorney before releasing any documents. The Compliance Officer will notify the practitioner and provide the practitioner with a copy of the subpoena.

d. Written or electronic documents related to a professional review other than the final MSQIC report, narrative letter and the practitioner's response shall be considered MSQIC working notes. Working notes shall be maintained in secured MSQIC files and not in the practitioner's quality file. The Quality Director will destroy working notes when the professional review process relating to the case is completed, or three months following the date the narrative letter is issued, whichever is earlier.

e. Documents, including reports and correspondence, prepared in connection with all professional review activities should be labeled a notice containing the following language or substantially similar language:

    "CONFIDENTIAL: This document contains information acquired by or provided to the BRH Medical Staff Quality Improvement Committee in its capacity as a professional review organization. This document is confidential and may not be copied, distributed, discussed, circulated or produced to any unauthorized individual or entity except as specifically provided by and in accordance with the Alaska Medical Review

Organization Act, AS 18.23.010-.040, and the policies and procedures of the BRH Medical Staff."

f. All persons attending a MSQIC meeting or otherwise participating in professional review activities will sign a statement of confidentiality before participating in the meeting or engaging in any other professional review activities. MSQIC members will sign the statement upon appointment and at least annually.

15.9 Conflict of Interest.

A member of the medical staff requested to perform professional review has a conflict of interest if for any reason he or she may not be able to render an unbiased opinion. Conflicts of interest may be absolute or potential.

a. An actual conflict of interest exists if the member:

1. is the involved practitioner or was otherwise personally involved in the care under review;

2. is a first degree relative or spouse, in a close personal relationship, or in a business relationship with the involved practitioner; or

3. is in economic competition with the involved practitioner, unless no other practitioner with the requisite expertise is reasonably available.

b. A potential conflict of interest exists if the member:

1. was directly involved in the patient's care, although not related to the issues under review; or

2. has a personal or professional conflict with the involved practitioner such that a reasonable person might conclude that the member may not be unbiased during the professional review process.

c. It is the obligation of the member to promptly and completely disclose to the MSQIC Chair any actual or potential conflict of interest.

d. If an actual conflict of interest exists, the member is disqualified from participating in the case under review. When a potential conflict is disclosed, the MSQIC Chair will determine if the conflict is such that the member should be disqualified. The MSQIC Chair's decision is final.

e. A disqualified member may not participate or be present during MSQIC discussions or deliberations on the case under review, other than to provide specific information if requested by the MSQIC.

ARTICLE XVI: AMENDMENTS

16.1 Any member of the Active Medical Staff may submit a proposed Bylaw amendment at any regular meeting of the Medical Staff.

a. The proposed amendment shall be referred to the MSEC for review. The MSEC may refer the proposed amendment for comment to any other Medical Staff committee or to an ad hoc Bylaw Committee.

b. Following receipt of comments, if any, the MSEC will make a recommendation concerning the proposed amendment and will present the recommendation at a subsequent regular Medical Staff meeting (first reading). No action on the proposal will be taken at this meeting.

c. The proposed amendment will be considered for adoption at the next regular Medical Staff meeting (second reading), and may be adopted by a majority vote of the Active Staff members present and voting.

c. Amendments adopted by the Medical Staff are effective when approved by the Hospital Board.

16.2 The MSEC may adopt technical amendments to these Bylaws that are, in its judgment, technical or legal modifications or clarification, reorganization or renumbering, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression, inaccurate cross-references, or to reflect changes in committee names. Technical amendments shall be presented to the Medical Staff at a regular meeting, and will be adopted and forwarded to the Hospital Board if unanimously approved at the meeting. If not adopted unanimously, the amendments will be reviewed in accordance with Section 16.1 above.

16.3 Bylaw amendments of any type become effective when agreed to by the Hospital Board.

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

ARTICLE XVII: ADOPTION OF REVISED BYLAWS

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

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

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

ADOPTED by the Active Medical Staff on __July 5, 2011.

ATTEST:

_____
Chief of Staff

_____
Medical Staff Secretary

APPROVED by the City and Borough of Juneau Hospital Board on ___July 26, 2011.

ATTEST:

_____
Hospital Board Chair

_____
Chief Executive Officer