



MEDICAL STAFF BYLAWS

PROVIDENCE ALASKA MEDICAL CENTER

APPROVED by the Providence Alaska Region Board

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Christine Kramer, ANP, Chair

Final Approval at PHSA
Regional Board Meeting

Date: 04/21/2021

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Lindsay Cobb, MD, Chief of Staff

Final Approval at Medical
Executive Committee Meeting

Date: 11/09/2020

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Lindsay Cobb, MD, Chief of Staff

Final Approval at General
Staff Meeting

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ARTICLE 1: GENERAL

1.A. TIME LIMITS

Time limits referred to in the Bylaws, Rules and Regulations and related policies and manuals are advisory only and are not mandatory, unless it is expressly stated.

1.B. DELEGATION OF FUNCTIONS

1.B.1 When a function is to be carried out by a member of Medical Center Administration, by a Medical Staff Leader or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

1.B.2 When a Medical Staff or Allied Health Staff member is unavailable or unable to perform an assigned function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.C. INDEMNIFICATION

The Medical Center will provide a legal defense for, and will indemnify, all Medical Staff Leaders, peer review committees, members, and authorized representatives when engaged in those capacities, in accordance with applicable laws and the Medical Center's Bylaws.

1.D. ANNUAL MEDICAL STAFF DUES

1.D.1 Annual Medical Staff dues shall be recommended by the Medical Executive Committee and outlined in the Medical Staff Financial Procedures policy.

1.D.2 The Medical Staff Treasurer or designee shall notify the Medical Executive Committee in writing of any contemplated change in Medical Staff dues at least 30 days before the meeting at which voting on such proposed changes is to take place.

1.D.3 All Medical Staff members shall pay annual dues with the following exceptions:

- (a) Honorary Staff;
- (b) Locum Tenens staff (residing out of state);
- (c) Staff with only telemedicine privileges; and
- (d) Staff that joined the Medical Staff within the last three months of the year (October-December of previous year).

1.D.4 The Allied Health Professional Staff shall pay annual dues.

1.D.5 Annual dues for the Medical Staff and for the AHP Staff shall be due and payable at the time of appointment, and thereafter on December 31 for the upcoming calendar year. A dues notice of payment will be sent by November 30 of each year.

1.D.6 Failure to pay dues within 45 days of appointment will result in the following with an appropriate delinquency notification:

- (a) Dues not received after 45 days – Annual dues will double for both Medical Staff and AHPs.
- (b) Dues not received after 75 days – Annual dues will quadruple for both Medical Staff and AHPs.
- (c) Dues not received after 90 days – Medical Staff membership and clinical privileges will be subject to voluntary relinquishment until quadrupled dues are paid in full.
- (d) Dues that remain unpaid after 120 days, the practitioner’s membership and clinical privileges will be permanently relinquished and the practitioner must reapply to the Medical Staff as a new applicant.
- (e) Failure to pay dues by December 31 for the upcoming year (if December 31 falls on a weekend, payment is due by the following first business day) will result in the following with an appropriate delinquency notification:
 - (i) January 1 – January 31 – Annual dues will double for both Medical Staff and AHPs.
 - (ii) February 1 – February 28 – Dues not received after 75 days – Annual dues will quadruple for both Medical Staff and AHPs.
 - (iii) March 1 – Annual dues will quadruple for both Medical Staff and AHPs.
 - (iv) April 1 – If dues have not been received in the Medical Staff Services Department by April 1, then member must reapply to the Medical Staff or the AHP Staff.

1.E. EMPLOYMENT

Appointment and clinical privileges, and the process for considering an individual’s request for the same, are not part of the employment process and it is understood that the Medical Center’s employment policies and processes are not applicable.

1.F. DEFINITIONS The following definitions apply to terms used in these Bylaws and related policies, manuals, Rules and Regulations:

- (a) “ALLIED HEALTH PROFESSIONALS” (“AHPs”) means individuals other than members of the Medical Staff who are authorized by law and by the Medical Center to provide patient care services. The categories of allied health professionals practicing at the Medical Center are set forth in Appendix A to the Medical Staff Credentials Policy. Allied health professionals are described as Licensed Independent Providers, Certified Nurse Midwives, Certified Registered Nurse Anesthetists, Advanced Practice Clinicians or Dependent Providers in the Medical Staff Bylaws documents:
 - (i) “LICENSED INDEPENDENT PROVIDER” means an Allied Health Professional who is permitted by law and by the Medical Center to provide patient care services without direction or supervision, within the scope of his or her license and consistent with the clinical privileges granted. Licensed Independent Providers also include those physicians not appointed to the Medical Staff who seek to exercise certain limited clinical privileges as moonlighting residents.

- (ii) “CERTIFIED NURSE MIDWIFE” (“CNM”) means an Allied Health Professional who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges, but who is required by the Medical Center to have a written Collaborative Physician agreement.
- (iii) “CERTIFIED REGISTERED NURSE ANESTHETIST” (CRNA) means an Allied Health Professional who provides anesthesia to patients in all aspects of anesthesia care consistent with granted clinical privileges, but who is required by the Medical Center to have a written Collaborative Physician agreement.
- (iv) “ADVANCED PRACTICE CLINICIAN” (“APC”) means an Allied Health Professional who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges, but who is required by law and/or the Medical Center to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a Supervising Physician pursuant to a written supervision or collaborative agreement.
- (v) “DEPENDENT PROVIDER” means Allied Health Professionals who are permitted by law and the Medical Center to function only under the direction of a Supervising Physician, pursuant to a written supervision agreement and consistent with the scope of practice granted.
- (b) “ALLIED HEALTH STAFF” (“AHP Staff”) means those licensed independent providers, CNMs, CRNAs, and APCs who have been appointed to this Staff by the Board.
- (c) “APPLICANT” means any physician, dentist, oral surgeon, psychologist, podiatrist, or AHP who has submitted an application for initial appointment or reappointment to the Medical Staff or the Allied Health Staff or for clinical privileges.
- (d) “BOARD” means the Community Ministry Board of the Medical Center, which has the overall responsibility for the Medical Center, or its designated committee.
- (e) “CHIEF EXECUTIVE OFFICER” (“CEO”) means the individual appointed by the Board to act on its behalf in the overall management of Medical Center.
- (f) “CHIEF MEDICAL OFFICER” (“CMO”) means the individual appointed by the Medical Center to act as the Chief Medical Officer of the Medical Center, in cooperation with the Chief of Staff.
- (g) “CLINICAL PRIVILEGES” or “PRIVILEGES” means the authorization granted by the Board to render specific clinical procedures and patient care services, subject to the provisions of this Policy.
- (h) “CORE PRIVILEGES” or “CORE” means a defined grouping of clinical privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency or fellowship training for that specialty or subspecialty and that have been determined by the Medical Staff Leaders and Board to require closely related skills and experience.
- (i) “DAYS” means calendar days.
- (j) “DENTIST” means a doctor of dental surgery (“D.D.S.”) or doctor of dental medicine (“D.M.D.”).

- (k) “MEDICAL CENTER ADMINISTRATION” means the Chief Executive Officer or designee, including the administrator on call.
- (l) “MEDICAL CENTER” means Providence Alaska Medical Center, including all facilities within its provider-based status, as set forth in Appendix B.
- (m) “MEDICAL EXECUTIVE COMMITTEE” (“MEC”) means the Medical Executive Committee of the Medical Staff.
- (n) “MEDICAL STAFF” means all physicians, dentists, oral surgeons, and podiatrists who have been appointed to the Medical Staff by the Board.
- (o) “MEDICAL STAFF LEADER” means any Medical Staff officer, department chair, section chief, or committee chair.
- (p) “MEMBER” means any physician, dentist, oral surgeon, psychologist, podiatrist, nurse practitioner, or physician assistant who has been granted Medical Staff or Allied Health Staff appointment by the Board to practice at the Medical Center.
- (q) “NOTICE” means written communication by regular U.S. mail, e-mail, facsimile, or Medical Center mail.
- (r) “PATIENT CONTACTS” includes any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Medical Center or affiliate, including outpatient facilities.
- (s) “PHYSICIAN” includes both doctors of medicine (“M.D.s”) and doctors of osteopathy (“D.O.s”).
- (t) “PODIATRIST” means a doctor of podiatric medicine (“D.P.M.”).
- (u) “PSYCHOLOGIST” means an individual with a Ph.D. or Psy.D. in clinical psychology.
- (v) “RESTRICTION” means a mandatory concurrent consultation, where the consultant must approve the proposed procedure or treatment before privileges may be exercised, or concurrent proctoring for greater than 30 days. It does not include performance improvement steps placed upon the exercise of privileges, such as general consultation, second opinions, concurrent proctoring for less than 30 days, monitoring, education, training, mentoring or specification of a maximum number of patients, nor does it include a limitation on the exercise of clinical privileges resulting from an exclusive arrangement with another physician or group of physicians or other action by the Board.
- (w) “SCOPE OF PRACTICE” means the authorization granted to a Dependent Provider to perform certain clinical activities and functions under the supervision of a supervising physician.
- (x) “SPECIAL NOTICE” means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

- (y) “SPECIAL PRIVILEGES” means clinical privileges that fall outside of the core privileges for a given specialty, which require additional education, training, or experience beyond that required for core privileges in order to demonstrate competence.
- (z) “SUPERVISING PHYSICIAN” means a member with clinical privileges, who has agreed in writing to supervise or collaborate with an Advanced Practice Clinician, Certified Nurse Midwife, Certified Registered Nurse Anesthetist, or Dependent Provider pursuant to any applicable written supervision or collaborative agreement, for the actions of the Advanced Practice Clinician, Certified Nurse Midwife, Certified Registered Nurse Anesthetist, or Dependent Provider while he or she is practicing in the Medical Center.
- (aa) “SUPERVISION” means the supervision of, or collaboration with, an Advanced Practice Clinician, Certified Nurse Midwife, Certified Registered Nurse Anesthetist, or Dependent Provider by a supervising physician, that may or may not require the actual presence of the supervising physician, but that does require, at a minimum, that the supervising physician be readily available for consultation. The requisite level of supervision (general, direct, or personal) will be determined at the time each Advanced Practice Clinician, Certified Nurse Midwife, Certified Registered Nurse Anesthetist, or Dependent Provider is credentialed and will be consistent with any applicable written supervision or collaboration agreement.
- (bb) “UNASSIGNED PATIENT” means any individual who comes to the Medical Center for care and treatment who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him/her care while a patient at the Medical Center.

ARTICLE 2: CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff and Allied Health Staff set forth in the Credentials Policy are eligible to apply for appointment to one of the categories listed below. Categories, with the respective prerogatives and responsibilities, are summarized in the chart attached as Appendix A to these Bylaws.

2.A. PRIVILEGED MEDICAL STAFF

2. A.1 Qualifications: The Privileged Medical Staff shall consist of those Medical Staff Members who are granted clinical privileges at the Hospital, not including practitioners who fall into the categories of Allied Health, or Locum Tenens. Privileged Medical Staff Members consists of practitioners with the degrees of MD, DO, DPM, DDS, or DMD.

Prerogatives:

- (a) vote in general and special meetings of the Medical Staff and applicable department and committee meetings;
- (b) hold office, serve on Medical Staff committees, and serve as department chair and committee chair; and
- (c) exercise clinical privileges granted.

Responsibilities:

- (d) serving on committees, as reasonably requested;
- (e) providing specialty coverage for the Emergency Department and accepting referrals from the Emergency Department for follow-up care of patients.
 - (i) Requests for exemption from Emergency Department call coverage will be at the discretion of the Department Chair, MEC, and the Board. The request will be reviewed by the department chair and a recommendation made to the MEC. In reviewing a request, consideration should be given to need and the effect on others who serve on the Emergency Department call roster. The MEC's recommendation will be subject to final action by the Board. A member who is relieved of the obligation of providing coverage may be required to resume on-call duties if the Board determines, at a later date, that call coverage in the member's specialty area is not adequate; or that call coverage from a member's specialty is now needed. Consideration for requests to be excused from providing emergency call coverage will be granted to:
 - Specialties which are not required to participate in emergency call coverage.
 - Members of the Privileged Staff who are 65 years of age, or older, plus 10 years on staff.
- (f) providing care for unassigned patients;
- (g) participating in the professional practice evaluation and performance improvement processes;
- (h) accepting inpatient consultations, when requested; and
- (i) paying application fees, annual dues, and assessments.

2.B. LOCUM TENENS STAFF

2.B.1 Qualifications: Desire appointment of privileges solely for the purpose of being able to provide coverage assistance to Privileged Staff members or as requested by PAMC;

- (a) when providing coverage assistance for a Privileged Staff member, will be entitled to admit and/or treat patients who are the responsibility of the Privileged Staff member who is being covered (i.e., the Privileged Staff member's own patients or unassigned patients who present through the Emergency Department when the Privileged Staff member is on call);

2.B.2 Duration: Locum Tenens Staff will be appointed for a one (1) year period, after which their privileges will be automatically relinquished. If Locum Tenens desire to practice for a period of longer than one (1) year then they shall apply for Privileged status.

2.B.3 Rights:

- (a) may attend Medical Staff and department meetings if invited (without vote);
- (b) may not hold office or serve as department chair or committee chair unless waived by MEC and the Board;
- (c) may exercise clinical privileges granted; and

- (d) are a courtesy provided by the Hospital, and the modification, denial, or termination of such Locum Tenens privileges does not entitle the practitioner to any of the procedural rights provided in the Bylaws or Medical Staff Policies with respect to hearing or appeals.

2.B.4 Responsibilities:

- (a) providing specialty coverage for the Emergency Department and accepting referrals from the Emergency Department for follow-up care of patients;
- (b) providing care for unassigned patients;
- (c) accepting inpatient consultations, when requested;
- (d) must cooperate in the professional practice evaluation and performance improvement processes; and
- (e) paying application fees.

2.C. COMMUNITY AFFILIATE STAFF

2.C.1 Qualifications: The Community Affiliate Staff will consist of members of the Medical Staff who:

- (a) desire to be associated with, but who do not intend to establish a practice at, this Medical Center;
- (b) are interested in pursuing professional and educational opportunities, including continuing medical education, available at the Medical Center; and
- (c) satisfy the qualifications for appointment set forth in the Credentials Policy, but are exempt from the qualifications pertaining to response time, **malpractice insurance**, and course requirements.

2.C.2 Prerogatives: The grant of appointment to the Community Affiliate Staff is a courtesy only, which may be terminated by the Board upon recommendation of the MEC, with no right to a hearing or appeal. Community Affiliate Staff members:

- (a) may attend meetings of the Medical Staff and applicable departments (without vote);
- (b) may not hold office or serve as department chair;
- (c) may serve on committees (with vote), including as committee chair (except for Allied Health staff);
- (d) may attend educational activities sponsored by the Medical Staff and the Medical Center;
- (e) may refer patients to members of the Medical Staff for admission and care;
- (f) are encouraged to communicate directly with Privileged Staff members about the care of any patients referred, as well as to visit any such patients and record a courtesy progress note in the medical record containing relevant information from the patient's outpatient care;

- (g) may review the medical records and test results (via paper or electronic access) for any patients who are referred;
- (h) may perform preoperative history and physical examinations in the office and have those reports entered into the Medical Center's medical records;
- (i) are not granted inpatient or outpatient clinical privileges and, therefore, may not admit patients, attend patients, write orders for inpatients, perform consultations or otherwise participate in the management of clinical care to patients at the Medical Center; and
- (j) may refer patients to the Medical Center's diagnostic facilities and order such tests.

2.C.3 Responsibilities:

- (a) must pay application fees, annual dues, and assessments.

2.D. HONORARY STAFF

2.D.1 Qualifications: The Honorary Staff will consist of members of the Medical Staff who:

- (a) have a record of previous long-standing service to the Medical Center, have retired from the active practice of medicine; and, in the discretion of the MEC, are in good standing at the time of initial application for membership on the Honorary Staff; or
- (b) are recognized for outstanding or noteworthy contributions to the medical sciences.
- (c) Once an individual is appointed to the Honorary Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application.

2.D.2 Prerogatives:

- (a) may not consult, admit, or attend to patients;
- (b) may attend Medical Staff and department meetings when invited to do so (without vote);
- (c) may be appointed to committees (with vote);
- (d) may not hold office or serve as department chair or committee chair; and
- (e) are entitled to attend educational programs of the Medical Staff and the Medical Center; and

2.D.3 Responsibilities:

- (a) are not required to pay application fees, dues, or assessments.

2.E. ADMINISTRATIVE STAFF

2.E.1 Qualifications: The Administrative Staff will consist of members of the Medical Staff who:

- (a) are not otherwise eligible for another staff category and who are employed by or have a contract with the Medical Center or Medical Staff to perform administrative activities.
- (b) Administrative Staff membership will automatically terminate on the date on which the member's affiliation with the Medical Center is terminated.

2.E.2 Rights:

- (a) Administrative Staff members are not eligible to hold Medical Staff office, to vote, or to serve on standing Medical Staff committees, except where designated in their job descriptions and provided for in these Bylaws.

2.E.3 Responsibilities:

- (a) must pay applicable fees, annual dues, and assessments;
- (b) devote their full time to performing administrative duties at the Medical Center; and
- (c) are not engaged in any clinical practice and do not have the responsibility for patient care, except as these activities may directly relate to an administrative duty.

2.F. ALLIED HEALTH STAFF

2.F.1 Qualifications: The Allied Health Staff is not a category of the Medical Staff, but is included in this Article for convenient reference.

2.F.2 Prerogatives:

- (a) may attend and participate in Medical Staff, department meetings without vote, unless indicated in the Department's rules and regulations;
- (b) may not hold office or serve as department chair or committee chair;
- (c) may exercise such clinical privileges or scope of practice as granted; and
- (d) may be invited to serve on committees (with vote).

2.F.3 Responsibilities:

- (a) must cooperate in the professional practice evaluation and performance improvement processes;
- (b) must pay application fees, annual dues, and assessments.

2.G. TEMPORARY STAFF

2.G.1 Qualifications: The Temporary Staff will consist of non-members of the Medical Staff who:

- (a) have met all requirements as outlined in the Credentials Policy; AND

- (b) have been granted temporary privileges for specialized care and desire to follow their patients during their hospitalization; OR
- (c) who meet the “interim” requirements; OR
- (d) who provide practice coverage for a specified period of time to a member of the Staff.

2.G.2 Rights:

- (a) Temporary Staff are not members of the Medical Staff.
- (b) may not attend or participate in Medical Staff meetings;
- (c) may not hold office or serve as department chair or committee chair;
- (d) the Chief Executive Officer, or designee, may at any time, upon the recommendation of the President of the Staff or Chief Medical Officer, terminate a Practitioner's temporary privileges effective immediately; and
- (e) shall not have any of the rights or prerogatives of membership, but shall abide by all applicable hospital and Medical Staff Bylaws, Rules and Regulations and other governance documents.

2.H. EXTERNAL PROCTORS

2.H.1 Qualifications: The External Proctor Staff will consist of non-members of the Medical Staff who:

- (a) have been granted authorization to act as a proctor;
- (b) provide proctoring services, not available from a current member of the Medical Staff, at the request of a member of the Staff; and
- (c) satisfy the qualifications for authorization set forth in the Credentials Policy.

2.H.2 Rights:

- (a) may not admit, treat, examine, consult, write or give verbal orders, perform or assist (except verbally) with procedures, write in the medical record, or otherwise participate directly in the care of any patient;
- (b) the Chief Executive Officer, or designee, may at any time, upon the recommendation of the President of the Staff or Chief Medical Officer, terminate a Practitioner's proctoring authorization effective immediately;
- (c) shall not have any of the rights or prerogatives of membership, but shall abide by all applicable hospital and Medical Staff Bylaws, Rules and Regulations and other governance documents;
- (d) authorization may be granted for a period of up to one year;
- (e) may not attend or participate in Medical Staff meetings; and

- (f) may not hold office or serve as department chair or committee chair.

2.I. DISASTER PRIVILEGES

- (a) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the Chief Medical Officer or the Chief of Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners (“volunteers”). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.
- (b) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.
 - (i) A volunteer’s identity may be verified through a valid government-issued photo identification (i.e., driver’s license or passport).
 - (ii) A volunteer’s license may be verified in any of the following ways: (1) current Medical Center picture ID card that clearly identifies the individual’s professional designation; (2) current license to practice; (3) primary source verification of the license; (4) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (5) identification by a current Medical Center employee or Medical Staff or Allied Health Staff member who possesses personal knowledge regarding the individual’s ability to act as a volunteer during a disaster.
 - (iii) Primary source verification of a volunteer’s license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Medical Center.
 - (iv) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer’s demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.
 - (v) The Medical Staff will oversee the care provided by volunteer licensed independent practitioners. This oversight will be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Medical Center.

ARTICLE 3: OFFICERS

3.A. DESIGNATION: The Medical Staff will have the following officers:

- (a) Chief of Staff;
- (b) Vice Chief of Staff;

- (c) Treasurer; and
- (d) Immediate Past Chief of Staff.

3.B. ELIGIBILITY CRITERIA:

Only those members of the Medical Staff who satisfy the following criteria initially and continuously will be eligible to serve as an officer and Members at Large of the Medical Staff (unless an exception is recommended by the MEC and approved by the Board). They must:

- (a) have served on the Medical Staff for at least three years (as reasonable and feasible);
- (b) have no pending adverse recommendations concerning appointment or clinical privileges;
- (c) not presently be serving as a Medical Staff officer, Board member, or department chair at any other hospital and will not so serve during their terms of office;
- (d) be willing to faithfully discharge the duties and responsibilities of the position;
- (e) have experience in a leadership position or other involvement in performance improvement functions for at least two years;
- (f) participate in Medical Staff Leadership training as determined by the MEC;
- (g) have demonstrated an ability to work well with others; and
- (h) not have any financial relationship (i.e., an ownership or investment interest in or compensation arrangement) with an entity that competes with the Medical Center. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner.

3.C. DUTIES

3.C.1 Chief of Staff: The Chief of Staff will:

- (a) act in coordination and cooperation with the CMO, the CEO, and the Board in matters of mutual concern involving the care of patients in the Medical Center;
- (b) represent and communicate the views, policies and needs, and report on the activities, of the Medical Staff to the CEO, CMO, and the Board;
- (c) call, preside at, and be responsible for the agenda of meetings of the Medical Staff and the MEC;
- (d) promote adherence to the Bylaws, policies, rules and regulations of the Medical Staff and to the policies and procedures of the Medical Center;
- (e) serve on the Board; and

- (f) perform functions authorized in these Bylaws and other applicable policies, including collegial intervention in the Credentials Policy.

3.C.2 Vice Chief of Staff: The Vice Chief of Staff will:

- (a) assume the duties of the Chief of Staff and act with full authority as Chief of Staff in his/her absence;
- (b) perform other duties as are assigned by the Chief of Staff or the MEC; and
- (c) automatically succeed the Chief of Staff at the beginning of the next Medical Staff year (unless the Chief of Staff is reelected) or sooner should the office become vacated for any reason during the Chief's term of office.

3.C.3 Treasurer: The Treasurer will:

- (a) oversee the collection of and accounting for any Medical Staff funds and make disbursements authorized by the MEC; and
- (b) perform other duties as are assigned by the Chief of Staff or the MEC.

3.C.4 Immediate Past Chief of Staff: The Immediate Past Chief of Staff will:

- (a) serve as an advisor to other Medical Staff Leaders; and
- (b) perform other duties as are assigned by the Chief of Staff or the MEC.

3.D. NOMINATION AND ELECTION PROCESS

3.D.1 Nominating Committee:

The MEC will appoint at least three members of the Medical Staff to serve on the Nominating Committee, including at least two Past Chiefs of Staff, when possible. Members of the Nominating Committee must meet the qualifications set forth in Section 3.B of these Bylaws. The Chief of Staff and the CMO will be *ex officio* members, without vote, on the Nominating Committee.

3.D.2 Nominating Process:

- (a) Not less than 45 days prior to the annual meeting of the Medical Staff, the Nominating Committee will prepare a slate of nominees for each Medical Staff office and for any at-large member position of the MEC that will be vacant. Notice of the nominees will be provided to the Medical Staff at least 30 days prior to the election.
- (b) Additional nominations may be submitted, in writing, by a petition signed by at least 10% of the voting members of the Medical Staff. The petition must be presented to the Chair of the Nominating Committee at least ten days prior to the annual meeting.

- (c) In order for a nominee to be placed on the ballot, the candidate must be willing to serve and must, in the judgment of the Nominating Committee, satisfy the qualifications in Section 3.B of these Bylaws.
- (d) Nominations from the floor will not be accepted.

3.D.3 Election:

- (a) The election will take place at a meeting of the Medical Staff. If there are two or more candidates for any office or position, the vote will be by written ballot.
- (b) The candidates receiving a majority of the votes cast will be elected, subject to Board confirmation.
- (c) If no candidate receives a simple majority vote on the first ballot, a run-off election will be held promptly between the two candidates receiving the highest number of votes.

3.E. TERM OF OFFICE, VACANCIES AND REMOVAL

3.E.1 Term of Office:

- (a) Officers will assume office on the first day of the Medical Staff year.
- (b) Medical Staff officers will serve an initial two-year term and may be reelected for up to two additional two-year terms.
- (c) At-large members of the MEC will serve a two-year term and may be elected to serve additional two-year terms.

3.E.2 Vacancies:

- (a) If there is a vacancy in the office of Chief of Staff, the Vice Chief of Staff will serve until the end of the unexpired term of the Chief of Staff.
- (b) If there is a vacancy in the office of Vice Chief of Staff or Treasurer, the MEC will appoint an individual, who satisfies the qualifications set forth in Section 3.B of these Bylaws, to the office until a special election can be held. The appointment will be effective upon confirmation by the Board.
- (c) If there is a vacancy in the position of an at-large member of the MEC, the MEC will appoint an individual, who satisfies the qualifications set forth in Section 3.B of these Bylaws, to the position until a special election can be held. The appointment will be effective upon confirmation by the Board.

3.E.3 Removal:

- (a) Removal of an elected officer or an at-large member of the MEC may be effectuated by a two-thirds vote of the Medical Staff or a three-fourths vote of the MEC, or by the Board for:
 - (i) failure to comply with applicable policies, Bylaws, or the Rules and Regulations;
 - (ii) failure to perform the duties of the position held;

- (iii) conduct detrimental to the interests of the Medical Staff or the Medical Center;
 - (iv) an infirmity that renders the individual incapable of fulfilling the duties of that office; or
 - (v) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws.
- (b) Prior to scheduling a meeting to consider removal, a representative from the Medical Staff, MEC or the Board will meet with and inform the individual of the reasons for the proposed removal proceedings.
 - (c) The individual will be given at least ten days' special notice of the date of the meeting at which removal is to be considered. The individual will be afforded an opportunity to address the MEC, the Privileged Staff, or the Board, as applicable, prior to a vote on removal.
 - (d) Removal will be effective when confirmed by the Board.

ARTICLE 4: CLINICAL DEPARTMENTS

4.A. ORGANIZATION

4.A.1 Organization of Departments:

- (a) The Medical Staff may be organized into the clinical departments as listed in the Medical Staff Organization Manual.
- (b) Subject to the approval of the Board, the MEC may create or eliminate departments, create or eliminate sections within departments, or otherwise reorganize the department structure, including but not limited to the creation of service lines.
- (c) Sections representing sub-specialties may be established within the departments as specified in these Bylaws, Policies and Department Rules and Regulations. Such sections shall be directly responsible to departments. The chair of the department shall designate chiefs of the sub-sections as per Department Rules and Regulations.

4.A.2 Assignment to Departments:

- (a) Upon initial appointment to the Medical Staff, each member will be assigned to a clinical department. Assignment to a particular department does not preclude an individual from seeking and being granted clinical privileges typically associated with another department.
- (b) An individual may request a change in department assignment to reflect a change in the individual's clinical practice.

- #### **4.A.3 Functions of Departments:** The departments are organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the department; (ii) to monitor the practice of individuals with clinical privileges or a scope of practice in a given department; and (iii) to provide appropriate specialty coverage in the Emergency Department, consistent with the provisions in these Bylaws and related documents.

4.B. DEPARTMENT CHAIRS

4.B.1 Qualifications: Each department chair will:

- (a) be a Privileged Staff member;
- (b) be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process; and
- (c) satisfy the eligibility criteria in Section 3.B.

4.B.2 Selection and Term of Department Chairs:

- (a) Except as otherwise provided by contract, when there is a vacancy in a department chair position, or a new department is created, the department will elect a new chair. The election of a chair by the department will be forwarded to the MEC and Board for final action.
- (b) Except as may otherwise be provided by contract, a department chair will serve a term of two years and may succeed himself or herself for two additional terms.
- (c) Each department chair may appoint a designee to perform functions, including chairing department meetings and serving on committees when the chair is unable to be present, subject to the approval of the Chief of Staff in consultation with the CMO. The chair is expected to attend 75% of department and applicable meetings of the Medical Executive Committee, and any applicable quality-related committee.

4.B.3 Performance Evaluation for Department Chairs:

- (a) A performance evaluation of the department chair will be initiated by the CMO, who may appoint a committee to assist in this function.
- (b) The following factors may be addressed as part of the evaluation:
 - (i) quality and support of the department as it interfaces with other Medical Center departments;
 - (ii) communication, coordination, quality and service of care within the department;
 - (iii) effectiveness of the performance improvement program; and
 - (iv) where appropriate, contribution to patient care, education and research.
- (c) The CMO will prepare a written report of the evaluation and provide a copy to the relevant department chair. The Chief of Staff will also receive a copy of the report and have an opportunity to comment on it.
- (d) The CMO will monitor the department chair's improvement activities and report progress to the Chief of Staff and the Board.

4.B.4 Removal of Department Chairs:

- (a) Removal of a department chair may be effectuated by a two-thirds vote of the department or a three-fourths vote of the MEC, or by the Board for:
 - (i) failure to comply with the Bylaws or applicable policies, or rules and regulations;
 - (ii) failure to perform the duties of the position held;

- (iii) conduct detrimental to the interests of the Medical Staff or the Medical Center;
 - (iv) an infirmity that renders the individual incapable of fulfilling the duties of that office; or
 - (v) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws.
- (b) Prior to scheduling a meeting to consider removal, a representative from the department, MEC, or Board will meet with and inform the individual of the reasons for the proposed removal proceedings.
 - (c) The individual will be given at least ten days' special notice of the date of the meeting at which removal is to be considered. The individual will be afforded an opportunity to address the department, the MEC, or the Board, as applicable, prior to a vote on removal.
 - (d) Removal will be effective when approved by the Board.

4.B.5 Duties of Department Chairs: Each department chair is responsible for the following functions, either individually or in collaboration with the duly approved designee and, as applicable, Medical Center personnel:

- (a) all clinically-related activities of the department;
- (b) all administratively-related activities of the department, unless otherwise provided for by the Medical Center;
- (c) continuing surveillance of the professional performance of individuals in the department who have delineated clinical privileges, including performing ongoing and focused professional practice evaluations;
- (d) recommending criteria for clinical privileges that are relevant to the care provided in the department;
- (e) evaluating requests for clinical privileges for each member of the department;
- (f) assessing and recommending off-site sources for needed patient care, treatment, and services not provided by the department or the Medical Center;
- (g) the integration of the department into the primary functions of the Medical Center;
- (h) the coordination and integration of interdepartmental and intradepartmental services;
- (i) the development and implementation of policies and procedures that advance quality and that guide and support the provision of care, treatment, and services;
- (j) recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;
- (k) determination of the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;
- (l) continuous assessment and improvement of the quality of care, treatment, and services provided;
- (m) maintenance of quality monitoring programs, as appropriate;

- (n) the orientation and continuing education of persons in the department;
- (o) recommendations for space and other resources needed by the department; and
- (p) performing functions authorized in the Credentials Policy, including collegial intervention efforts.

ARTICLE 5: MEDICAL STAFF COMMITTEES AND PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. GENERAL

5.A.1 Appointment:

- (a) This Article and the Medical Staff Organization Manual outline the committees of the Medical Staff that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board.
- (b) Except as otherwise provided by these Bylaws or the Medical Staff Organization Manual, the Chief of Staff will appoint the members and the chair of each Medical Staff committee, in consultation with the CMO. Committee chairs must satisfy the criteria in Section 3.B of these Bylaws. The Chief of Staff will also recommend Medical Staff representatives to Medical Center committees.
- (c) The CMO will make appointments of administrative staff to Medical Staff committees. Administrative staff will serve on Medical Staff committees without the right to vote.
- (d) Chairs and members of standing committees will be appointed for an initial term of two years, but may be reappointed for additional terms.
- (e) Chairs and members of standing committees may be removed and vacancies filled by the Chief of Staff.
- (f) The Chief of Staff will be an *ex officio* member, without vote (except in the case of a tie), on all Medical Staff committees.
- (g) The CMO, CEO and CMIO will be *ex officio* members, without vote, on all Medical Staff committees.
- (h) A Board member may attend Medical Staff committee meetings as discussed in advance with the applicable committee chair, the Chief of Staff or the CMO.

5.A.2 Meetings, Reports and Recommendations: Except as otherwise provided, committees will meet, as necessary, to accomplish their functions, and will maintain a permanent record of their findings, proceedings, and actions. Committees will make timely written reports to the MEC.

5.B. MEDICAL EXECUTIVE COMMITTEE

5.B.1 Composition:

- (a) The MEC will include:
 - (i) the Chief of Staff;
 - (ii) the Vice Chief of Staff;

- (iii) the Treasurer;
- (iv) the Immediate Past President;
- (v) the clinical department chairs;
- (vi) the Medical Director of Health and Wellness;
- (vii) the Trauma Medical Director;
- (viii) one at-large member for every 200 Medical Staff members;
- (ix) Chair of the Graduate Medical Education Committee, *ex officio*, with vote;
- (x) Chair of the Credentials Committee, *ex officio*, with vote;
- (xi) CEO and the CMO, *ex officio*, without vote;
- (xii) The Chair of the Bylaws Committee, with vote.

(b) The Chief of Staff will serve as chair of the MEC, without vote, except in the event of a tie.

(c) The Chair of the Board may attend meetings of the MEC, *ex officio*, without vote.

(d) Other individuals may be invited to MEC meetings as guests, without vote.

5.B.2 Duties: The MEC is delegated the primary authority over activities related to the Medical Staff and to performance improvement activities. This authority may be removed or modified by amending these Bylaws and related policies. The MEC is responsible for the following:

- (a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between MEC meetings);
- (b) recommending directly to the Board on at least the following:
 - (i) the Medical Staff's structure;
 - (ii) the mechanism used to review credentials and to delineate individual clinical privileges;
 - (iii) applicants for Medical Staff appointment and reappointment;
 - (iv) delineation of clinical privileges for each eligible individual;
 - (v) participation of the Medical Staff in Medical Center performance improvement activities and the quality of professional services being provided by the Medical Staff;
 - (vi) the mechanism by which Medical Staff appointment may be terminated;
 - (vii) hearing procedures; and
 - (viii) reports and recommendations from Medical Staff committees, departments, and other groups, as appropriate;
- (c) consulting with Administration on quality-related aspects of contracts for patient care services;
- (d) providing oversight and guidance with respect to continuing medical education activities;
- (e) reviewing or delegating the review of quality indicators to facilitate uniformity regarding patient care services;
- (f) providing leadership in activities related to patient safety;
- (g) providing oversight in the process of analyzing and improving patient satisfaction;

- (h) ensuring that, at least every three years or other time period in accordance with applicable state law or other requirements, the Bylaws and applicable policies are reviewed and updated;
- (i) providing and promoting effective liaison among the Medical Staff, Administration, and the Board;
- (j) recommending clinical services, if any, to be provided by telemedicine;
- (k) reviewing and approving all standing orders for consistency with nationally recognized and evidence-based guidelines; and
- (l) performing any other functions as are assigned to it by these Bylaws, the Credentials Policy or other applicable policies.

5.B.3 Meetings: The MEC will meet at least ten times a year and more often if necessary to fulfill its responsibilities and maintain a permanent record of its proceedings and actions.

5.C. PERFORMANCE IMPROVEMENT FUNCTIONS

- (a) The Medical Staff is actively involved in the measurement, assessment, and improvement of at least the following:
 - (i) patient safety, including processes to respond to patient safety alerts, meet patient safety goals, and reduce patient safety risks;
 - (ii) the Medical Center's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services core measures;
 - (iii) medical assessment and treatment of patients;
 - (iv) medication usage, including review of significant adverse drug reactions, medication errors and the use of experimental drugs and procedures;
 - (v) the utilization of blood and blood components, including review of significant transfusion reactions;
 - (vi) operative and other invasive procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;
 - (vii) appropriateness of clinical practice patterns;
 - (viii) significant departures from established patterns of clinical practice;
 - (ix) use of information about adverse privileging determinations regarding any practitioner;
 - (x) the use of developed criteria for autopsies;
 - (xi) sentinel events, including root cause analyses and responses to unanticipated adverse events;
 - (xii) healthcare associated infections;
 - (xiii) unnecessary procedures or treatment;
 - (xiv) appropriate resource utilization;
 - (xv) education of patients and families;
 - (xvi) coordination of care, treatment, and services with other practitioners and Medical Center personnel;
 - (xvii) accurate, timely, and legible completion of patients' medical records;
 - (xviii) the required content and quality of history and physical examinations, as well as the time frames required for completion, which are set forth in Article 9 of these Bylaws;
 - (xix) review of findings from the ongoing and focused professional practice evaluation activities that are relevant to an individual's performance; and

- (xx) communication of findings, conclusions, recommendations, and actions to improve performance to appropriate Medical Staff members and the Board.
- (b) A description of the committees that carry out monitoring and performance improvement functions, including their composition, duties, and reporting requirements, is contained in the Medical Staff Organization Manual.

5.D. CREATION OF STANDING COMMITTEES AND SPECIAL TASK FORCES

- (a) In accordance with the amendment provisions in the Medical Staff Organization Manual, the MEC may, by resolution and upon approval of the Board and without amendment of these Bylaws, establish additional committees to perform one or more staff functions. The MEC may also dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions.
- (b) Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special task force will be performed by the MEC.
- (c) Special task forces will be created and their members and chairs will be appointed by the Chief of Staff and the MEC. Such task forces will confine their activities to the purpose for which they were appointed and will report to the MEC.

ARTICLE 6: MEETINGS

6.A. GENERAL

- (a) The Medical Staff year is January 1 to December 31.
- (b) Except as provided in these Bylaws or the Medical Staff Organization Manual, each department and committee will meet as often as needed to perform their designated functions.
- (c) Meetings may be conducted by telephone conference or by other electronic means at the discretion of the applicable chair.

6.B. PROVISIONS COMMON TO ALL MEETINGS

6.B.1 Prerogatives of the Presiding Officer:

- (a) The Presiding Officer of each meeting is responsible for setting the agenda for any regular or special meeting of the Medical Staff, department, division, or committee.
- (b) The Presiding Officer has the discretion to conduct any meeting by telephone conference or videoconference.
- (c) The Presiding Officer shall have the authority to rule definitively on all matters of procedure. While Robert's Rules may be used for reference, in the discretion of the Presiding Officer, it shall not be binding. Rather, specific provisions of these Bylaws and Medical Staff, department, division, or committee custom shall prevail at all meetings and elections.

6.B.2 Notice:

- (a) Medical Staff members will be provided with notice of regular meetings of the Medical Staff and regular meetings of departments and committees. Notice will be provided via regular U.S. mail, e-mail, Medical Center mail or by posting in a designated location at least 14 days in advance of the meeting.
- (b) When a special meeting of the Medical Staff, department or committee is called, the notice period will be 48 hours. Posting may not be the sole mechanism for providing notice.
- (c) Notices will state the date, time, and place of the meetings.
- (d) The attendance of any individual at any meeting will constitute a waiver of that individual's notice of the meeting.

6.B.3 Quorum and Voting:

- (a) For any regular or special meeting of the Medical Staff, department or committee, those voting members present (but not fewer than two members) will constitute a quorum. Exceptions to this general rule are as follows:
 - (i) for meetings of the MEC, the Credentials Committee, and the Physician Quality Committee, the presence of at least 50% of the voting committee members will constitute a quorum; and
 - (ii) for any amendments to these Medical Staff Bylaws, at least 10% of the voting staff will constitute a quorum.
- (b) Once a quorum is established, the business of the meeting may continue and actions taken will be binding.
- (c) Recommendations and actions taken by the Medical Staff, departments and committees will be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority of the voting members.
- (d) As an alternative to a formal meeting, the voting members of the Medical Staff, a department or committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, or telephone, and their votes returned to the Presiding Officer by the method designated in the notice. Except for amendments to these Bylaws and actions by the MEC, the Credentials Committee, and the Physician Quality Committee (as noted in (a)), a quorum for purposes of these votes will be the number of responses returned to the Presiding Officer by the date indicated. The question raised will be determined in the affirmative and will be binding if 51% of the responses returned so indicate.
- (e) Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote.
- (f) There shall be no proxy voting.

6.B.4 Minutes

- (a) Minutes of Medical Staff, department and committee meetings will be prepared and signed by the Presiding Officer.
- (b) Minutes will include a record of the attendance of members and the recommendations made.
- (c) At minimum, a yearly report of Medical Staff, department and committee activities will be reported to the MEC.
- (d) The Board will be kept apprised of and act on the recommendations of the Medical Staff.
- (e) A permanent file of the minutes of meetings will be maintained by the Medical Center.

6.B.5 Confidentiality:

- (a) Medical Staff business conducted by committees and departments is considered confidential and proprietary and should be treated as such.
- (b) Members of the Medical Staff who have access to, or are the subject of, credentialing or peer review information must agree to maintain the confidentiality of the information.
- (c) Credentialing and peer review documents, and information contained in these documents, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by the Credentials Policy or other applicable Medical Staff or Medical Center policy.
- (d) A breach of confidentiality may result in the imposition of disciplinary action.

6.C. ATTENDANCE

6.C.1 Regular and Special Meetings:

- (a) Members of the Medical Staff are encouraged to attend Medical Staff and applicable department and committee meetings.
- (b) Chairs are expected to attend 75% of applicable meetings.
- (c) Members of the MEC, the Credentials Committee and the Physician Quality Committee are required to attend at least 75% of the regular meetings. Failure to attend the required number of meetings may result in replacement of the member.

ARTICLE 7: BASIC STEPS

The details associated with the following Basic Steps are contained in the Credentials Policy in a more expansive form.

7.A. QUALIFICATIONS FOR APPOINTMENT AND REAPPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical Staff, or the Allied Health Staff, or for the grant of clinical privileges, an applicant must demonstrate appropriate education, training, experience,

current clinical competence, professional conduct, licensure, and ability to safely and competently perform the clinical privileges requested as set forth in the Credentials Policy.

7.B. PROCESS FOR CREDENTIALING AND PRIVILEGING

- (a) Complete applications for appointment and privileges will be transmitted to the applicable department chair, who will review the individual's education, training, and experience and prepare a written report stating whether the individual meets all qualifications. This report will be forwarded to the Credentials Committee.
- (b) The Credentials Committee will review the chair's report, the application, and supporting materials and make a recommendation. The recommendation of the Credentials Committee will be forwarded, along with the department chair's report, to the MEC for review and recommendation.
- (c) The Executive Committee may accept the recommendation of the Credentials Committee; refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the Executive Committee is to grant appointment or reappointment and/or privileges, it will be forwarded to the Board for final action. If the recommendation of the Executive Committee is unfavorable, the individual will be notified by the Chief of Staff of the right to request a hearing.

7.C. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

7.C.1 Appointment and clinical privileges may be automatically relinquished if an individual:

- (a) fails to do any of the following:
 - (i) timely complete medical records;
 - (ii) satisfy threshold eligibility criteria;
 - (iii) complete and comply with educational or training requirements;
 - (iv) maintain the minimum amount of professional liability insurance;
 - (v) comply with request for fitness for practice evaluation
 - (vi) respond to collegial intervention
 - (vii) provide information requested
 - (viii) provide information that could affect privileges
 - (ix) attend a required meeting to discuss issues or concerns
- (b) is charged, indicted, convicted, or pleads guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse; (ii) controlled substances; (iii) illegal drugs; (iv) violent act; (v) sexual misconduct; (vi) moral turpitude; or (vii) child or elder abuse.
- (c) makes a misstatement or omission on an application form;
- (d) in the case of an allied health professional, fails, for any reason, to maintain an appropriate supervision/collaborative relationship with a Supervising/Collaborating Physician as defined in the Credentials Policy;

- (e) Remains absent on leave for longer than one year, unless an extension is granted;
- (f) Is subject to disciplinary action by the human resources department of Providence or its affiliates, or termination of employment contract with Providence or its affiliates, if applicable;
- (g) state license is revoked, restricted, suspended or placed on probation;
- (h) DEA certificate is revoked, restricted, suspended or placed on probation;

7.C.2 Automatic relinquishment will take effect immediately and will continue until the matter is resolved, if applicable.

7.D. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

- (a) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the CEO, the Chief of Staff, the chair of the relevant clinical department, the CMO, the MEC, or the Board chair is authorized to suspend or restrict all or any portion of an individual's clinical privileges pending an investigation.
- (b) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the CMO or the MEC.
- (c) The individual will be provided a brief written description of the reason(s) for the precautionary suspension.
- (d) The MEC will review the reasons for the suspension within a reasonable time under the circumstances, not to exceed 7 days.
- (e) Prior to, or as part of, this review, the individual will be given an opportunity to meet with the MEC.

7.E. INDICATIONS AND PROCESS FOR PROFESSIONAL REVIEW ACTIONS

Following an investigation, the MEC may recommend suspension or revocation of appointment and/or clinical privileges based on concerns about (a) clinical competence or practice; (b) the safety or proper care being provided to patients; (c) violation of ethical standards or the Bylaws, policies, rules and regulations of the Medical Center or the Medical Staff; or (d) conduct that is considered lower than the standards of the Medical Center or disruptive to the orderly operation of the Medical Center or its Medical Staff.

7.F. HEARING AND APPEAL PROCESS

- (a) The hearing will begin no sooner than 30 days after the notice of the hearing, unless an earlier date is agreed upon by the parties.
- (b) The Hearing Panel will consist of at least three members in good standing or there will be a Hearing Officer.
- (c) The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.

- (d) A stenographic reporter will be present to make a record of the hearing.
- (e) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer:
 - (i) to call and examine witnesses, to the extent they are available and willing to testify;
 - (ii) to introduce exhibits;
 - (iii) to cross-examine any witness;
 - (iv) to have representation by counsel who may be present but may not call, examine, and cross-examine witnesses or present the case;
 - (v) to submit a written statement at the close of the hearing; and
 - (vi) to submit proposed findings, conclusions and recommendations to the Hearing Panel.
- (f) The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.
- (g) The Hearing Panel (or Hearing Officer) may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.
- (h) The affected individual and the MEC may request an appeal of the recommendations of the Hearing Panel (or Hearing Officer) to the Board.

ARTICLE 8: AMENDMENTS

8.A. MEDICAL STAFF BYLAWS

- (a) Amendments to these Bylaws may be proposed by a petition signed by 25% of the voting members of the Medical Staff, by the Bylaws Committee, or by the MEC.
- (b) Proposed amendments must be reviewed by the MEC prior to a vote by the Medical Staff. The MEC will provide notice of proposed amendments, including amendments proposed by the voting members of the Medical Staff as set forth above, to the voting staff. The MEC may also report on any proposed amendments, either favorably or unfavorably, at the next regular meeting of the Medical Staff or at a special meeting called for such purpose.
- (c) The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, the amendment must receive a majority of the votes cast by the voting staff at the meeting.
- (d) In the alternative, the MEC may present any proposed amendments to the voting staff by written or electronic ballot, returned to the Medical Staff Office by the date indicated by the MEC. Along with the proposed amendments, the MEC may, in its discretion, provide a written report on them, either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast.
- (e) The MEC will have the power to adopt such amendments to these Bylaws which are needed because of reorganization, renumbering, or punctuation, spelling or other errors of grammar or expression.
- (f) Amendments will be effective only after approval by the Board.

- (g) If the Board has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference will be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the CEO within two weeks after receipt of a request.
- (h) Neither the MEC, the Medical Staff, nor the Board can unilaterally amend these Bylaws.

8.B. OTHER MEDICAL STAFF DOCUMENTS

- (a) In addition to the Medical Staff Bylaws, there will be policies, procedures, and rules and regulations that are applicable to members and other individuals who have been granted clinical privileges or a scope of practice.
- (b) An amendment to the Credentials Policy, the Medical Staff Organization Manual, or the Medical Staff Rules and Regulations may be made by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists. Notice of any proposed amendments to these documents will be provided to each voting member of the Medical Staff at least 30 days prior to the vote by the MEC. Any voting member may submit written comments on the amendments to the MEC.
- (c) Amendments to the Credentials Policy, or any other Medical Staff policy, the Medical Staff Organization Manual, or the Medical Staff Rules and Regulations may also be proposed by a petition signed by at least 25% of the voting members of the Medical Staff. Notice of any such proposed amendment to these documents will be provided to the MEC at least 30 days prior to being voted on by the Medical Staff. Any such proposed amendments will be reviewed by the MEC, which may comment on the amendment before it is forwarded to the Medical Staff for vote.
- (d) Other policies of the Medical Staff may be adopted and amended by a majority vote of the MEC. No prior notice is required.
- (e) The MEC and the Board will have the power to provisionally adopt urgent amendments to the rules and regulations that are needed in order to comply with a law or regulation, without providing prior notice of the proposed amendments to the Medical Staff. Notice of provisionally adopted amendments will be provided to each member of the Medical Staff as soon as possible. The Medical Staff will have 30 days to review and provide comments on the provisional amendments to the MEC. If there is no conflict between the Medical Staff and the MEC, the provisional amendments will stand. If there is conflict over the provisional amendments, the process for resolving conflicts set forth below will be implemented.
- (f) Adoption of and changes to the Credentials Policy, Medical Staff Organization Manual, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.
- (g) Amendments to Medical Staff policies are to be distributed or otherwise made available to Medical Staff members and those otherwise holding clinical privileges, in a timely and effective manner.

8.C. CONFLICT MANAGEMENT PROCESS

- (a) When there is a conflict between the Medical Staff and the MEC, supported by a petition signed by 25% of the voting staff, with regard to:
 - (i) a new Medical Staff Rule and Regulation proposed by the MEC or an amendment to an existing Rule and Regulation; or
 - (ii) a new Medical Staff policy proposed by the MEC or an amendment to an existing policy,a special meeting of the Medical Staff to discuss the conflict will be called. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the Rules and Regulations or policy at issue.
- (b) If the differences cannot be resolved at the meeting, the MEC will forward its recommendations, along with the proposed recommendations pertaining to the Medical Staff Rules and Regulations or policies offered by the voting members of the Medical Staff, to the Board for final action.
- (c) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.
- (d) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Rules and Regulations or other Medical Staff policies directly to the Board. Communication from Medical Staff members to the Board will be directed through the CEO, who will forward the request for communication to the Board Chair. The CEO will also provide notification to the MEC by informing the Chief of Staff of such exchanges. The Board Chair will determine the manner and method of the Board's response to the Medical Staff member(s).

ARTICLE 9: HISTORY AND PHYSICAL

9.A. General Documentation Requirements

- (a) A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services) by an individual who has been granted privileges by the Medical Center to perform histories and physicals. Outpatients undergoing invasive procedures without moderate or deep sedation do not require a history and physical.
- (b) The scope of the medical history and physical examination will include, as pertinent:
 - (i) patient identification;
 - (ii) chief complaint;
 - (iii) history of present illness;
 - (iv) review of systems, to include at a minimum:
 - cardiovascular;
 - respiratory;
 - gastrointestinal;

- neuromusculoskeletal; and
 - skin;
- (v) personal medical history, including medications and allergies;
 - (vi) family medical history;
 - (vii) social history, including any abuse or neglect;
 - (viii) physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;
 - (ix) data reviewed;
 - (x) assessments, including problem list;
 - (xi) plan of treatment; and
 - (xii) if applicable, signs of abuse, neglect, addiction or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion will be documented in the plan of treatment.
 - (xiii) In the case of a pediatric patient, the history and physical examination report must also include:
 - developmental age;
 - length or height;
 - weight;
 - head circumference (if appropriate);
 - immunization status.
- (c) When the history and physical examination is not performed or recorded in the medical record before a surgical, diagnostic operative or invasive procedure, the operation or procedure will be canceled unless the attending physician states in writing that an emergency situation exists. If it is an emergency situation and a history and physical has been dictated but has not been transcribed, there will be a statement to that effect in the patient's chart, with an admission note by the attending physician. The admission note must be documented immediately prior to surgery (same day as surgery) and will include, at a minimum, an assessment of the patient's heart rate, respiratory rate and blood pressure.

9.B. H&Ps Performed Prior to Admission

- (a) Any history and physical performed more than 30 days prior to an admission or registration is invalid and may not be entered into the medical record.
- (b) If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record. However, in these circumstances an update is required and the patient must also be evaluated within 24 hours after the patient physically arrives for admission/registration but prior to the surgery/invasive procedure, and the update recorded in the medical record.
- (c) The update of the history and physical examination will be documented as an interval note, based upon an examination of the patient and must (i) reflect any changes in the patient's condition since the date of the original history and physical that might be significant for the planned course of treatment or (ii) state that there have been no changes in the patient's condition. For patients undergoing procedures that require or have requested anesthesia services, the anesthesia pre-procedure assessment note does not satisfy the interval note requirement.

- (d) In the case of readmission, previous records will be made available by the Medical Center for review for use by the practitioners caring for the patient.

9.C. Cancellations, Delays, and Emergency Situation

- (a) When the history and physical examination is not recorded in the medical record before a surgical or other invasive procedure (including, but not limited to, procedures performed in the operating suites, endoscopy, colonoscopy, bronchoscopy, cardiac catheterizations, radiological procedures with sedation, and procedures performed in the Emergency Room), the operation or procedure will be canceled or delayed until an appropriate history and physical examination is recorded in the medical record, unless the attending physician states in writing that an emergency situation exists.
- (b) In an emergency situation, when there is no time to record either a complete or a Short Stay history and physical, the attending physician will record an admission or progress note immediately prior to the procedure. The admission or progress note will document, at a minimum, an assessment of the patient's heart rate, respiratory rate, and blood pressure. Immediately following the emergency procedure, the attending physician is then required to complete and document a complete history and physical examination.

9.D. Short Stay Documentation Requirements

A Short Stay History and Physical Form, approved by the MEC, may be utilized for (i) ambulatory or same day procedures, or (ii) short stay observations which do not meet inpatient criteria. These forms will document the chief complaint or reason for the procedure, the relevant history of the present illness or injury, and the patient's current clinical condition/physical findings.

9.E. Prenatal Records

The current obstetrical record will include a complete prenatal record. The prenatal record may be a legible copy of the admitting physician's office record transferred to the Medical Center before admission. An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

ARTICLE 10: CHIEF MEDICAL OFFICER

The CMO will be appointed by the Chief Executive, Providence Health and Services Alaska upon recommendation of the CEO and will be responsible to the CEO as the CMO of the Medical Center. The CMO will perform such duties and functions as may be delegated from time to time by the CEO, which may include, but not be limited to, the following:

- (a) assisting the CEO in the implementation of the Medical Center's performance improvement program;
- (b) serving as an ex officio member of all departments and all Medical Staff committees;
 - (i) CMO may serve as a voting member of the Credentials Committee if approved by the Committee
- (c) serving as an advisor to the Medical Staff and the Chief of Staff for proper staff organization and Bylaws;
- (d) assisting department chairs in the performance of their duties;
- (e) supervising the operation of the medical library;
- (f) actively participating in the preparation and presentation of budgets for each department in conjunction with Administration;

- (g) acting as the Medical Center's medical liaison, after consultation with the CEO, to local, state and federal agencies;
- (h) assisting the CEO in the supervision and direction of hospital-based physicians;
- (i) endeavoring to maintain accreditation status;
- (j) coordinating the medical education activities within the Medical Center; and
- (k) serving as liaison to academic affiliations of the Medical Center.

ARTICLE 11: ADOPTION

These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any previous Medical Staff Bylaws, Rules and Regulations, policies, manuals or Medical Center policies pertaining to the subject matter contained herein.

APPENDIX A
MEDICAL STAFF CATEGORIES SUMMARY

	<i>Privileged</i>	<i>Locum Tenens</i>	<i>Community Affiliate</i>	<i>Allied Health</i>	<i>Administrative</i>	<i>Honorary</i>
<i>Prerogatives</i>						
<i>Exercise clinical privileges</i>	<i>Y</i>	<i>Y</i>	<i>N</i>	<i>Y</i>	<i>N</i>	<i>N</i>
<i>May attend meetings</i>	<i>Y</i>	<i>Y</i>	<i>Y</i>	<i>P</i>	<i>Y</i>	<i>Y</i>
<i>Voting privileges</i>	<i>Y</i>	<i>P</i>	<i>N</i>	<i>P</i>	<i>P</i>	<i>P</i>
<i>Hold office</i>	<i>Y</i>	<i>N, unless waiver</i>	<i>N, unless waiver</i>	<i>N</i>	<i>N</i>	<i>N</i>
<i>Responsibilities</i>						
<i>Serve on committees</i>	<i>Y</i>	<i>N</i>	<i>Y</i>	<i>Y</i>	<i>Y</i>	<i>Y</i>
<i>Emergency call coverage</i>	<i>Y</i>	<i>Y</i>	<i>N**</i>	<i>N</i>	<i>N</i>	<i>N</i>
<i>Dues</i>	<i>Y</i>	<i>N</i>	<i>Y</i>	<i>Y</i>	<i>N</i>	<i>N</i>
<i>Comply w/guidelines</i>	<i>Y</i>	<i>Y</i>	<i>Y</i>	<i>Y</i>	<i>N</i>	<i>N</i>

Y = *Yes*

N = *No*

P = *Partial (with respect to voting, only when appointed to a committee or outlined in Department's Rules & Regulations)*

*** = *May be required by MEC if insufficient coverage*

**** = *May be required to accept ED referrals for follow-up*