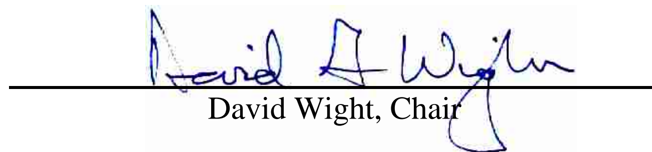
BYLAWS

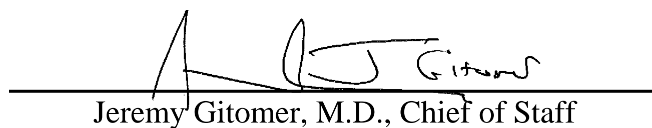
OF THE MEDICAL STAFF OF

PROVIDENCE ALASKA MEDICAL CENTER

APPROVED by the Providence Health & Services Alaska Region Community Ministry Board



David Wight, Chair — November 29, 2011 (Date)



Jeremy Gitomer, M.D., Chief of Staff — November 29, 2011 (Date)

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PREAMBLE TO THE BYLAWS
OF THE MEDICAL STAFF OF
PROVIDENCE ALASKA MEDICAL CENTER

Providence Alaska Medical Center ("Medical Center") is a Roman Catholic sponsored medical institution in Alaska, owned and operated by Providence Health & Services (PH&S). PH&S is organized as a nonprofit corporation under the laws of the state of Washington.

Medical Center's primary mission is to care for the sick and the injured, and to promote wellness and minimize suffering. It also serves pregnant women, their newborn infants, and other individuals seeking to preserve their health. To these several ends the Medical Center is dedicated to patient care, education, and research.

The Medical Staff of the Medical Center is a single, self governing organization responsible to the Providence Health System Alaska Region Board for clinical, teaching, and research work performed there as well as the responsibility to oversee care, treatment, and services provided by practitioners at the Medical Center. The Medical Staff shall be called upon for advice regarding professional problems and policies. The Providence Health System Alaska Region Board acts through its appointed Chief Executive.

Each patient admitted to Medical Center shall have an admitting physician who is a member of the Medical Staff who shall have primary responsibility for the patient until formally signed over to another physician. Medical Staff members will supervise and be ultimately responsible for the services of their clinical assistants, and share in the responsibility for the services of the Medical Center Medical Staff. Transfer of these responsibilities can be made only with the evident acceptance of another staff member, and by clear written directive. Because of these and other responsibilities, mechanisms are hereinafter established to insure that all staff members are well qualified to exercise these roles.

BYLAWS OF THE MEDICAL STAFF OF PROVIDENCE ALASKA MEDICAL CENTER

DEFINITIONS

The term "Medical Center" is defined as Providence Alaska Medical Center, Providence Extended Care Center, Mary Conrad and Horizon House. The Medical Center is also the primary medical facility in the state of Alaska providing medical education and training to medical students and residents. The Medical Staff must maintain up to date knowledge and proficiency within their specialty so that those receiving education and training are qualified to provide the best care to patients.

1. The term "Medical Staff" is defined as all medical and osteopathic physicians, dentists and podiatrists who are practicing within the limits of their State of Alaska License and who are privileged to attend patients in the Medical Center.
2. The term "Board" is defined as the Board of Directors responsible for conducting the affairs of PH&S, which for purposes of these Bylaws and, except as the context otherwise requires, shall be deemed to act through the authorized actions of the Providence Health System Alaska Region Board, the officers of the corporation and through the Chief Executive of Providence Health System Alaska Region and the Administrator of the Medical Center.
3. The term "Administrator" is defined as the individual appointed by the Board to act on its behalf in the overall management of the Medical Center. The term "Administrator" includes a duly appointed Acting Administrator serving when the Administrator is away from the Medical Center. The Medical Staff may rely upon all actions of the Administrator as being the actions of the Board taken pursuant to a proper delegation of authority from the Board.
4. The term "Member" is defined as any physician, dentist, or podiatrist appointed to, and maintaining membership in any category of the Medical Staff in accordance with these Bylaws.
5. The term "Allied Health Professionals (AHP)" is defined in the Allied Health Professionals and Clinical Staff Credentialing Plan.
6. He, him, his, and himself mean equally respectively she, her, hers, and herself.
7. Patient Contact" includes an admission, each subsequent patient day, an emergency room evaluation, the performance of a surgical or other diagnostic or therapeutic procedure, or a consultation. A referral to another practitioner in a different specialty area who admits and manages the patient is counted as a contact for both the referring and the admitting/managing practitioner. Hospital credentialed physician is described as:
   a. A doctor of medicine or doctor of osteopathy who, by virtue of education, training and demonstrated competence, is granted clinical privileges by the hospital to perform a specific diagnostic or therapeutic procedure(s) and who is fully licensed to practice medicine;
   b. A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State and who is acting within the scope of his or her license;
   c. A doctor of podiatric medicine, but only with respect to functions which he or she is legally authorized by the State to perform.
8. Acronyms:
   a. AACPM: American Association of Colleges of Podiatric Medicine
   b. ABMS: American Board of Medical Specialties
   c. ABPS: American Board of Podiatric Surgery
   d. ACGME: Accreditation Council for Graduate Medical Education
   e. ADA: American Dental Association
   f. ADA: American Disabilities Act
   g. AEGD: Advanced Education in General Dentistry
   h. AHP: Allied Health Professional
   i. AMA: American Medical Association

j. AOA: American Osteopathic Association
k. CMO: Chief Medical Officer
l. CRC: Conflict Resolution Committee
m. DEA: Drug Enforcement Agency
n. FPPE: Focused Professional Practice Evaluation
o. GPR: General Practice Residency
p. JCC: Joint Conference Committee
q. MEC: Medical Staff Executive Committee
r. OPPE: Ongoing Professional Practice Evaluation
s. PAMC: Providence Alaska Medical Center
t. PHSA: Providence Health & Services (Alaska)

ARTICLE I
NAME

The name of this organization shall be the Providence Alaska Medical Center Medical Staff.

ARTICLE II
PURPOSE

The role of the Medical Staff is to support each other in the pursuit of medical excellence for patients.

ARTICLE III
MEDICAL STAFF MEMBERSHIP

SECTION 1. NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff of Providence Alaska Medical Center is a privilege, which shall be extended only to professionally competent physicians, dentists, and podiatrists who continuously meet the qualifications, standards and requirements set forth in these Bylaws, Policies, and in the Rules and Regulations of the Medical Staff.

SECTION 2. QUALIFICATIONS FOR MEMBERSHIP

A. Only physicians, dentists and podiatrists who continuously meet the following qualifications are eligible for Medical Staff membership:

B. Shall maintain in force at all times a current, valid, license from the Alaska State Medical Board to practice medicine, osteopathy, dentistry or podiatry.

C. A current, valid DEA Registration (some specialties do not require a DEA Registration for practice and will be reviewed on a case by case basis).

D. For MD/DO's satisfactory completion of an approved ACGME or AOA (or the approved equivalent in Canada and England) postgraduate residency training program in the specialty in which clinical privileges are requested.

E. For DDS/DMD's satisfactory completion of an approved ADA AEGD or GPR program in dentistry that is at least 2 years in duration. For Oral Surgeons, an ADA approved residency in Oral and Maxillofacial Surgery which must include a minimum of 48 months of full-time training in a hospital-based residency.

F. For DPM's satisfactory completion of an approved AACPM Podiatry postgraduate 24-36 month residency in Podiatric Medicine.

G. Third year residents in the Providence Alaska Family Medicine Residency program, who are licensed as a medical doctor or doctor of osteopathy in the State of Alaska and approved by the Residency Director will be allowed to apply for privileges at Providence Health and Services facilities in Alaska for the purposes of moonlighting.

H. An applicant must be board certified or progressing towards board certification by the ABMS, the AOA, the ADA, the ABPS and/or their equivalents as recognized in Canada and England. Applicants/re-applicants progressing toward board certification must become board certified in the specialty for which they hold privileges within five (5) years of the completion of their training. Once board certified the applicant/re-applicant must maintain board certification as stipulated by their specialty board during their tenure on staff at PAMC. Current members of the Medical Staff *prior to November 2006* who do not meet the requirements stated in paragraphs D, E and F above are exempt from meeting these requirements as long as they continuously remain members of the Medical Staff in good standing.

I. Shall maintain in force at all times professional liability insurance in not less than the minimum amounts specified in MS Policy 900-060 "Professional Liability Insurance Requirements".

J. No record of conviction or nolo contender of a felony related to competency, conduct or a crime against a person that could reasonably be expected to impact Medical Staff responsibilities and/or exercise of clinical privileges.

K. Continuing Medical Education as required by the Alaska State Medical Board.

L. Adhere to a high standard of professional ethics including, but no limited to, prohibitions against fee-splitting, "ghost" surgery, delegating the responsibility for diagnosis or care of patients to a practitioner not qualified to undertake that responsibility, and failure to obtain informed patient consent for treatments.

M. Must be able to work cooperatively with others so as not to adversely affect patient care.

N. To keep as confidential, as required by state & federal law as well as hospital and Medical Staff policy, all information or records received in the physician-patient relationship.

O. Must be willing to participate in and properly discharge those responsibilities determined by the Medical Staff and the Board.

P. An applicant shall not be denied Medical Staff membership or privileges because of ancestry, gender, sexual orientation, faith, or on the basis of any other criterion unrelated to the delivery of quality patient care in the Medical Center.

Q. Residents in training at the Medical Center shall not hold appointments to the Medical Staff and shall not be granted specific clinical privileges. Rather, they shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, Medical Staff policy, and/or training protocols approved by the program director and the Board. The management of each patient's care, treatment, and services (including patients under the care of participants in professional graduate education programs) is the responsibility of the supervising Medical Staff member with appropriate clinical privileges.

SECTION 3. CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

PROCEDURE

A. CREDENTIALING PROCESS**:**

1. Applicants for membership on the Medical Staff of PAMC provide the Medical Staff Services Department with a completed application for membership on the Medical Staff, which includes:
   a. Relevant training, experience
   b. Current licensure to practice
   c. Certification of specialty if appropriate
   d. Proof of Professional Liability Insurance coverage
   e. Evidence of competence for requested privileges

f. Current government issued identification (e.g. Drivers License, Passport, Military ID)

g. Free of Medicare/Medicaid Sanctions. This is not the same as opting out of accepting Medicare and/or Medicaid.

2. The staff of the Medical Staff Services Department, following the procedures outlined in the Credentials Procedure Manual, verifies the applicant's information and identity.

3. Completed and verified applications are evaluated by the Medical Staff for recommendation for membership and privileges. The Providence Health & Services Alaska (PHSA) Region Community Ministry Board reviews the recommendations and is responsible for granting Medical Staff membership and privileges.

B. INITIAL GRANTING, RENEWAL AND REVISION OF PRIVILEGES

1. During the initial application for Medical Staff membership process and periodically thereafter, the practitioner may request clinical privileges. Following the procedures outlined in the Credentials Procedure Manual, requests for privileges are evaluated by the Medical Staff. Recommendations are forwarded to the PHSA Regional Board for granting or renewal of privileges.

2. Medical Staff clinical privileges are reviewed for renewal not to exceed 24 months. Practitioners will be reappointed as outlined in the Credentials Procedure Manual/Policy by department and/or specialty. Some practitioners will experience renewal periods that are less than 24 months as they are transitioned onto the reappointment cycle stated above.

3. The process for renewal of clinical privileges includes an evaluation of the practitioner's ability to perform the requested privileges based on performance during the period of their practice as a member of the Medical Staff. If information on performance is available from another institution where the practitioner has privileges, it will be considered as well.

4. Clinical privileges must be site specific.

C. EXPEDITED CREDENTIALING AND PRIVILEGE PROCESS

The Medical Staff has an expedited process for appointments and reappointments to the Medical Staff and the granting of clinical privileges when criteria for that process, as outlined in the Credentials Procedure Manual, are met. To expedite initial appointments to membership and granting of privileges, the PHSA Regional Board delegates the authority to render those decisions to the Credentials Committee where a committee of at least two voting members of the Board are present.

D. TEMPORARY PRIVILEGES

1. The procedure for granting temporary privileges is outlined in the Credentials Procedure Manual.

2. The circumstances for which the granting of temporary privileges are acceptable are the following:

   a. To fulfill an important patient care, treatment, and service need.

   b. When a new applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Executive Committee and the governing body. These temporary privileges may not exceed 120 days in a calendar year.

E. DISASTER PRIVILEGES

1. Disaster privileges may be granted by the Hospital Administrator, Chief Medical Officer or the Chief of Staff and/or his/her designee(s) when the Emergency Management Plan has been activated and the hospital is unable to handle the immediate patient needs.
2. The procedure for granting disaster privileges is outlined in MS 900-004 Emergency/Disaster Credentialing policy.

F. TELEMEDICINE PRIVILEGES

1. Credentialing and privileging of practitioners who provide telemedicine services may be fulfilled by written agreement whether PAMC is the originating site or the distant site of telemedicine services. Practitioners providing telemedicine services must be privileged and credentialed in accordance with PAMC Medical Staff bylaws and policies. See MS 900-070 Telemedicine policy for additional details and definitions.

G. PRACTITIONER COMPETENCY

1. In correlation with the Joint Commission standards, the medical staff complies with the following to ensure current and ongoing practitioner competency:
   a. Six areas of General Competencies developed by the ACGME and ABMS to include:
      1.) Patient Care

      Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.

      2.) Medical/Clinical Knowledge

      Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others.

      3.) Practice-Based Learning and Improvement

      Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

      4.) Interpersonal and Communication Skills

      Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.

      5.) Professionalism

      Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity (race, culture, gender, religion, ethnicity, sexual preference, language, mental capacity, and physical disability) and a responsible attitude toward their patients, their profession, and society.

      6.) Systems-based practice

      Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

   b. Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) – process as defined in MS 920-045 Professional Practice Evaluation policy.

H. OTHER CREDENTIALING & PRIVILEGING DOCUMENTS

Credentials Documents that hold additional information regarding the processes of credentialing and privileging at PAMC and are considered part of these bylaws are:

1. Medical Staff Credentials Manual that includes: New Applicants, Reappointments, Maintenance of Expirables, Primary Source Verification.
2. Allied Health Professionals Credentials Manual.
3. Medical staff policies including but not limited to: Acceptable Clinical References, Burden of Proof, Clinical Privileges, Application Fees, Disposition of Applications, Orientation, Leave of Absence, Locum Tenens, Proctoring, Professional Liability Insurance, Telemedicine, Practitioner Wellness, Substance Impairment, and Code of Conduct.

I. CONDITIONS FOR PRIVILEGES OF MEDICAL STAFF PRACTITIONERS OTHER THAN MD/DO's

1. ADMISSIONS
   a. When dentists and oral surgeons and podiatrists who are members of the medical staff admit patients, a physician member of the medical staff with admitting privileges must assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the dentists, oral surgeons or podiatrists lawful scope of practice.
   b. Oral and maxillofacial surgeons who have successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Office of Education and have been determined by the medical staff to be competent to do so, may perform a history and physical examination and determine the ability of their patient to undergo surgical procedures the oral and maxillofacial surgeon proposes to perform. Completion of a history and physical by a qualified oral and maxillofacial surgeon under this subsection (b) shall satisfy the appraisal portion of the requirements. For patients with existing medical conditions or abnormal findings beyond the surgical indications, a physician member of the medical staff with admitting privileges must conduct or directly supervise the admitting history and physical examination, except the portion related to oral and maxillofacial surgery, and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the oral and maxillofacial surgeon's lawful scope of practice.

2. SURGERY
   Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the chair of surgery, subsection chair or the chair's designee.

3. MEDICAL APPRAISAL
   All patients admitted for care in a hospital by a dentist or oral and maxillofacial surgeon or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and the dentists or oral and maxillofacial surgeons and podiatrists, shall seek consultation with a physician member to determine the patient's medical status and need for medical evaluation whenever the patient's clinical status indicates the presence of a medical problem. Where a dispute exists regarding proposed treatment between a physician member and a dentist or podiatrist based upon medical or surgical factors outside of the scope of licensure of the dentist or podiatrist, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate department(s).

4. MEDICAL HISTORY & PHYSICAL EXAMINATION (H&P's) COMPLETION REQUIREMENTS
   a. The H&P's for patients are completed and documented by a physician, oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

b. A medical history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after inpatient admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician (as defined by Centers for Medicare and Medicaid Services, "CMS"), or other qualified licensed individual in accordance with Alaska State law and hospital policy. For a medical history and physical examination that was completed within 30- days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia.

c. Additional information regarding history and physical documentation requirements is delineated in Medical Staff Policy MS 920-040 "Standards of Practice and Compliance of the Medical Record for the Medical Staff".

SECTION 4. ANNUAL STAFF DUES

A. Annual Medical Staff dues shall be governed by the most recent action, which has been recommended by the Medical Executive Committee and adopted at a regular or special General Staff meeting.

B. The Medical Staff Treasurer or designee shall notify each staff member 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.

C. All Medical Staff members shall pay annual dues of $130 with the following exceptions:

1. Honorary Staff,
2. Consulting Staff (residing out of state) and
3. Provisional Staff that joined the Medical Staff within the last three months of the year (October – December of previous year).

D. Annual dues of $130 shall be due and payable at the time of appointment, and thereafter on December 31st for the upcoming calendar year. A dues notice of payment will be mailed by November 30th of each year.

E. Failure to pay dues by December 31st for the upcoming year (if December 31st falls on a weekend, payment is due by the following first business day) will result in the following with an appropriate delinquency notification:

1. January 1st – January 31st - Annual dues will double to $260.00.
2. February 1st – February 28th – Annual dues increase to $520.00.
3. March 1st - Medical staff membership and clinical privileges will be subject to voluntary relinquishment until dues of $520.00 are paid in full.
4. April 1st – If dues of $520.00 have not been received in the Medical Staff Services Department by April 1st, then member must reapply to the Medical Staff.

SECTION 5. ETHICAL REQUIREMENTS

A. Each Member who accepts membership on the Medical Staff agrees to abide by the ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES.

B. A person who accepts membership on the Medical Staff agrees to abide strictly by the following medical ethics as appended, or the principles of ethics of the American Dental Association, whichever is applicable.

1. The principal objective of the medical profession is to render service to humanity with full respect for the dignity of individuals.
2. Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

3. A physician should practice a method of healing founded on a scientific basis.
4. The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal, unethical or incompetent conduct of fellow members of the profession.
5. A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.
6. In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision. His fee should be commensurate with the services rendered. He should neither pay nor receive a commission for referral of patients.
7. A physician should seek consultation upon request in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.
8. A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.
9. The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.
10. All individuals appointed to the Medical Staff shall be expected to use their authority without malice, to treat others with dignity and respect, and to work collegially with other health care professionals, Medical Staff leadership, hospital management and personnel.
11. Itinerant surgery shall be proscribed. Post-operative care will be rendered by the operating surgeon unless it is delegated to another physician who is as well qualified to continue this essential aspect of total surgical care.

SECTION 6. CODE OF CONDUCT

A. All members of the medical staff and allied health professionals staff agree to abide by the Medical Staff Code of Conduct policy detailed in MS 980-050. This commitment will be renewed every two years at time of reappointment for all current members and AHP. Each new applicant must attest to follow the policy prior to their application being considered complete.

SECTION 7. RESPONSIBILITIES OF MEMBERSHIP

A. A member of the Medical Staff is not obligated to participate in any scheme which directly or indirectly limits medical care to patients. By virtue of staff membership a physician affirms the cardinal principle that treatment of patients is governed by medically determined need.

B. Medical Staff members direct the care of their own patients. A physician, dentist, or podiatrist is not responsible for the actions of other physicians; dentists; podiatrists, clinical assistants, unless acting as the supervisor of that person. Once involved, a physician, dentist, or podiatrist may not discontinue care until discharge without arranging for the further care of the patient by another Member with appropriate privileges. Responsibility for care of a patient is usually elective on the part of the physician or may be an obligation based on Federal, State, Hospital, or Department, rules and regulations.

ARTICLE IV
CATEGORIES OF THE MEDICAL STAFF

All appointments to the Medical Staff shall be made by the Board and shall be to one of the following categories: Active, Provisional, Courtesy, Affiliate, Consulting and Honorary. Transfer from one category to another shall be accomplished only upon recommendation of the Credentials and Medical Executive Committees and approval of the Board. All appointees shall be assigned to a specific department, but shall be eligible for clinical privileges in other departments as applied for and recommended pursuant to these Bylaws and approved by the Board. Appointment to the Medical Staff is not the same as the granting of privileges.

SECTION 1. ACTIVE STAFF

A. Qualifications:

1. The Active Staff at the Medical Center shall consist of those physicians, dentists, and podiatrists who:
   a. have served on the Provisional Staff and have completed FPPE;
   b. are located close enough (office and residence) to the Medical Center to fulfill their responsibilities, as consistent with their clinical privileges,
   c. are cognizant of the needs of the Medical Center and community, and provide timely and continuous care to Medical Center patients; and
   d. regularly admit patients, or otherwise are regularly involved in the care of patients of the Medical Center. "Regularly" means at least 24 patient contacts per 12-month period, or
2. Members who have primarily an outpatient practice, with few admissions, such as allergy and dermatology, may qualify for the Active Staff through demonstrated active participation and regular attendance at Medical Staff Department meetings and service on Medical Staff Committees.
3. Failure to meet the above requirements in any two consecutive years shall render the appointee ineligible to apply for reappointment to the Active Staff. Such ineligibility does not trigger any procedural rights.

B. Prerogatives:

1. Active Staff appointees are entitled to:
   a. vote,
   b. hold office,
   c. serve on Medical Staff committees,
   d. attend General Staff and department meetings; and
   e. may be entitled to admit and treat patients within the limits of their assigned clinical privileges.

C. Responsibilities:

1. Active Staff appointees are expected to assume all the functions and responsibilities of appointment to the Active Staff, including:
   a. participating in continuous quality improvement;
   b. serving on committees; and
   c. payment of annual dues.
2. In addition, Active Staff appointees with admitting privileges shall:
   a. participate in and monitor activities, including the evaluation of Provisional Staff; and
   b. participate in Emergency Call, as assigned by each department.

SECTION 2. PROVISIONAL STAFF

A. Qualifications:

1. Appointments to the Provisional Staff shall be limited to those physicians, dentists and podiatrists who are in the process of becoming eligible for appointment to the Active or Courtesy Staff category.
2. Those appointed to the Provisional Staff will be so for at least 1 month and not to exceed 24 months. This time frame will be used to transition the new Medical Staff members to the current reappointment process used at PAMC.
3. FPPE for the new Provisional Staff must be completed before the practitioner can be moved to Active or Courtesy Staff.

B. Prerogatives:

1. Provisional Staff appointees are entitled to:
   a. Vote, but may NOT hold a medical staff leadership or department chair position.
   b. May be entitled to admit and treat patients within the limits of their assigned clinical privileges;

C. Responsibilities:

1. Provisional Staff appointees must assume all the functions and responsibilities of appointment to the Active Staff, including:
   a. participate in Emergency Call, as assigned by each department;
   b. participating in continuous quality improvement and monitoring activities;
   c. serving on committees; and
   d. payment of annual dues.

SECTION 3. COURTESY STAFF

A. Qualifications:

1. Courtesy Staff shall consist of physicians, dentists and podiatrists of demonstrated competence qualified for Active Staff appointment.
2. FPPE must be completed before the practitioner can be moved to Courtesy Staff.
3. They must be appointed to the active staff category of another hospital.

B. Prerogatives:

1. Courtesy Staff appointees may:
   a. serve on Medical Staff Committees;
   b. not vote except for committees to which they belong,
   c. may not hold medical staff leadership or department chair position;
   d. may be entitled to admit and treat patients within the limits of their assigned clinical privileges.

C. Responsibilities:

1. Courtesy Staff appointees must:
   a. participate in Emergency Call as assigned by each department,
   b. be located close enough (office and residence) to the Medical Center to fulfill their responsibilities, as consistent with their clinical privileges,
   c. be cognizant of the needs of the Medical Center and community, and provide timely and continuous care to

Medical Center patients; and

d. pay the requisite annual dues.

SECTION 4. AFFILIATE STAFF

A. Qualifications:

1. The Affiliate Staff shall consist of practitioners who meet education and training requirements for Active Staff and have a valid Alaska license who belong to one of the following groups, but who do not choose to request Medical Staff privileges as independent practitioners or take an active role in the medical staff organization.

   a. Government employees such as public health officers who have no, or very limited clinical medical practice activities. (e.g., city and state health offices.)

   b. Physicians with a history of activity and support of Providence Alaska Medical Center, but who now request, with the concurrence of their department, this category of more limited hospital activity due to special circumstance such as age or physical disability.

   c. Refer and Follow: Physicians who are in the specialty of Family Medicine, Internal Medicine or Pediatrics who have an agreement with the appropriate Hospitalist Group for the admitting and treatment of their patients and who no longer admit patients to PAMC. Physicians qualifying under these terms shall have no admitting, attending, treatment or provide surgical services privileges to any patient independently at PAMC. They may occasionally visit patients, but the Hospitalist Group must remain the active responsible party for the patient.

   d. Physicians that are assigned as part-time faculty for the Alaska Family Medicine Residency Program. Physicians qualifying under this item shall only admit, attend, treat or provide surgical services to those patients associated with the Residency Program. They may not admit, attend, treat or provide surgical services to any patient independently of the Residency Program.

   e. Physicians that are working on a part-time basis for the Palliative Care Program at PAMC or other Providence associated facilities, e.g. Mary Conrad Center, Providence Extended Care Center, Hospice, Providence Matanuska Healthcare, Providence Eagle River Campus, etc. Physicians qualifying under this item, shall only admit, attend, treat or provider surgical services to those patients associated with the program for which they identify association. No individual admission, attendance, treatment or surgical service to a patient outside of a designated program association is permitted.

   f. Other special circumstances as approved by the Medical Executive Committee.

B. Prerogatives:

1. Affiliate Staff appointees:

   a. may attend meetings and continuing education courses and have access to the UAA Consortium Library;

   b. may not vote, hold medical staff leadership, department chair or committee chair position, nor serve on any standing committees; and

   c. do not have admitting, treatment or surgical privileges at the Medical Center except when working in association with the qualifying programs listed above in Section 4.A.1.

   d. may apply to change to Active Staff privileges, if qualified.

C. Responsibilities:

1. Affiliate Staff

   a. shall pay the requisite annual dues.

   b. are not required to attend meetings.

SECTION 5. CONSULTING STAFF

A. Prerequisites:

1. Consultant Staff appointees:
   a. Must reside outside of the Municipality of Anchorage Borough.
   b. Must be on the active staff of a non-Anchorage hospital.
   c. May not vote, hold office, or serve on any standing committees.
   d. Shall be excused from Emergency call.

B. Responsibilities:

1. Consultant Staff appointees:
   a. Shall not have admitting privileges. (Any patient admitted to PAMC must have an Active, Provisional, or Courtesy staff member who shall have primary responsibility for the patient.)
   b. Must be identified in the orders as a consulting physician for the particular patient.
   c. Shall not exceed those clinical privileges granted by the Board.
   d. Must have a license to practice in the state if required by state law.
   e. Shall pay annual dues except for those residing out of state.

C. Permissible Activities:

1. May teach students or staff members.
2. May provide expertise on the care of one or more PAMC patients.
3. May provide information or ongoing support to the admitting Medical Staff member regarding the care of the patient.
4. May assist the admitting physician in surgical procedures, if requested by the physician.
5. May write progress notes in the chart.
6. May write orders in the chart, but they must be co-signed by the admitting physician.

SECTION 6. HONORARY STAFF

Honorary Staff membership is reserved for persons of outstanding medical reputation and attainment who the Medical Staff wishes to honor.

A. A Member is nominated by an Active Medical Staff Member and elected to Honorary membership at a General Staff meeting.

   a. Nomination must be received in writing and turned into the Medical Staff Services Department.
   b. Department Chairs will review and approve the nomination.
   c. The Credentials Committee, MEC and the Board will also approve the nomination.
   d. Although nominated and recommended through the credentialing process, no member shall be considered Honorary, unless so elected at a General Medical Staff Meeting.

B. Members of the Honorary Staff may serve on committees, vote, and hold office, but need not attend meetings or pay dues.

C. Although members of the Honorary Staff need not possess a current Alaska license, a license must be held in order to participate in patient care.

D. This staff status will not automatically mean a physician holds privileges at the Medical Center.

E. Honorary physicians, who wish to hold privileges, must go through or continue in the reappointment process. In addition

these physicians will be classified as Honorary-Active staff status if they hold privileges.

SECTION 7. VISITING PROFESSORS OR PROCTORING PHYSICIANS FROM OUTSIDE OF THE HOSPITAL

A. They must submit the application created for this process.

B. Apply to the State of Alaska for license/activity permission, if the physician is not licensed in the State of Alaska and has no plans to apply for a state license. (Submit a letter to the state medical board requesting permission for the physician to practice in Alaska, and details of that practice session.) A letter granting permission must be received from the State Medical Board.

C. Application will be processed using primary source verification of licensure (FSMB), AMA profile, NPDB, to include review of the NPDB.

D. Submit documentation to prove competency for the procedure being requested to proctor/perform.

E. Medical Staff membership will not be granted and privileges will be granted only for the specific case(s) and/or period of time specified.

F. Visiting professors or proctoring physicians shall abide by these Bylaws, the Rules and Regulations, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Hospital, as applicable to his/her activities in association with the Hospital.

G. These physicians are not part of the regular medical staff and are not entitled to the hearing process.

SECTION 8. ALLIED HEALTH PROFESSIONAL STAFF

A. AHP refers to health care professionals, other than a physician, dentist or podiatrist, who holds a license or legal credential, as required by Alaska law or medical staff policy to provide certain professional services. "Allied Health Professionals Staff" means those AHP's who pursuant to the terms of these bylaws, are not eligible for medical staff membership, but have been granted a service authorization to provide certain clinical services. At PAMC those AHP's are as follows:

1. **AHP:**
   a. Certified Nurse Midwives – CNM
   b. Advanced Nurse Practitioners – ANP
   c. Certified Physician Assistants – PA-C
   d. Clinical Psychologists – PhD

2. **AHP – Clinical Staff:**
   a. Perfusionist
   b. Surgical Assistant – SA
   c. Registered Nurse – RN
   d. Registered Nurse First Assistant – RNFA
   e. Dental Assistant – DA
   f. Pathology Assistant – PA

3. **AHP – Handled be Human Resources and not credentialed through the Medical Staff processes:**
   a. Social Workers – SW
   b. Licensed Marriage & Family Therapists – LMFT
   c. Psychiatry ED Registered Nurses – RN
   d. Licensed Professional Counselors – LPC
   e. Registered Dietitians – RD

B. The Allied Health Professionals Staff requirements are detailed in the Allied Health Professionals Credentials Manual.

ARTICLE V
CLINICAL PRIVILEGES

SECTION 1. DELINEATION OF PRIVILEGES

A. Except as provided in the Policies and Procedures, every practitioner practicing in the Medical Center shall be entitled to exercise only those clinical privileges specifically granted by the Board. All requests for clinical privileges shall be processed as provided in the Policies and Procedures.

SECTION 2. EMERGENCY PRIVILEGES

A. In the case of emergency, any Member or any person who has clinical privileges, to the degree permitted by the person's license and regardless of department affiliation, specialty staff status or clinical privileges, shall be permitted and expected to do everything possible to save the life of a patient or to save the patient from serious harm, using every facility of the Medical Center necessary, including the calling for any consultation necessary or desirable.

SECTION 3. PRIVILEGES OF EMPLOYED OR CONTRACT PRACTITIONERS

A. A practitioner employed by the Medical Center, or providing services pursuant to a contract with the Medical Center, either full-time or part-time, must be a Member of the Medical Staff. A practitioner who is or who will be providing professional services pursuant to a contract or to employment must meet appropriate appointment qualifications, must be evaluated for appointment, reappointment and clinical privileges in the same manner, and must fulfill all of the obligations of the practitioner's category in the same manner as any other applicant or Member.

ARTICLE VI
CORRECTIVE ACTION AND SUMMARY SUSPENSION

A. Any person may make a complaint and request corrective action be taken against any Member or AHP whose conduct or activities are considered by the person making the complaint to be below or substantially different from the standards of the Medical or AHP Staff, or disruptive to the operations of the Medical Center.

B. Details of investigations, formal corrective actions, suspensions (precautionary, automatic, summary) are detailed in MS 980-100 Investigation, Hearing and Appeals Plan policy.

ARTICLE VII
FAIR HEARING PLAN

A. The Medical Executive Committee shall adopt procedures necessary to implement more specifically the general principles found within these Bylaws, the Bylaws of the Board, and applicable laws regarding hearings and contested matters. These procedures are entitled the Fair Hearing Plan and are detailed in MS 980-100 Investigation, Hearing and Appeals Plan. An applicant for or a Member of the Medical Staff who is the subject of an adverse recommendation of the Medical Executive Committee or adverse action of the Board, as defined in these Bylaws, is entitled to a hearing and to appellate review as provided in the Fair Hearing Plan. The Fair Hearing Plan shall be set forth in the Policies and Procedure, MS 980-100 Investigation, Hearing and Appeals Plan, and incorporated into these Bylaws. The Fair Hearing Plan may be amended or repealed as provided in these Bylaws. The composition of the any fair hearing committee is detailed in this policy.

ARTICLE VIII
OFFICERS

SECTION 1. OFFICERS OF THE MEDICAL STAFF

A. The officers of the Medical Staff, elected by the General Staff include:

1. President (also known as the Chief of Staff);
2. Vice-President (also known as Chief of Staff – Elect);
3. Immediate Past-President;
4. Treasurer; and
5. Members-at-Large (One Member-at-Large for every 200 and part thereof, of the Active Staff physicians on staff at PAMC).

SECTION 2. QUALIFICATION OF OFFICERS

A. Officers must be members of the Active Staff in good standing (no sanctions, suspensions, behavior or quality issues for the previous three (3) years) at the time of nomination and election and must remain members in good standing during their terms of office. Failure to maintain such status shall immediately create a vacancy in the office involved. Officers should also:

1. Have experience in a Medical Staff leadership position or equivalent.
2. Should be trained in Medical Staff leadership or demonstrate a willingness to consider attending leadership training.
3. Recognize and agree to the time commitment necessary to perform Medical Staff duties
4. Agree during the term of office not to be a Medical Staff leader, department chair or Board member of any another hospital
5. Recognize the responsibility and demonstrate that ability to communicate well with the Medical Staff, administration, and the Board.

SECTION 3. ELECTION OF OFFICERS

A. Those Members who are eligible to vote in accordance with these Bylaws shall elect officers at the annual fall meeting of the Medical Staff.

B. A nominating committee shall recommend candidates in accordance with MS 940-040 Nominating Committee policy**.**

C. Nominations may also be made from the floor.

SECTION 4. TERM OF OFFICE

A. All officers serve a term of two (2) years. Officers shall take office on the first day of the calendar year.

SECTION 5. VACANCIES IN OFFICE

A. The Medical Executive Committee of the Medical Staff shall appoint an Active Staff Member in good standing to fill any vacancy of office during the Medical Staff year, except the Chief of Staff. If there is a vacancy in the office of the Chief of Staff, the Vice-President shall serve the remainder of the term.

SECTION 6. DUTIES OF OFFICERS

A. President**:** The President shall serve as the chief administrative officer of the Medical Staff to:

1. Act in coordination with the Administrator in all matters of mutual concern within the Medical Center;
2. Call, preside at, and be responsible for the agenda of all meetings of the General Medical Staff;
3. Preside at and be a voting member of the Medical Executive Committee in the event of a tie;
4. Serve as ex officio member on all other Medical Staff committees;
5. Preside at the Senior Leadership administrative meeting whose membership includes the Vice-President, Immediate Past President, the Administrator, the Chief Medical Officer and other members as deemed appropriate;
6. Be responsible for compliance and enforcement of Medical Staff Bylaws; Policies and Procedures; and Rules and Regulations for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards herein provided with regard to appointments, corrective actions, summary suspensions, hearings and appeals, etc.;
7. Be responsible for the Medical Staff's clinical activities and/or implementing its administrative functions;
8. Appoint committee members to all standing, special and multidisciplinary Medical Staff committees, except the Medical Executive Committee and other committees, all or some of whose members, are required by these Bylaws to be selected in a different manner;
9. Represent the views, policies, needs and grievances of the Medical Staff to the Chief Executive of the Alaska Region and/or the Administrator;
10. Receive and interpret to the Medical Staff the policies of the Board, as transmitted by the Chief Executive, and report to the Chief Executive and the Administrator on the performance of the Medical Staff's responsibility to provide medical care;
11. Serve as a member on the Board responsible for the approval of all medical staff credentialing, privileging, policies and other appropriate medical staff activities;
12. Support the concept that educational activities of the Medical Staff be adequately funded and housed and that appropriate programs are planned by the departments and committees of the Medical Staff;
13. Be the spokesperson for the Medical Staff in its external professional and public relations; and
14. Perform all other duties required of the Chief of Staff under these Bylaws, the Policies and the Rules and Regulations of the Medical Staff.

B. Vice-President: In the absence of the President the Vice-President shall assume all the duties and have the authority of the President. The Vice-President shall be a member of the Medical Staff Executive Committee of the Medical Staff; shall automatically succeed the President when the latter ceases to serve for any reason; and shall perform such further duties to assist the President as the President may from time to time request. The Vice-President shall also attend the Senior Leadership administrative meeting, chair the Nominating Committee, and be a voting member of the Credentials Committee and the Bylaws Committee.

C. Immediate Past-President: In the absence of the President and Vice-President, the Immediate Past-President shall assume all the duties and have the authority of the President. The Immediate Past-President shall be a voting member of the Medical Executive Committee of the Medical Staff a voting member of the Credentials Committee and a member of the

Senior Leadership administrative meeting**.**

D. Treasurer: The Treasurer shall be a voting member of the Medical Executive Committee of the Medical Staff, and see to the safeguarding of medical staff funds, the administration of medical staff expenditures, the collection of dues, and make appropriate periodic reports of status of same to the Medical Staff and the Medical Staff Executive Committee.

E. Members-At-Large: There will be one Member-at-Large for every 200 and part thereof, of the Active Staff physicians at PAMC. Members-at-Large of the active Medical Staff shall be nominated and elected to serve a two-year term of office with overlapping years of service. Members-at-Large will be voting members of the Bylaws Committee and the Medical Executive Committee.

SECTION 7. REMOVAL FROM OFFICE

A. The Medical Staff may remove any officer for stated cause, by petition of fifty-one percent (51%) of the Active Staff members and a subsequent two-thirds (2/3) vote by ballot of the Active Staff.

B. Such stated causes include and should not be limited to:

1. Involvement and discipline through the Code of Conduct policy; or
2. Dereliction of duties.

C. Automatic removal from office will occur due to:

1. Loss of a valid State of Alaska Medical or Dental license;
2. Loss of Medical Staff membership; or
3. Involuntary loss of privileges at the Medical Center.

ARTICLE IX
DEPARTMENTS

SECTION 1. ORGANIZATION OF DEPARTMENTS OF THE MEDICAL STAFF

A. The Medical Staff shall establish the departments enumerated in these Bylaws. Each department shall be responsible to the Medical Staff for the promotion of high quality care at the Medical Center in the areas of professional practice and specialization subject to the department's authority, and for reviewing the professional performance of members rendering care at the Medical Center in such areas and specialties.

B. Sections representing sub-specialties shall be established within the departments as specified in these Bylaws, Policies and Department Rules and Regulations. Such sections shall be directly responsible to the departments. Each department shall have a chair with overall responsibility for the supervision and satisfactory discharge of the functions of the department. The chair of the department shall designate chiefs of the sub-sections as per Department Rules and Regulations.

SECTION 2. DEPARTMENTS OF THE MEDICAL STAFF

A. Departments of the Medical Staff shall be:

1. Anesthesia;
2. Emergency Medicine;
3. Family Medicine;
4. Medicine;
5. Obstetrics/Gynecology;

6. Orthopedics;
7. Pathology;
8. Pediatrics;
9. Psychiatry;
10. Radiology; and
11. Surgery.

SECTION 3. QUALIFICATIONS, SELECTION TENURE AND REMOVAL OF DEPARTMENT CHAIRS

A. Each chair shall be a member of the Active Staff in good standing (no sanctions, suspensions, behavior or quality issues for the previous three (3) years) and shall be board certified or shall affirmatively establish comparable competence, through the credentialing process, and must be qualified by training, experience, and demonstrated ability for the position.

B. Department chairs shall be nominated and elected by department members and confirmed by the Chief of Staff. If a department chair cannot be found, the Chief of Staff can appoint an interim chair in conjunction with the department's approval. Whenever a Department chair is out of town or otherwise unavailable to perform duties as Department chair, he/she must appoint an interim chair and notify the Medical Staff Services Department. The interim chair should preferably be a past Department chair or someone with credentialing experience whenever possible. Department chairs should also:

   1. Demonstrate a willingness to consider attending leadership training.
   2. Recognize and agree to the time commitment necessary to perform Medical Staff duties.
   3. Agree during the term of office not to be a Medical Staff leader, department chair or Board leader at any other hospital.
   4. Recognize the responsibility and demonstrate that ability to communicate well with the Medical Staff, administration, and the Board.

C. Department chairs may be removed from office for stated cause, by petition of two-thirds of the Active Staff members of the department.

   1. Such stated causes include and should not be limited to:
      a. Involvement and discipline through the Code of Conduct policy, or;
      b. Dereliction of duties.
   2. Automatic removal from office will occur due to:
      a. Loss of a valid State of Alaska Medical or Dental license
      b. Loss of Medical Staff membership at Providence Alaska Medical Center
      c. Involuntary loss of privileges at Providence Alaska Medical Center

SECTION 4. ROLES AND RESPONSIBILITIES OF DEPARTMENT CHAIRS

Each Department Chair:

A. Participates as a member of the Medical Executive Committee with responsibility for making recommendations on Medical Center and departmental policy in order to promote high quality patient care.

B. Is responsible for establishing or eliminating committees for the purpose of improving the efficiency and quality of patient care rendered by the department and conducting peer review, and forwarding notification of such actions to the Medical Executive Committee.

C. Assures that department and committee meetings are held at appropriate intervals and at least quarterly in accordance with state law.

D. Acts as presiding officer at department meetings.

E. Reviews and provides oversight in the clinically related activities of the department.

F. Participates in administrative activities of the department and reports professional and administrative activities within the department to the Chief of Staff and the appropriate Administrator for the department.

G. Provides continuous surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.

H. Recommends to the medial staff the criteria for clinical privileges that are relevant to the care provided in the department.

I. Recommends clinical privileges for each member of the department,

J. Assesses and recommends to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization.

K. Participates in the integration of the department into the primary functions of the organization.

L. Participates in the coordination and integration of interdepartmental and intradepartmental services.

M. Assesses and recommends development and implementation of policies and procedures that guide and support the provision of care, treatment and services.

N. Acts as custodian of the Departments Rules & Regulations (if applicable for the Department).

O. Recommends a sufficient number of qualified and competent persons to provide care, treatment, and service.

P. Determines qualifications and competence of licensed independent practitioners who provide patient care, treatment, and services.

Q. Determines qualifications and competence of department or clinical service personnel who are NOT licensed independent practitioners (excludes employed staff of the hospital) who provide patient care, treatment and service. The Department Chair may assign a designee as appropriate for the oversight of these activities.

R. Provides continuous assessment and improvement of the quality of care, treatment and services.

S. Reviews and maintains quality control programs, as appropriate.

T. Provides oversight and participates as needed in orientation and continuing education of all persons in the department.

U. Recommends space and other resources needed by the department or service.

SECTION 5. FUNCTIONS OF DEPARTMENTS

A. Each department shall establish its own criteria for recommending clinical privileges in the department to be approved by the Medical Executive Committee and the Board.

B. Each department shall systematically evaluate the effectiveness and efficiency of the care of selected patients by its members. Review shall be based primarily upon the medical record, but may include inspection of x-ray, tissues, and other specimens and may include interviews of persons involved in the case. The department shall conduct regular conferences to consider some of these cases, scrutinizing particularly deaths, errors in diagnoses and treatment, unforeseen complications and unsolved clinical problems. Such meetings may be limited to Members or to members of the department.

C. Each department will provide Emergency Call coverage for the Medical Center. Each department is responsible for establishing the mechanism to facilitate coverage. The Medical Executive Committee, in consultation with the Department Chair and the Emergency Department will determine inadequate coverage. Additional detail may be found in MS 920-010 Call Coverage Requirements policy as well as Department Rules and Regulations (where applicable).

SECTION 6. ASSIGNMENT TO DEPARTMENTS

A. The Medical Executive Committee shall, after consideration of the recommendations of the chair of the appropriate clinical department, and the Credentials Committee, recommend department assignments for all members in accordance with their qualifications. There may be times when a practitioner is assigned to one or more departments based on specialty overlap. These recommendations will be forwarded to the Board for approval.

ARTICLE X
COMMITTEES

A. There shall be two primary standing committees of the Medical Staff designated by these Bylaws:

1. Medical Staff Executive Committee (MEC)
2. Credentials Committee

B. There shall be further standing and special committees as may from time to time be necessary and desirable. Should that be determined, a policy shall be created and implemented that provides the working charter and guidelines for such committee. See individual committee policies for detail.

C. The Medical Executive Committee may, by resolution, establish a Medical Staff committee to perform one or more of the Medical Staff functions required by these Bylaws (see Medical Staff policies).

SECTION 1. MEDICAL STAFF EXECUTIVE COMMITTEE (MEC)

A. The Medical Staff delegates authority to the MEC to carry out Medical Staff responsibilities. The MEC carries out its work within the context of the hospital functions of governance, leadership and performance improvement. The MEC has the primary authority for activities related to self-governance of the Medical Staff and for performance improvement of the professional services provided by licensed independent practitioners and other dependant practitioners privileged through the Medical Staff process.

B. Active and Honorary members of the organized Medical Staff, of any discipline or specialty, are eligible for membership on the Medical Executive Committee and must be in good standing (see MS 980-100 Investigation, Hearing and Appeals Plan). The Medical Executive Committee acts on behalf of the organized Medical Staff between General Medical Staff meetings. Composition: The Medical Executive Committee shall be a standing committee and shall consist of the following members:

1. Voting Members
   a. The officers of the Medical Staff,
   b. The chair of each Medical Staff department,
   c. The Credentials Committee Chair, and/or their designee,
   d. The Trauma Committee Chair, so long as the committee exists.
2. Voting Special Considerations
   a. The majority of voting members of the MEC must be fully licensed physicians actively practicing at the Hospital.
   b. No one person may serve in more than one voting role on the MEC.
   c. Voting by proxy or sending a stand-in for a voting member is not permitted.
3. Non-Voting Members
   a. The Graduate Medical Education Committee Chair, so long as the committee exists,
   b. Administrator,
   c. Chief Medical Officer,
   d. Chief Nurse Executive,

e. Member of the Board.

4. The Medical Executive Committee shall have discretion to invite other Members and support staff to participate in its meetings. Those other members or support staff, may provide information to the MEC for consideration, but may NOT vote on issues before the committee

C. Duties: The duties of the Medical Executive Committee shall be:

1. To represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws.

2. To coordinate the activities and general policies of departments.

4. To receive and act upon committee and department reports.

5. To implement policies of the Medical Staff.

6. To provide liaison between the Medical Staff and the Administrator.

7. To recommend action to the Administrator on matters of a medical-administrative nature.

8. To make recommendations on Medical Center management matters (for example, long-range planning) to the Board through the Administrator.

9. To ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Medical Center.

10. To fulfill the Medical Staff organization's accountability to the Board for the medical care rendered to patients in the Medical Center.

11. To review the reports of each Medical Staff Committee, Department, and other assigned activity groups and act upon recommendations made appropriately.

12. To review the report of the Credentials Committee on all applicants and to make recommendations to the Board for staff membership, assignments to departments and delineation of clinical privileges

13. To review the report of the Credentials Committee regarding the performance and clinical competence of members with clinical privileges and, as a result of such reviews, to make recommendations for reappointments and renewal of, or changes, in clinical privileges to the Board.

14. To review and report to the Board on the organized Medical Staff's structure.

15. To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all Members.

16. To report at each General Staff meeting.

D. Meetings: The Medical Executive Committee shall meet at least ten times per year and maintain a permanent record of its proceedings and actions.

E. Quorum Requirement for Regular and Special Meetings: Due to the important business the Medical Executive Committee conducts on behalf of the Medical Staff, a quorum of 51% of the voting members is required to conduct business, where a vote or consensus of members is required.

F. Removal of MEC Members:

1. If a member of the MEC does not attend at least 60% of all meetings in the calendar year, the elected Officers of the Medical Staff, may remove the member and appoint a new member until the next election of the organized Medical Staff if an officer or appropriate Department if a Department Chair.

2. MEC members may be removed from office for cause, by a two-thirds vote of the MEC members.

3. Such stated causes include and should not be limited to:

a. Involvement and discipline through the Code of Conduct policy, or;

b. Dereliction of duties.

4. Automatic removal from the MEC and the role held by the member will occur due to:
   a. Loss of a valid State of Alaska Medical or Dental license
   b. Loss of Medical Staff membership at Providence Alaska Medical Center
   c. Involuntary loss of privileges at Providence Alaska Medical Center

G. CONFLICT RESOLUTION PROCESS FOR THE MEC AND THE MEDICAL STAFF:

1. Should there be issues of conflict between the medical staff and the MEC on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto, the process outlined below will be followed. Nothing in the foregoing is intended to prevent the medical staff members from communicating with the governing body on a rule, regulation, manual or policy adopted by the organized medical staff or the MEC. The governing body determines the method of communication.

   a. A Conflict Resolution Committee (CRC) shall be formed. The committee shall be composed of 5 MEC members (3 of which must be the current chief of staff and at least 2 of the members at large), and at least 6 members on the general medical staff that do not currently serve in a leadership position at PAMC (at least one representative from Internal Medicine and Surgery must be included as the largest departments of the PAMC Medical Staff). Whenever possible attempts to include a representative from each of the recognized medical staff departments should be made. The chair of the CRC will be the chief of staff. All eleven members will be voting members, including the CRC chair.

   b. A collegial resolution is the goal of the CRC. However, if such a result can not be found the majority vote shall be the final ruling of the CRC. The decision of the CRC will go to the board for their approval. If an approval can not be granted, the similar committee at the board level called the "Joint Conference Committee (JCC)" shall convene. The detail of the JCC shall be outlined in Medical Staff Policy (MS 980-100) "Investigation, Hearing and Appeals".

SECTION 2. QUALITY IMPROVEMENT AND REVIEW FUNCTIONS PERFORMED BY MEDICAL STAFF COMMITTEES

A. A description of other Medical Staff committees that perform systematic monitoring and quality improvement activities and other review functions shall be set forth in the Medical Staff Policies. It shall be a function of the Medical Staff to review:

1. Medical assessment and treatment of patients;
2. Use of information about adverse privileging decisions for any practitioner privileged through the Medical Staff process;
3. Use of medications;
4. Use of blood and blood components;
5. Use of operative and other procedures;
6. Appropriateness of clinical practice patterns,
7. Significant departures from established patterns of clinical practice; and
8. Use of developed criteria for autopsies.

B. Further detailed information regarding quality improvement and review functions for the Medical Staff is maintained in MS 920-045 Professional Practice Evaluation policy. This policy includes detailed information regarding Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE).

ARTICLE XI
MEETINGS

SECTION 1. GENERAL MEDICAL STAFF MEETINGS

A. Regular Meetings of the General Medical Staff: There shall be at least one General Staff Meeting held each year, although in general two are scheduled on an annual basis, one in April and one in October.

1. Notice - Written notice stating the agenda, place, day and hour of any general staff meeting shall be conspicuously posted, or delivered either personally, by facsimile, email or by mail to each Medical Staff member entitled to be present not less than four working days, and with the notice or a reminder, not more than twenty days before the date of such meeting.

2. Manner of Action - Except as otherwise provided, the action of a majority of the Active Members present and voting at a General Staff Meeting shall be the action of the group. Methods of voting may include voice votes, show of hands, ballots or general consent. An affirmative vote of the majority of the members present shall be a simple majority and shall be required to pass items of business needing a vote or consensus with the exception of the adoption or amendment of these Bylaws. A two-thirds majority of the Active Members present and voting at a general staff meeting shall be required for adoption or amendment of the Bylaws. For purposes of these Bylaws, those Medical Staff members with voting privileges are deemed to be present for purposes of voting if he or she has requested and been granted an excused absence from the meeting. For voting purposes, members granted an excused absence may vote by an absentee ballot.

3. Quorum - There are no quorum requirements for regularly scheduled General Staff Meetings. Those members present at the start of the meeting shall constitute a quorum for conducting business.

4. Order of Business and Agenda - The Chief of Staff shall determine the order of business at a regular General Staff Meeting.

B. Special Meetings of the General Medical Staff

1. Calling a Special Meeting - A special meeting of the General Medical Staff may be called by the Chief of Staff or the Chief of Staff must call a meeting at the written request of the Board, the Executive Committee or by twenty-five percent of the Members of the Active Staff.

2. Quorum Requirements at a Special Meeting - Except as otherwise provided in these Bylaws, the presence of thirty percent (30%) of those Medical Staff members with voting privileges shall constitute a quorum at any special General Staff Meeting. An Active Member is deemed to be present for purposes of establishing a quorum if he or she has requested and been granted an excused absence from the meeting.

SECTION 2. DEPARTMENT AND COMMITTEE MEETINGS

A. Regular Meetings
Each committee and department shall determine the time for holding regular meetings. Medical Staff departments shall hold regular meetings at least quarterly to perform departmental functions. Committees shall meet as needed. The details of the committee will be addressed in individual policies of the Medical Staff for that committee.

1. Notice - Written notice stating the place, day and hour of any committee or department meeting shall be sent to each member not less than three (3) days before the time of such meeting.

2. Manner of Action - The action of a majority of the members of a committee or department present and voting at a meeting shall be the action of the group. For purposes of these Bylaws, a member of a committee or department is deemed to be present for purposes of voting if he or she has requested and been granted an excused absence from the meeting.

3. Quorum - A quorum for conducting business at committee and department meetings shall be defined as those voting members present for a regular scheduled meeting at the start of the meeting unless otherwise defined in these bylaws or

committee policy. At a minimum, the presence of three physicians including the chair or the chairs designee is required.

B. Special Meetings

1. Calling a Special Meeting - A special meeting of any committee or department may be called for at the request of the respective Department or Committee Chair or by the Chief of Staff.
2. Quorum Requirements - The presence of thirty percent (30%) of the Active Members of a department at a department meeting shall constitute a quorum. The presence of fifty percent (50%) of the members of a committee shall constitute a quorum. A committee or department member is deemed to be present for purposes of establishing a quorum if he or she has requested and been granted an excused absence from the meeting.

SECTION 3. MINUTES

Minutes of all meetings shall be prepared and shall include at a minimum a record of attendance and the vote taken on each matter. Copies of such minutes shall be approved by the attendees, and made available to the Medical Executive Committee and Medical Staff. A permanent file of the minutes of each meeting shall be maintained and are available in the Medical Staff Services Department.

SECTION 4. RULES OF ORDER

The latest edition of *The Standard Code of Parliamentary Procedure* shall prevail at all meetings unless waived.

SECTION 5. RIGHTS OF EX OFFICIO MEMBERS; PARTICIPATION BY ADMINISTRATOR

Except as otherwise provided in these Bylaws, persons serving as ex officio members of a committee shall have all rights and privileges of regular members, except they shall not vote or be counted in determining the existence of a quorum. The Administrator or his/her designee may attend any regular and/or special meetings of the Medical Staff, committees and/or departments.

SECTION 6. PROVISIONS FOR MAILED BALLOT

The Medical Executive Committee is authorized to establish a procedure for voting on Medical Staff matters by facsimile, email or by mail for each member eligible to vote. A vote via telephone is acceptable with two authenticated confirmations by members of the Medical Staff Services Department

ARTICLE XII
CONFIDENTIALITY, IMMUNITY, AND LIABILITY

SECTION 1. SPECIAL DEFINITIONS

A. For the purposes of this article, the following definitions will apply:

1. "Information" means all acts, communications, records of proceedings, minutes, other records, reports, memoranda, statements, recommendations, data, and other disclosures, whether in written, recorded, computerized or oral form, relating to professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.
2. "Representative" means a Board, any Board member, a committee, a chief executive officer or administrator of a hospital or other health care institution or their designee; a Medical Staff department, committee, and individuals who serve thereon; and any individual authorized by any of the foregoing to perform specific information

gathering or disseminating functions.

3. "Third parties" means both individuals and organizations providing information to any representative.

SECTION 2. AUTHORIZATION AND CONDITIONS

A. As conditions of applying for, or exercising Medical Staff membership or clinical privileges within the Medical Center, the practitioner:

1. Authorizes representatives of the Medical Staff and Medical Staff Services Department as the Medical Staff's designee to solicit, provide, and act upon information bearing on the practitioner's professional ability and qualifications;
2. Agrees to be bound by the Bylaws, rules and regulations, manuals, and the governing policies and procedures of the Medical Staff and of the Medical Center;
3. Acknowledges that the provisions of this article and the application are express conditions to the practitioner's staff membership and the exercise of clinical privileges at the Medical Center.

SECTION 3. CONFIDENTIALITY OF INFORMATION

A. Information regarding the maintenance of quality patient care shall, to the fullest extent permitted by law, be kept confidential. This information shall not become part of any particular patient's file or of the general records of the Hospital.

SECTION 4. IMMUNITY FROM LIABILITY

A. No representative of the Medical Center or Medical Staff shall be liable for damages or other relief for any action, statement or recommendation made within the scope of the person's duties as a representative, if such representative acts in good faith, makes a reasonable effort to ascertain the truthfulness of the facts, and reasonably believes that the action, statement, or recommendation is warranted by such facts. No representative of the Medical Center, Medical Staff, or third party shall be liable for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of the Medical Center, Medical Staff, other health care facility, or organization of health professionals concerning a practitioner who is or has been an applicant to or a Member of the staff, or who did or does exercise clinical privileges or provide specified services at the Medical Center, provided that such representative or third party acts in good faith.

SECTION 5. RELEASES

A. Each practitioner shall, upon request of the Medical Center, execute general and specific releases in accordance with the tenor and import of this article. Execution of such releases shall not be a prerequisite to the effectiveness of this article.

ARTICLE XIII
AUTHORITY

A. These Bylaws and the inherent extensions thereof shall be the ultimate governing document of the Medical Staff, and shall supersede any policies, procedures, or documents to the contrary.

ARTICLE XIV
ADOPTION

A. These Bylaws shall be adopted at any regular meeting or at any special meeting called for such purpose, in accordance with the voting and quorum requirements for adoption of the Bylaws set forth in Article XI. Upon such adoption by the Medical Staff and upon approval by the Board, these Bylaws shall become effective and shall replace any previous Bylaws of the Medical Staff.

B. The governing body approves and complies with the medical staff bylaws. The bylaws of the medical staff (and all other medical staff policies, etc.) shall not conflict with the boards bylaws. The organized medical staff enforces and complies with the medical staff bylaws.

ARTICLE XV
AMENDMENTS

A. Medical Staff Members with voting privilege may amend these Bylaws from time to time. The proposed amendment will be distributed to the Active Medical Staff Members no less than one month before the General Staff meeting at which it is to be voted upon. The proposed amendment may be presented at either a regular General Staff meeting or at a special meeting called for that purpose. The voting and quorum requirements for amending the Bylaws are set forth in Article XI.

B. Following adoption by the Active Medical Staff, the amendment will be recommended to the Board for their consideration. If the Board approves the amendment, it will be incorporated into these Bylaws.

C. The Medical Staff at a General or Special meeting may authorize a vote of these bylaws outside of the regular or special meeting format as needed.

D. Neither the Board nor the Medical Staff may unilaterally amend these bylaws.

ARTICLE XVI
MEDICAL STAFF POLICIES AND PROCEDURES

A. Medical Staff Policies and Procedures shall be established and incorporated herein by this reference, to further govern Medical Staff issues following review and approval by the Medical Executive Committee. All Members, Allied Health Professionals and Clinical Staff are expected to follow such policies and procedures. The Medical Staff Policy Triage Committee (CMO, Bylaws Chair, Chief of Staff and Hospital Administrator) meet to determine the route of all MS policies through the Bylaws Committee and/or the MEC for review. . Following recommended approval from the MEC, all Medical Staff policies go to the Voting General Medical Staff for a thirty (30) day review period prior to implementation. Following the review period, if less than 10 % have comment or disagree with the proposed policies; MS policies shall be submitted to the Governing Board for approval and implemented immediately following while PAMC/MS policies will be implemented immediately following the 30 day review period.

B. Should more than 10% of the Active Medical Staff indicate disagreement with proposed policies, such proposed policies will be presented to the General Medical Staff for discussion and vote at the next available General Medical Staff Meeting. Following a majority vote in favor of a change the policy will be moved to the Governing Board for approval and implemented immediately following. If a vote for a change to a policy fails, it is returned to the Bylaws Committee for further review.

C. All MS Policies are reviewed annually. Those policies that are under annual review and experience any of the items below, can move directly to MEC for approval and be implemented immediately following board approval.

Simple edits and simple revisions to the policies and procedures without changing the meaning of any part of the

policies and procedures in the following manner:

1. Policies up for annual review that reflect no changes and will be renewed as is.
2. Renumber sections, parts of sections, articles, chapters, and titles;
3. Modify the wording of section or subsection titles, or delete subsection titles;
4. Change capitalization for the purpose of uniformity;
5. Substitute the proper calendar date for "effective date of this Act," "date of passage of this Act," and other phrases of similar import;
6. Correct manifest errors that are clerical, typographical, or errors in spelling, or errors by way of additions or omissions;
7. Correct personnel titles, as positions change or emerge;
8. Rearrange sections, combine sections or parts of sections with other sections or parts of sections, divide long sections into two or more sections, and rearrange the order of sections to conform to a logical arrangement of subject matter as may most generally be followed in the Bylaws.
9. Shall edit and revise the Bylaws as they are acted upon by the Medical Staff, without changing the meaning of any bylaw, so as to avoid the use of pronouns denoting masculine or feminine gender.

ARTICLE XVII
PROVIDENCE ALASKA MEDICAL CENTER AND PROVIDENCE HEALTH SYSTEM POLICIES

Providence Alaska Medical Center and Providence Health & Services Alaska policies that impact physician practice shall be made available to the Medical Staff either via email, internet access or can be viewed in the Medical Staff Services Department.

ARTICLE XVIII
ADMINISTRATIVE AMENDMENTS

A. The Medical Staff Services Department shall be allowed to make simple edits and simple revisions to these Bylaws without changing the meaning of any part of the Bylaws in the following manner:

1. Renumber sections, parts of sections, articles, chapters, and titles;
2. Modify the wording of section or subsection titles, or delete subsection titles;
3. Change capitalization for the purpose of uniformity;
4. Substitute the proper calendar date for "effective date of this Act," "date of passage of this Act," and other phrases of similar import;
5. Correct manifest errors that are clerical, typographical, or errors in spelling, or errors by way of additions or omissions;
6. Correct personnel titles, as positions change or emerge;
7. Rearrange sections, combine sections or parts of sections with other sections or parts of sections, divide long sections into two or more sections, and rearrange the order of sections to conform to a logical arrangement of subject matter as may most generally be followed in the Bylaws.
8. Shall edit and revise the Bylaws as they are acted upon by the Medical Staff, without changing the meaning of any bylaw, so as to avoid the use of pronouns denoting masculine or feminine gender.

9. Changes shall be reported to the Medical Executive Committee.

ARTICLE XIX
REVIEW

The Medical Executive Committee shall review these Bylaws, as well as the policies and procedures, rules and regulations of the Medical Staff, no less than every other year. Changes or revisions so noted by this review shall be processed through the amendment process stated in these Bylaws.

END OF BYLAWS