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**OUR LADY OF LOURDES MEDICAL CENTER**

**MEDICAL STAFF BYLAWS**

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BYLAWS OF THE MEDICAL STAFF OF

OUR LADY OF LOURDES MEDICAL CENTER

PREAMBLE

WHEREAS, the Our Lady of Lourdes Medical Center is a non-profit corporation organized under the laws of the State of New Jersey; and

WHEREAS, its purpose is to serve as a general Medical Center providing patient care, and participating in education and research; and

WHEREAS, it is recognized that the medical staff is to strive for quality patient care in the Medical Center, that the medical staff must work with and is subject to the ultimate authority of the Trustees of Our Lady of Lourdes Medical Center, Inc., a New Jersey non-profit corporation, and that the cooperative efforts of the medical staff, management, and Trustees are necessary to fulfill the objective of providing quality patient care to its patients;

THEREFORE, the practitioners practicing in Our Lady of Lourdes Medical Center hereby agree to carry out the functions delegated to the medical staff by the Board in conformity with these bylaws, rules and regulations, and the charter, bylaws, policies, rules and regulations of Our Lady of Lourdes Medical Center, Inc.
DEFINITIONS

1. **Allied Health Practitioner** means a practitioner who is neither employee of the Medical Staff nor a member of the medical staff, is not a member of the medical staff, does not have delineated clinical privileges and does not have the rights and privileges of a member of the medical staff.

   **Independent Allied Health Practitioner** means an individual who is neither an employee of the Medical Center nor a member of the medical staff, and who is licensed or regulated by the State of New Jersey, and permitted by law and the Medical Center to provide patient care services without direction and supervision.

   **Dependent Allied Health Practitioner** means an individual, other than a licensed physician, dentist or podiatrist, whose authority to perform patient care duties is dependent upon direction and/or supervision by a member of the medical staff.

2. **Board of Trustees of the Lourdes Health System** is the governing body of the health system for Our Lady of Lourdes Medical Center.

3. **Board of Trustees or Trustees or Board or Governing Body** means the Board of Trustees of Our Lady of Lourdes Medical Center, Inc.

4. **CEO (Chief Executive Officer)** means the individual appointed by the President/CEO of Lourdes Health System to act on his/her behalf in the operational and administrative management of the Medical Center.

5. **Clinical Privileges or Privileges** means the permission granted to a practitioner or an independent allied health practitioner to render specific diagnostic, therapeutic, medical, dental, or surgical services.

6. **Dentist** means an individual who has been awarded the degree of doctor of dentistry (D.D.S.) or doctor of dental medicine (D.M.D.).

7. **Ex-Officio** means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.
8. **Fair Hearing Plan** means the procedures set forth in Article XVI.

9. **Good Standing** means the staff member has met the attendance requirements during the previous medical staff year, is not in arrears in dues payment, and is not under a suspension of his/her appointment or admitting privileges.

10. **Medical Center** means our Lady of Lourdes Medical Center, Inc.

11. **Medical Executive Committee or MEC** means the executive committee of the medical staff.

12. **Medical Staff** means the formal organization of all licensed physicians, dentists, and podiatrists who are privileged to attend patients in the hospital and who are permitted by the laws and regulations of the State of New Jersey and by the Medical Center to exercise independent professional care and judgment for patient care services.

13. **Medical Staff Membership/Members** refers solely to practitioners who have been duly appointed by, and are subject to the ultimate authority of, the Board of Trustees to render professional services.

14. **Medical Staff Year** means the period from January 1 through December 31.

15. **Oral Surgery** means the branch of surgery pertaining to or involving the maxillofacial skeleton, including the mouth and associated structures.

16. **Physician** means an individual who has been awarded the degree of doctor of medicine (M.D.) or doctor of osteopathic medicine (D.O.).

17. **Podiatrist** means an individual who has been awarded the degree of doctor of podiatric medicine (D.P.M.).

18. **Podiatry** means the diagnosis or treatment of or holding out of a right or ability to diagnose or treat any ailment of the human foot, including local manifestation of systemic diseases as they appear on the lower leg or foot (but not the treatment of systemic diseases of any other part of the body) or the right or ability to treat the same by one or more of the following means: local medical, mechanical, surgical, manipulative, and physiotherapeutic, including the application of any of the aforementioned means to the lower leg or ankle for the treatment of a
foot ailment. Such means shall not be construed to include the amputation of the leg.

19. **Policy of Exclusivity** is that policy adopted by the Board of Trustees setting forth the terms and conditions upon which exclusive contracts may be granted to practitioners and allied health practitioners.

20. **Practitioner** means, unless otherwise expressly limited, any appropriately licensed physician, oral surgeon, dentist or podiatrist applying for, or exercising, clinical privileges in this organization.

21. **Prerogative** means a participatory right granted, by virtue of staff category or otherwise, to a staff member and exercisable subject to the conditions imposed in these bylaws and in other Medical Center and medical staff policies.

22. **President** means the individual jointly appointed by the Lourdes Health System Board and Catholic Health East System to act on their behalf in the overall administrative management of the Lourdes Health System.

23. **President of the Medical Staff** means a licensed physician elected by the active medical staff to serve as the Chief Executive Officer of the medical staff.

24. **Qualified Oral Surgeon** means an individual who has successfully completed a program in oral surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education.

25. **Special Notice** means written notification sent by certified mail, return receipt requested.

26. **Chief Medical Officer** means an individual appointed by the Board to supervise the functioning of the various departments and to serve as the head of the professional staff.
ARTICLE I - NAME

The name of this organization shall be "The Medical Staff of Our Lady of Lourdes Medical Center."
ARTICLE II - PURPOSES AND RESPONSIBILITIES

2.1 PURPOSES

The purposes of the staff are:

A. To be the formal organizational structure through which:

1. The benefits of membership on the staff may be obtained by individual practitioners; and,

2. The obligations of staff membership may be fulfilled.

B. To serve as the primary means for accountability to the Board for the appropriateness of the professional performance and ethical conduct of its membership and to strive toward assuring that the pattern of patient care in the Medical Center is consistently maintained at the level of quality and efficiency achievable by the state of the healing arts and the resources locally available.

C. To provide a means through which the staff may participate in the Medical Center's policy-making and planning process.

D. To support research and educational activities in the interest of improving patient care, the skills of persons providing health services, and the promotion of the general health of the community.

E. To provide a means whereby problems of a medical-administrative nature may be discussed and resolved by the medical staff, by the Board of Trustees, and by the President.

2.2 RESPONSIBILITIES

The responsibilities of the staff, to be fulfilled through the actions of its officers, departments and committees, include:
2.2-1 To account for the quality and appropriateness of patient care rendered by all practitioners and allied health practitioners authorized to practice in the Medical Center through the following measures:

   A. A credentials program, including mechanisms for appointment and reappointment, and the matching of clinical privileges to be exercised or of specified services to be performed, with the verified credentials and current demonstrated performance of the applicant, staff member or allied health practitioner;

   B. A continuing education program, fashioned at least in part on the needs demonstrated through the patient care assessment and other performance improvement programs;

   C. A review program to allocate inpatient and outpatient medical and health services based upon patient specific determinations of individual medical needs;

   D. An organizational structure that allows continuous monitoring of patient care practice;

   E. Review and evaluation of the quality of patient care through valid and reliable institutional performance improvement programs.

2.2-2 To recommend to the Board action with respect to appointments, reappointments, staff category, departmental and division assignments, clinical privileges, and corrective action.

2.2-3 To account to the Board for the quality and efficiency of patient care rendered to patients in the Medical Center through regular reports and recommendations concerning the implementation, operation and results of the performance improvement activities.

2.2-4 To initiate and pursue corrective action with respect to practitioners and dependent and independent allied health practitioners when warranted.

2.2-5 To develop, administer and achieve compliance with these bylaws, the rules and regulations of the staff, and other patient care related Medical Center policies.
2.2-6 To assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet these needs.

2.2-7 To exercise the authority granted by these bylaws as necessary to adequately fulfill the foregoing responsibilities.
ARTICLE III - STAFF MEMBERSHIP

3.1 NATURE OF STAFF MEMBERSHIP

Membership on the medical staff of Our Lady of Lourdes 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. Appointment to and membership on the staff shall confer on the staff member only such clinical privileges and prerogatives as have been granted by the Board in accordance with these bylaws, and shall include staff category, and department and division assignments.

3.2 BASIC QUALIFICATIONS FOR MEMBERSHIP

3.2-1 Basic Qualifications. Those qualified for membership on the medical staff shall be physicians, dentists, oral surgeons and podiatrists licensed to practice in the State of New Jersey who are not currently excluded from participation in Medicare, Medicaid or any other federal or state program providing health care benefits which is funded directly or indirectly by the United States government shall submit an “Individual” National Provider Identifier (NPI) with the initial application (except for RN”s), and New Jersey Medicaid Provider or Non-Billing Provider Number and who are permitted by the laws and regulations of the State of New Jersey and by the Medical Center to provide patient care services in the Medical Center and who:

A. Document their experience, background, training, demonstrated ability, current competency, professional ethics, physical and mental health status, and their ability to work harmoniously with medical and staff personnel, with sufficient adequacy to demonstrate to the staff and Board that they will provide care to patients at the generally recognized professional level of quality, in an economically efficient manner, taking into account patients' needs, the available Medical Center facilities and resources and utilization standards in effect at the Medical Center;

B. In the case of Doctors of Medicine, Osteopathy and Dentistry and Podiatry, initial appointments to the Medical Staff will not be made unless the applicant can provide
proof that he/she is qualified for certification by one of the Boards recognized by the American Board of Medical Specialties and/or the American Board of Osteopathic Specialties and/or American Board of Podiatric Medicine and/or American Board of Oral Maxillofacial Surgery.

Board Certification or active candidacy for Board certification in a practitioner’s area of requested privileges shall be required at the time of application for initial medical staff appointment and reappointment for Doctors of Medicine, Osteopathy, Dentistry, Oral Surgery, and Podiatry joining the medical staff after November 4, 2002. Applicants for staff membership who have not achieved Board certification within five years of becoming candidates for certification will not be considered for staff appointment or reappointment. Active candidates for Board certification joining the medical staff after November 6, 1996 who do not become certified within five years of the date they become active candidates will be deemed to have voluntarily relinquished staff appointment and privileges. Podiatric surgeons who are active candidates for board certification who do not become certified within seven years of the date they became active candidates will be deemed to have voluntarily relinquished staff appointment and privileges. Individuals who are otherwise deemed qualified for appointment in a subspecialty area but are not considered active candidates for subspecialty certification because they have not received Board certification in their primary specialty will be considered for appointment if they have fulfilled all other requirements for appointment in their area of requested privileges and have been candidates for Board certification in their primary specialty for less than five years.

The Board of Trustees may waive these requirements because of institutional needs.

C. Are determined to be professionally competent, on the basis of two (2) positive recommendations for appointment from clinicians who are familiar with the applicant’s professional work and competence during the prior two (2) years, and references from the director(s) of all graduate and post-graduate training programs in which the applicant participated, and case audits, and to adhere strictly to the ethics of their respective professions, to work harmoniously with other staff physicians and other
personnel, and to be willing to participate in the discharge of staff responsibilities; and,

D. Provide evidence of professional liability insurance coverage in an amount to be determined by the Board after consultation with the Medical Executive Committee.

3.2-2 Health Status. When the Medical Executive Committee or Board has reason to question the physical and/or mental health status of a practitioner, the practitioner shall be required to submit to an evaluation of his/her physical and/or mental health status by a physician or physicians acceptable to him/her and the Board, as a prerequisite to further consideration of his/her application for appointment or reappointment, to the exercise of previously granted privileges, or to maintenance of his/her staff appointment.

3.2-3 Effect of Other Affiliations. No physician, dentist, or other practitioner is entitled to membership on the staff or to the exercise of particular clinical privileges solely because he/she is licensed to practice in this or in any other state, or because he/she is a member of any professional organization, or is certified by any clinical board, or presently or formerly held staff membership or privileges at another health care facility or in another practice setting.

3.2-4. Nondiscrimination. Staff membership or particular clinical privileges shall not be denied on the basis of any criterion unrelated to the efficient delivery of patient care at the generally recognized professional level of quality in the Medical Center, to professional ability and judgment, including, but not limited to, gender, sex, age, race, creed, color and national origin.

3.3 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP

Each member of the staff shall:

A. Provide his/her patients with continuous care of the generally recognized professional level of quality and efficiency;
B. Abide by the medical staff bylaws and rules and regulations, and by all other established standards, policies, rules, and bylaws of the Medical Center;

C. Discharge such staff, department, division, committee and Medical Center functions for which he/she is responsible by appointment, election, or otherwise;

D. Prepare and complete promptly, in the prescribed manner, the medical and other required records for all patients he/she admits or in any way provides care to in the Medical Center;

E. Abide by the ethical principles of his/her profession and discipline including, but not limited to, the Ethical and Religious Directives for Catholic Health Facilities as promulgated by the U.S. Catholic Conference and to: refrain from fee splitting or other inducements relating to patient referral; provide for continuous care of his/her patients; refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a practitioner who is not qualified to undertake this responsibility and who is not adequately supervised; seek consultation whenever necessary; and refrain from providing surgical or medical services when not physically present except under emergency circumstances;

F. Notifying the President within two weeks of the revocation, restriction, suspension, curtailment or surrender of his/her professional license by any state, or of his/her revocation, restriction, suspension or curtailment of staff membership or privileges at any hospital or other health care institution, or of the commencement of a formal investigation, or the filing of charges, by the New Jersey Department of Health or any law enforcement agency or health regulatory agency of the United States or any other state, or of the filing of a suit and/or claim against the practitioner alleging professional liability, or any formal proceeding before any third-party provider or state agency, board or society, or any change in provider status. In addition, as a condition of consideration for initial and continued appointment to the Medical Staff, every applicant shall specifically agree to provide, with or without request, new or updated information to the President that is pertinent to any question on the application form, including but not limited to any change in participation status in any federal health program,
including any exclusion or other sanctions imposed or recommended by the Federal Department of Health and Human Services, or any state agency, concerning alleged quality problems in patient care.

G. Provide services to all patients without personal physicians in accordance with the protocol adopted by the staff delineating responsibility for services to such patients and in accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA);

H. Participate in educational programs conducted and/or sponsored by the staff and/or Medical Center; and

I. Inform his/her patient(s) of the name and function of any medical staff member, other than himself/herself, providing health care services to the patient.

J. Participate in Focused and Ongoing Professional Practice Evaluations as determined to be necessary by the Medical Staff.

K. Each patient admitted to the hospital shall have a comprehensive history and physical examination that includes a provisional diagnosis performed by the attending physician or physician designee approved by the Medical Center. A history and physical shall be performed within 30 days preceding an inpatient admission or proposed surgery or within 24 hours after admission. Necessary laboratory tests, as guided by the patient’s underlying medical condition, shall be conducted within seven days preceding the proposed surgery. A comprehensive and complete history and physical is required for all in-patient status admissions. A comprehensive and complete history and physical shall include the following: the chief complaints, details of the present illness, including where appropriate, assessment of the patient’s emotional, behavioral, and social status; relevant past, psycho-social and family histories appropriate to the age of the patient; an inventory by body systems; relevant physical examination; conclusions and impressions. A short form history and physical is permitted for same-day stay patients provided the patient is discharged to home prior to midnight of the day of the procedure. The short stay history and physical should include relevant portions of the following: chief complaint, history of present illness, past medical history, social history, medications, allergies, physical examination, and assessment and conclusions. Both
comprehensive and short form history and physicals shall include an examination of the heart, lungs, and abdomen, in addition to any other findings that are relevant to the patient's problem and care. Any same-day stay patient who remains in the hospital after midnight is considered to be admitted as an in-patient and a complete, comprehensive history and physical is required within 24 hours.

In regard to services for children and adolescents, an evaluation of the patient's developmental age; consideration of educational needs and daily activities as appropriate; the parent's report or other documentation of the patient's immunization status; and the family's and/or guardian's expectations for, and involvement in, the assessment, treatment and continuous care of the patient.

An admission note by attending physician in all cases shall be written as soon as possible after admission. The admission history and physical examination may be performed by individuals who are not licensed independent health practitioners, such as housestaff, advanced practitioner nurses, and physician assistants, whose scope of practice includes this function and shall be conducted under the supervision of, or through appropriate delegation by, the attending physician. The attending physician retains accountability for the patient's history and physical examination and will countersign it within 24 hours of admission.

Each patient admitted to the hospital shall have the appropriate diagnostic studies. Any patient who is undergoing surgery and has had their history and physical completed in the 30 day time frame prior to their admission for surgery shall have a progress note dated the day of surgery if there is any change in their clinical status which is not reflected on the original history and physical.

Qualified oral-maxillofacial surgeons and podiatrists who admit patients for elective surgical procedures may perform the medical history and physical examination on those patients, if they have such privileges, and may assess the medical risks of the proposed surgical and/or other invasive procedures.

Dentists are responsible for the part of their patient's history and physical examination that relates to dentistry.
A history and physical performed by a physician who is not a member of the Our Lady of Lourdes Medical Staff is not an acceptable document.

Other individuals who are permitted to provide patient care services independently may perform the medical history and physical examination, if granted such privileges, and if the findings, conclusions, and assessments of risk are confirmed or endorsed by a qualified physician prior to major diagnostic or therapeutic intervention, or within 24 hours, whichever occurs first.

3.4 DURATION OF APPOINTMENTS

3.4-1 Duration of Initial Appointments. All initial appointments to the staff shall be for a period of one (1) year from the date of appointment by the Board of Trustees.

3.4-2 Reappointment. Reappointment to the staff shall be for a period of two (2) years.

3.4-3 Modification of Appointment. Any modification of appointment or clinical privileges shall be for the period remaining in the appointment current at the date of such modification.

3.4-4 Monitoring Performance of New Appointees. New Appointees are monitored within the Performance Improvement monitoring process that exists for the Department in which they are appointed.

3.4-5 Appointments Provisional.

A. All initial appointments to the Medical Staff (regardless of the staff category) will be provisional for a period of 12 months (or longer, up to a maximum of 24 months, if recommended by the Credentials Committee and the relevant department Chair). All initial clinical privileges, whether granted at the time of initial appointment, reappointment or during the term of an appointment, will be considered provisional for a period as determined by the specific credentialing guidelines. During the provisional period, clinical privileges will be subject to focused professional practice evaluation as described below.
B. During the provisional period, the individual's exercise of the relevant clinical privileges will be evaluated by the Chair of the department in which the individual has clinical privileges. The evaluation may include chart review, monitoring of the individual's practice patterns, proctoring, external review and information obtained from other physicians.

C. During the provisional period, a member must arrange for, or cooperate in the arrangement of, the required numbers and types of cases to be reviewed/observed by the department Chair and/or designated observers.

D. If a member fails, within the designated time period, to admit or treat the number of patients that the Credentials Committee determined was required to permit an evaluation of the member's competence to exercise the newly granted privilege(s), the relevant clinical privileges will be relinquished.

E. If a member fails, during the provisional period, to fulfill all requirements relating to emergency service call responsibilities and/or cooperation with monitoring or observation conditions, at the expiration of the provisional period, all relevant clinical privileges will be relinquished.

F. When, based on the evaluation performed during the provisional period, clinical privileges are terminated, revoked, or restricted for reasons related to clinical competence and/or professional conduct, the individual will be entitled to a hearing and appeal.

G. If a member fails, during the provisional period, to fulfill all requirements of appointment relating to meeting attendance and completion of medical records, at the expiration of the provisional period, appointment to the Medical Staff shall be relinquished.

3.4-6 Contract Practitioners. Any staff member who has an exclusive contractual relationship with the Medical Center, or is either an employee, partner, or principal of, or in, an entity that has an exclusive contractual relationship with the Medical Center, relating to providing services to patients at the Medical Center, shall automatically and immediately lose such privileges as are within the scope of
the privileges made exclusive by such contractual relationship.

A. The expiration or other termination of the contractual relationship with the Medical Center; or

B. The expiration or other termination of the relationship of the staff member with the entity that has a contractual relationship with the Medical Center.

In the event of such a termination of staff appointment no rights to a hearing or appellate review provided in these bylaws, including those provided in Articles VIII and XVI shall apply.

3.5 LEAVE OF ABSENCE

3.5-1 Leave Status. A staff member may request a voluntary leave of absence from the staff by submitting a written request to the Medical Executive Committee and the President, which states the period of time for the leave (not to exceed one year). An extension may be requested by a physician in writing and approved by the Medical Executive Committee. A leave may be granted by the Medical Executive Committee, subject to such conditions or limitations as the Medical Executive Committee shall determine to be appropriate. During the period of a leave the staff member's privileges and prerogatives shall not be exercised and status will be in abatement.

3.5-2 Termination of Leave. At least thirty (30) days prior to the termination of the leave, or at any earlier time, the staff member may request reinstatement of his/her privileges and prerogatives by submitting a written notice to that effect to the President for transmittal to the Medical Executive Committee.

The staff member shall submit a written summary of his/her relevant activities during the leave. The Medical Executive Committee shall make a recommendation to the Board concerning the reinstatement of the member's privileges and prerogatives.

Failure, without good cause, to request reinstatement or to provide a requested summary of activities as above provided before termination of the leave shall result in automatic
termination of staff membership, privileges, and prerogatives, without right of hearing or appellate review. A request for staff membership subsequently received from a staff member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.
ARTICLE IV - CATEGORIES OF THE STAFF

4.1 CATEGORIES

The staff shall be divided into the following categories:

Honorary Medical Staff
Active Medical Staff
Consulting Medical Staff
Courtesy Medical Staff (Admitting/NonAdmitting)
Affiliate Medical Staff
Special Staff Category
    Part-time Medical Center Based Physicians
    House Staff Physicians
    Medical Students
    Regional Maternal Fetal

4.2 HONORARY MEDICAL STAFF

4.2-1 Qualifications. The honorary medical staff shall consist of physicians, dentists, and podiatrists, each of whom:

A. Has retired from the practice of medicine, or;

B. Has an outstanding professional reputation.

4.2-2 Prerogatives. The prerogatives of an honorary staff member shall be to:

A. Attend medical staff meetings at his/her pleasure; and,

B. Participate in non-clinical and educational Medical Center activities.

4.2-3 Responsibilities. Each member of the honorary staff shall:
A. Abide by the medical staff bylaws and rules and regulations, and by all other established standards, policies and rules and bylaws of the Medical Center; and,

B. Abide by the ethical principles of his/her profession and discipline including, but not limited to, the Ethical and Religious Directives for Catholic Health Facilities of the Catholic Health Association.

4.3 ACTIVE STAFF

4.3-1 Qualifications. The active staff shall consist of physicians, dentists, and podiatrists each of whom:

A. Meets the basic qualifications set forth in Section 3.2-1;

B. Is professionally based in the community served by the Medical Center; and

C. Regularly admits patients to, or is otherwise regularly involved in the care of patients in, the Medical Center.

4.3-2 Prerogatives. The prerogatives of an active staff member shall be to:

A. Admit patients to the Medical Center as follows:

1. A physician-member may admit patients according to his/her privileges;

2. A dentist-member may admit patients in conformity with the requirements of Section 6.3.

3. A podiatrist-member may admit patients in conformity with the requirements of Section 6.4.

B. Exercise such clinical privileges as are granted to him/her pursuant to Article VI, and, after review pursuant to the monitoring protocol has terminated, participate in emergency department coverage;

C. Vote on all matters presented at general and special meetings of the staff, and the department, division
and committees of which he/she is a member, and hold office in the staff organization, and in the department, division and committees of which he/she is a member, subject to the following limitations:

1. Non-physician members of the active medical staff may not be officers or Chair of the Medical Executive Committee of the medical staff, or Chair of any department, division or committee, except when serving as chief of a division in their particular specialty.

2. No member of the active medical staff may hold office in the staff organization or serve as a department Chair until he/she has been an active staff member for five (5) years. This provision may be waived in special circumstances as deemed by the Medical Executive Committee.

4.3-3 Responsibilities. Each member of the active staff shall:

A. Meet the basic responsibilities set forth in Section 3.3;

B. Retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Medical Center for whom he/she is providing services, or arrange a suitable alternative for such care and supervision;

C. Actively participate in the patient care assessment and other quality assessment activities required of the staff, in monitoring new appointees of his/her same profession, in serving on emergency department call rosters, if eligible, except as exempted by the Medical Executive Committee, and in discharging such other staff functions as may from time to time be required;

D. Satisfy the requirements set forth in Article XII for attendance at meetings of the staff and of the department, division and committees of which he is a member;

E. Pay dues and assessments as determined by the staff and approved by the Board; and,

F. Assume reasonable service, teaching, medical staff committee, and Medical Center responsibilities as determined by the staff and approved by the Board.
4.4 CONSULTING MEDICAL STAFF

4.4-1 Qualifications. The consulting medical staff shall consist of physicians, dentists and podiatrists who meet the basic qualifications set forth in Section 3.2-1 and qualify to provide consulting services.

4.4-2 Prerogatives. The prerogatives of a consulting staff member shall be to:

A. Provide consultation consistent with his/her professional knowledge and ability when requested by other members of the staff or when required by its rules and regulations;

B. Consulting staff members may, but shall not be required, to serve on committees;

C. Consulting staff members may write orders but have no admission privileges and are not eligible to carry out invasive procedures, but are granted delineated clinical privileges in accordance with their consultative function pursuant to Article VI; and

D. Consulting staff members may not vote or hold office.

4.4-3 Responsibilities. Each member of the consulting staff shall:

A. Meet the basic responsibilities set forth in Section 3.3;

B. Pay dues and assessments as determined by the staff and approved by the Board.

4.5 COURTESY STAFF

4.5-1 Qualifications. The courtesy staff shall consist of physicians, dentists, and podiatrists each of whom:
A. Meets the basic qualifications set forth in Section 3.2-1;

B. Is professionally based in the community served by the Medical Center; and,

4.5-2 Prerogatives. The prerogatives of a courtesy staff member shall be to:

A. Admit patients to the Medical Center as follows:

1. A physician-member may or may not admit patients according to his/her privileges;

2. A dentist-member may admit patients in conformity with the requirements of Section 6.3; and,

3. A podiatrist-member may admit patients in accordance with the requirements of 6.4.

B. Courtesy staff members may admit no more than six (6) patients per year, when a bed is available and under the proctoring of the chief of the department or division to which the courtesy staff member is assigned. Each case so admitted is subject to review by the chief concerned.

C. Courtesy staff members may exercise such clinical privileges as are granted to him/her pursuant to Article VI.

D. Courtesy staff members shall not be required, but may, and are encouraged, to attend meetings of the medical staff, and the department and division to which they are assigned.

E. Courtesy staff members may not perform invasive/operative procedures.

F. Courtesy staff members may not vote or hold office.

4.5-3 Responsibilities. Each member of the courtesy medical staff shall:

A. Meet the basic responsibilities set forth in
Section 3.3;

B. Retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Medical Center for whom he/she is providing services, or arrange a suitable alternative for such care and supervision;

C. Pay dues and assessments as determined by the staff and approved by the Board.

4.6 AFFILIATE MEDICAL STAFF

4.61. Qualifications. The Affiliate medical staff shall consist of physicians, dentists, and podiatrists who do not admit or attend patients in the Medical Center, or act as consultants, and meet the basic qualifications set forth in Section 3.2-1.

4.6-2 Prerogatives. Prerogatives of Affiliate Staff Members shall be to attend Medical Staff Meetings at his/her pleasure; and, participate in non-clinical and educational Medical Center activities.

4.6-3 Responsibilities. The responsibilities of an affiliate staff member shall be to:

A. Abide by the medical staff bylaws and rules and regulations, and by all other established standards, policies, rules, and bylaws of the Medical Center;

B. Abide by the ethical principles of his/her profession and discipline including, but not limited to, the Ethical and Religious Directives for Catholic Health Facilities of the Catholic Health Association;

C. Promptly notify the President of the revocation, restriction, suspension or curtailment of his/her professional license by any state, or of his/her revocation, restriction, suspension or curtailment of staff membership or privileges at any hospital or other health care institution, or by the commencement of a formal investigation, or the filing of charges, by the New Jersey Department of Health or any law enforcement agency or health regulatory agency of the United States or any other state, or of the filing of a suit and/or claim against the
practitioner alleging liability, or any formal proceeding before any third-party provider or state agency, board or society, or any change in provider status; and,

D. Participate in the educational programs conducted and/or sponsored by the staff and/or the Medical Center.

E. May not write orders and/or perform invasive/operative procedures.

F. May not vote or hold office.

G. May serve on committees at the prerogative of the President of the Medical Staff.

H. Pay dues and assessments as determined by the Staff and approved by the Board.

4.7 SPECIAL STAFF CATEGORIES

4.7-1 Part-Time Medical Center Based Physicians.

4.7-1.1 Qualifications. Part-time Medical Center-based physicians (e.g., emergency room, neonatologists, intensive care, etc.) shall meet the basic qualifications set forth in Section 3.2-1.

4.7-1.2 Prerogatives. The prerogatives of a part-time Medical Center based physician shall be to:

A. Exercise such clinical privileges as are granted to him/her pursuant to Article VI.

B. Emergency Room physicians may write admission orders after discussion with attending physician.

C. Part-time Medical Center based physicians may, but are not required, to attend staff, department and division meetings.

4.7-1.3 Responsibilities. Each part-time Medical Center based physician shall:
1. Meet the basic responsibilities set forth in Section 3.3;

2. Retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Medical Center for whom he/she is providing supervision; and,

3. Actively participate in the patient care performance improvement activities required by the staff, in monitoring new appointees, in serving on emergency department call rosters, if eligible, except as exempted by the Medical Executive Committee, and in discharging such other staff functions as may from time to time be required.

4.7-2 House-Staff Physicians. The house staff shall consist of duly qualified physicians and practitioners designated as fellows, residents or interns who participate in a professional training program of the Medical Center or other organizations with which the Medical Center has a written agreement to provide educational opportunities to such physicians and practitioners.

House-staff physicians and practitioners are not members of the medical staff, but they must conform with the pertinent obligations and requirements of the medical staff bylaws, rules and regulations, and of the departments to which they are assigned, as well as the terms of any agreement which they have signed with the Medical Center or their sponsoring institution. Each house-staff member shall be assigned to a department and shall be under the direction of the department Chair or his/her designee. The department Chair or his/her designee shall assign duties to the house-staff member in cooperation with the Medical Center and sponsoring institution, as appropriate.

Duly authorized and qualified house-staff members may complete history and physical examinations which are counter-signed within twenty-four (24) hours by the attending physician and/or practitioner, write or prescribe orders, and make entries in progress notes, subject to such further conditions and requirements as may be adopted by the department to which they are assigned and the rules and regulations of the medical staff. All orders written by unlicensed house-staff members must be countersigned within twenty-four (24) hours by a licensed physician and/or practitioner.
4.7-3 Medical Students. Medical students from approved and accredited osteopathy and medical schools may, for educational purposes, be assigned to specific departments and/or medical staff appointees, who shall be responsible for their actions and conduct in the Medical Center.

4.7-4 Regional Maternal Fetal

4.7-4.1 Purpose - The purpose of this staff category is to make the maternal fetal section of the Division of Obstetrics a truly regional facility by permitting qualified obstetricians the opportunity to attend their patients with high-risk pregnancies requiring the special facilities of a Level III Maternal Fetal Center.

4.7-4.2 Eligibility - All physicians will be eligible who are:

A. Board certified, or Board eligible in Obstetrics-Gynecology by the American Board of OB/GYN, or its equivalent osteopathic board;

B. In active obstetrical practice in the Southern New Jersey region and have demonstrated a desire to attend their patients of high-risk;

A. Satisfactorily credentialed by the Board of Trustees of Our Lady of Lourdes Medical Center to meet the criteria of this category.

4.7-4.3 Privileges - The physicians who are admitted to the staff shall:

A. Admit patients to the Medical Center for the purpose of using the Perinatal Consultative and Associate Services;

B. Obtain the approval of such patients for admission by the Chief of Perinatology and/or their designee;

C. Obtain consultation with the perinatologist at the Medical Center, and/or their designee;

D. Follow establish protocols for the purpose of management of high-risk pregnancies.
4.7-4.4 Objectives - There shall apply the same rules, regulations, and responsibilities in the care and management of obstetrical cases as applies to all staff members. The physician in this category shall participate in the quality assurance program as it may apply to their cases.

A. There shall be no Emergency Room, clinic or dues obligations.

B. There shall be no committee assignments, may not vote or hold office.

4.7-4.5 Appointment/Reappointment - Appointment/Reappointment to this section requires processing by the Credentials Committee, Medical Executive Committee and Board of Trustees similar to any other active staff appointment.

4.8 LIMITATION OF PREROGATIVES

The prerogatives set forth under each staff category are general in nature and may be subject to limitation by special conditions attached to a physician's, dentist's or podiatrist's staff appointment, by other sections of these bylaws, by the rules and regulations of the staff, or by policies of the Medical Center.

4.9 WAIVER OF QUALIFICATIONS

Any qualifications in this Article or any other Article of these bylaws not required by law or governmental regulation may be waived in the discretion of the Board, upon determination that such waiver will serve the best interests of the patients in the Medical Center.
ARTICLE V - PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

5.1 GENERAL PROCEDURE

The staff, with the assistance of the Medical Center, through its designated departments, divisions, committees, and offices, shall investigate and consider each application for appointment and reappointment to the staff and each request for modification of staff membership status and shall adopt and transmit recommendations thereof to the Board.

5.2 APPLICATION FOR INITIAL APPOINTMENT

5.2-1 Application Form. Each application for appointment to the staff shall be in writing, on the form prescribed by the Board, and signed by the applicant. All written requests for appointment forms from persons claiming to be physicians, oral surgeons, dentists, or podiatrists shall be processed by the President, and a copy of the medical staff bylaws, rules and regulations shall be furnished to each such applicant. The President shall notify department chair and division chiefs of the medical staff of the names of all applicants at the time the application is forwarded to applicant.

5.2-2 Content. The application form shall include such provisions as are necessary to secure information useful for evaluation of the applicant. In addition, the form shall include a statement that the applicant has been furnished a copy of the medical staff bylaws, Ethical and Religious Directives for Catholic Health Facilities, policy on Sexual Assault/Harassment by a Member of the Medical Staff, Guidelines, Policies and Methods Manual for Department, rules and regulations of the medical staff, and that he/she agrees to be bound by the terms thereof during the time the application is under consideration and, if staff appointment is granted, while a member of the staff.

5.2-3 Accuracy. Applicants have the burden of providing evidence that all the statements made and information given on the application are accurate. The applicant agrees that any material misstatement in, or omission from, is grounds for the Medical Center to stop processing the application. If appointment has been granted prior to the discovery of a
material misstatement or omission, appointment and privileges shall be deemed to be automatically relinquished. In either situation, there shall be no entitlement to a hearing or appeal. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Credentials Committee will review the individual's response and provide a recommendation to the Medical Executive Committee. The Medical Executive Committee will recommend to the Board whether the application should be processed further.

5.3 EFFECT OF APPLICATION

By applying for appointment to the staff, the applicant:

A. Signifies his/her willingness to appear for interviews in regard to his/her application;

B. Authorizes Medical Center representatives to consult with others who have been associated with him/her and/or who may have information bearing on his/her competence and qualifications;

C. Consents to the inspection by Medical Center representatives of all information required by state and federal agencies that may be material to an evaluation of his/her professional qualifications and ability to carry out the clinical privileges he/she requests as well as of his/her professional ethical qualifications for staff membership.

D. Releases from any liability all Medical Center representatives for their acts performed in good faith and without malice in connection with investigating and evaluating the applicant and his/her credentials.

E. Releases from all liability individuals and organizations who provide information, including otherwise privileged or confidential information, to Medical Center representatives in good faith and without malice concerning the applicant's ability, professional ethics, character, physical and mental health, emotional stability, ability to work harmoniously with other staff members and Medical Center personnel, and other qualifications for staff appointment and clinical privileges.
F. For purposes of this section, the term "Medical Center representative" includes: the Board, its members and committees, the President, the medical staff organization, all staff members, departments and committees which have responsibility for collecting or evaluating the applicant's credentials or acting upon his/her applications; and any authorized representative of any of the foregoing.

G. Signifies his/her willingness to be bound by the terms of the medical staff bylaws, rules and regulations of the medical staff, and the ethical code of the Catholic Health Association, and that he/she agrees to be bound by the terms thereof during the time the application is under consideration and, if staff appointment is granted, while a member of the staff.

H. Agrees to participate in Focused and Ongoing Professional Practice Evaluations as determined to be necessary by the Medical Staff.

5.4 PROCESSING THE APPLICATION

5.4-1 Applicant's Burden. The application form must be returned to the Chief Medical Officer within sixty (60) days or the credentialing process will be terminated. The applicant shall have the burden of producing adequate information for a proper evaluation of his/her experience, background, training, demonstrated ability, current competency, professional ethics, physical and mental status, and the ability to work harmoniously with medical and staff personnel, and of resolving any doubts about these or any of the other basic qualifications specified in Section 3.2.

5.4-2 Transmittal for Evaluation. The applicant shall deliver his/her application form to the President who shall, after determining that the application is complete and all pertinent materials have been secured, transmit in timely fashion a copy of the completed application form and all supporting materials to the credentials committee for evaluation. An application shall be deemed complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources.
If, upon receiving the applicant's application, the President determines that it is incomplete, he/she shall promptly notify the applicant. If the application has not been completed within sixty (60) days of such notification, it shall be deemed withdrawn with notification of same to the applicant. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. The applicant is responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed.

The President shall post the name of the applicant in the medical staff lounge along with a notice requesting any staff member with information pertinent to evaluation of the applicant to provide such information orally or in writing to the credentials committee.

5.4-3 Verification of Information. Upon receipt of the application form the credentials committee shall seek to collect or verify from the appropriate primary source, the references, licensure, DEA status, medical malpractice insurance coverage, and other qualification evidence submitted. The committee Chair shall promptly notify the applicant of any failures in such collection or verification efforts. Copies of the application and any additional information secured by the committee shall be provided to the Chair of the department and chief of the division or chair of the departments and chiefs of the divisions in which the applicant seeks privileges. The committee may also conduct an interview of the applicant to which the Chair of each department in which the applicant seeks privileges may be invited to attend and participate.

5.4-4 Granting of Delineated Clinical Privileges. The granting of delineated clinical privileges shall be based upon the following: (a) the applicant’s possession of a current license to practice in the State of New Jersey, professional liability insurance, and appropriate registrations and certifications including CDS and DEA registrations; exemption from the requirements to maintain a CDS for radiologists with imaging privileges only, teleradiologists, pathologists and telemedicine; (b) review of professional sanctions including all prior and pending challenges to any licensure or registration by the official licensing board of any state, specialty board, or governmental agency including but not limited to voluntary
or involuntary relinquishment, suspension, reduction or limitation of such licensure or registration; (c) review of the voluntary termination, resignation, relinquishment, reduction or limitation of the applicant’s medical staff appointment or clinical privileges at any hospital or health care facility; (d) the applicant’s ability to meet all current criteria for the requested clinical privileges; (e) the applicant’s education, training, experience, demonstrated current clinical competence, health status, results of performance improvement activity and any other relevant information requested; and (f) the medical center’s available resources and personnel.

5.4-5 Departmental/Divisional Action. Each department Chair and division chief of the department and division in which the applicant seeks privileges shall review the application, the supporting documentation, and such other information available to it that may be relevant to consideration of the applicant's qualifications for the staff category, department, and division affiliation, and clinical privileges requested. After such review, he/she shall transmit to the credentials committee a written report and recommendations as to staff appointment and, if appointment is recommended, as to staff category, department, division affiliations, clinical privileges to be granted, and any special conditions to be attached to the appointment. No recommendation regarding the applicant shall be made until or unless the department Chair and division chief meet with the applicant in person or via electronic media. The reason for each recommendation shall be stated and supported by reference to the completed application and all other documentation.

5.4-6 Medical Executive Committee Action. At its next regular meeting after receipt of the credentials committee report, including the recommendations, the Medical Executive Committee shall consider the report and such other relevant information available to it, including adequacy of the Medical Center's facilities and supportive services needed by the applicant for rendering care to his/her patients, and the need for additional staff members with the skills and qualifications of the applicant. The committee shall then forward to the President for transmittal to the Board a written report and recommendations on the prescribed form as to staff appointment and, if appointment is recommended, as to staff category, department, division affiliations, clinical privileges to be granted, and any special
conditions to be attached to the appointment. The committee may also defer action on the application pursuant to Section 5.4-6A. The reasons for each recommendation shall be stated and supported by reference to the completed application and all other documentation considered by the committee, all of which shall be transmitted with the report. Any minority views shall also be reduced to writing, supported by reasons and references, and transmitted with the majority report.

5.4-7 Effect of Medical Executive Committee Action.

A. Deferral: Action by the Medical Executive Committee to defer the application for further consideration must be followed up within forty-five (45) days with a subsequent recommendation for appointment with specified clinical privileges, or for rejection for staff membership;

B. Favorable Recommendation: When the recommendation of the Medical Executive Committee is favorable to the applicant, the President shall promptly forward the recommendation, together with the application form and its accompanying information and the reports and recommendations of the department or departments through the Joint Conference Committee to the secretary of the Board;

C. Adverse Recommendation: When the recommendation of the Medical Executive Committee is adverse to the applicant, the President shall so inform the applicant within ten (10) days by special notice, and he/she shall be entitled to the procedural rights as provided in Articles VIII and XVI. For the purposes of this Section 5.4-6C an "adverse recommendation" by the Medical Executive Committee is as defined in Sections 16.1-1 and 16.1-2.

5.4-8 Board Action.

A. On Favorable MEC Recommendation: The Board shall adopt or reject, in whole or in part, a favorable recommendation of the Medical Executive Committee, or refer the recommendation back to the Medical Executive Committee for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation may be made. If the Board's action is adverse to the applicant as defined in Sections 16.1-1 and 16.1-2, the President shall so inform the applicant within ten (10) days by special notice, and he/she
shall be entitled to the procedural rights as provided in Articles VIII and XVI.

B. Without Benefit of MEC Recommendation: If the Board does not receive a Medical Executive Committee recommendation within one hundred eighty (180) days of receipt by the credentials committee of the completed application from the President, if the applicant so requests in writing, the Board may take action on its own initiative. If such action is favorable, it shall become effective as the final decision of the Board.

If such action is adverse, as defined in Sections 16.1-1 and 16.1-2, the President shall so inform the applicant within ten (10) days by special notice, and he/she shall be entitled to the procedural rights as provided in Articles VIII and XVI;

C. After Procedural Rights: In the case of an adverse Medical Executive Committee recommendation pursuant to Section 5.4-6C or an adverse Board decision pursuant to Section 5.4-7 A or B, the Board shall take final action in the matter only after the applicant has exhausted or has waived his/her procedural rights as provided in Articles VIII and XVI. Action thus taken shall be the conclusive decision of the Board, except that the Board may defer final determination by referring the matter back for further reconsideration to the Joint Conference Committee. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Board shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the Board shall make a final decision either to appoint the applicant to the staff or to reject him/her for staff membership.

5.4-9 Conflict Resolution. Whenever the Board's proposed decision will be contrary to the Medical Executive Committee's recommendation, the Board shall submit the matter to the Joint Conference Committee for review and recommendation as provided in Sections 16.7-1 and 16.7-2 before making its final decision and giving notice of final decision required by Section 5.4-7.

5.4-10 Notice of Final Decision.
A. Notice of the Board's final decision shall be given to the President of the Medical Staff and the Chair of each department concerned, and to the applicant by means of special notice.

B. A decision and notice to appoint shall include:

1. The staff category to which the applicants appointed;

2. The department and division to which he/she is assigned;

3. The clinical privileges he/she may exercise; and

4. Any special conditions attached to the appointment.

5.5 REAPPOINTMENT PROCESS

5.5-1 Information Form for Reappointment  The President shall, at least ninety (90) days prior to the expiration date of the present staff appointment of each staff member, provide staff members with an interval information form prescribed by the Board for use in considering reappointment. Each staff member who desires reappointment shall, at least sixty (60) days prior to such expiration date, send his/her interval information form to the President. The applicant must have had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Medical Center must submit such information as may be requested by the department Chair or designee (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization), before the application will be considered complete and processed further. Failure, with good cause, to so return the form shall constitute a resignation of staff membership effective at the expiration of the member's current term, without entitlement to the procedural rights provided in Articles VIII and XVI. Each
year approximately one-half of the medical staff members shall be considered for reappointment for a two (2) year period, by a process to be determined by the Executive Committee.

5.5-2 Verification of Information. The President and/or Chief Medical Officer shall, in timely fashion, transmit the interval information reappointment form to the division chief, to the department Chair, credentials committee, and finally, to the Medical Executive Committee, for action. The credentials committee shall seek to collect or verify the additional information made available on each interval information reappointment form and to collect any other materials or information deemed pertinent, including information regarding the staff member's professional activities, performance and conduct in the Medical Center, and require CME specific to requested privileges, prior to transmitting the form to the Medical Executive Committee.

The Medical Executive Committee, after reviewing each interval information reappointment form and all other relevant information available to it, shall, on the prescribed form, forward to the President for transmittal to the Board its report and recommendation that appointment be either renewed, renewed with modified staff category, department, division affiliation, and/or clinical privileges, or terminated. The committee may also defer action. Each such report shall satisfy the requirements of Section 5.5-4. Any minority views shall also be reduced to writing and transmitted with the majority report.

5.5-3 Final Processing and Board Action. Thereafter, the procedure provided in Sections 5.4-6 through 5.4-10 shall be followed. For purposes of reappointment, the terms "applicant" and "appointment" as used in those sections shall be read, respectively, as "staff member" and "reappointment".

5.5-4 Basis for Recommendations. Each recommendation concerning the reappointment of a staff member and the clinical privileges to be granted upon reappointment shall be based upon evaluation of:

(a) medical/clinical knowledge, technical and clinical skills, clinical judgment and an understanding of the way in which care is provided in the Hospital,
(b) patient care that is compassionate, appropriate and effective,

(c) professionalism, including continuous professional development and responsible attitude toward their patients and their profession, and

(d) history or record completion practices, and

(e) interpersonal and communications skills and an understanding and sensitivity to diversity that enable them to maintain professional relationships with patients, families and other members of health care teams. The Credentials and/or Medical Executive Committees may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). Appointment may be recommended for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.

5.5-5 Time Periods for Processing. Transmittal of the interval information reappointment form to a staff member and his/her return of it shall be carried out in accordance with Section 5.5-1. Thereafter, except for good cause, all actions by the Medical Executive Committee and the Board shall be completed prior to the expiration date of the staff membership of the member being considered for reappointment.

In those situations where the Board has not acted on a pending application for reappointment and there is an important patient care need that mandates an immediate authorization to practice, including but not limited to an inability to meet on-call coverage requirements, or denying the community access to needed medical services, the President, Chief Medical Officer, or designee will have the authority to grant the individual temporary clinical privileges until such time as the Board can act on the application. Prior to granting temporary privileges, the President, Chief Medical Officer, or designee will consult with the chair of the applicable department, the Chair of the Credentials Committee, or the President of the Medical Staff. The temporary clinical privileges will be for a period not to exceed 120 days. In the event the application for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a
conditional reappointment for a period of less than two years may be granted pending the completion of that process.

5.6 BOARD APPLIED CRITERIA

The Board shall apply, in making its decisions in respect to appointments, reappointments, clinical privileges and modifications of appointments, the criteria stated in these bylaws and, in addition, shall consider the adequacy of the Medical Center's facilities and supportive services needed by the practitioner for rendering care to his/her patients, and the need for additional practitioners with the skill and qualifications of the practitioner.

5.7 REQUESTS FOR MODIFICATION OF APPOINTMENT

A staff member may, either in connection with reappointment or at any other time, request modification of his/her staff category, department/division assignment, or clinical privileges by submitting a written application to the President on the prescribed form. Such application shall be processed in substantially the same manner as provided in Section 5.5 for reappointment.

5.8 REAPPLICATION AFTER ADVERSE APPOINTMENT REAPPOINTMENT DECISION.

5.8-1 An applicant who has received a final adverse decision regarding appointment or reappointment shall not be eligible to reapply to the staff for a period of two (2) years. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as the staff or Board may require in demonstration that the basis for the earlier adverse action no longer exists.
ARTICLE VI - DETERMINATION OF CLINICAL PRIVILEGES

6.1 EXERCISE OF PRIVILEGES

Every practitioner and allied health practitioner performing patient care duties or services at the Medical Center by virtue of staff membership or otherwise shall, in connection with such practice and except as provided in Sections 6.5 and 6.6, be entitled to exercise only those clinical privileges or provide patient care duties and services as are specifically granted pursuant to the provisions of these bylaws and the staff rules and regulations.

All grants of clinical privileges shall be subject to the provisions of the policy of exclusivity adopted by the Board and any adverse recommendation or action respecting clinical privileges based on the policy of exclusivity shall not give rise to any right to a hearing or appellate review provided in these bylaws, including those provided in Articles VIII and XVI.

6.2 DELINEATION OF PRIVILEGES IN GENERAL

6.2-1 Requests. Each application for appointment and reappointment to the staff must contain a request for clinical privileges desired by the applicant. A request by a staff member pursuant to Section 5.6 for a modification of privileges must be supported by documentation of training and/or experience supportive of the request.

6.2-2 Basis for Privileges Determination. Requests for clinical privileges shall be evaluated on the basis of the practitioner's education, training, experience, and demonstrated competence and judgment. The basis for privileges determinations to be made in connection with periodic reappointment or otherwise shall include observed clinical performance and the documented results of the patient care quality assessment activities conducted at the Medical Center required by these and the Medical Center corporate bylaws.

Privileges determinations shall also be based on pertinent information concerning clinical performance.
obtained from other sources including, but not limited to, other health care facilities where a practitioner exercises clinical privileges. This information shall be added to and maintained in the staff file established for a staff member.

Focused Professional Practice Review, as defined by the Medical Staff, will occur for all new privilege requests and where determined to be appropriate for significant concerns that arise related to clinical competency. Failure to participate in or satisfactorily meet the criteria for competency during the Focused Review shall results in failure to grant and/or voluntary relinquishment of the required privilege(s).

6.2-3 Surgical Privileges.

A. All applicants for staff appointment seeking surgical privileges must have completed the number of years of residency in a surgical residency or other specialty residency with a substantial surgical component, approved by the Accrediting Committee on Graduate Medical Education or the Committee on Postdoctoral Training of the American Osteopathic Association sufficient to satisfy the specialty board requirements for eligibility to become certified, in effect at the date application for staff membership is submitted;

B. A dentist applicant for staff appointment seeking oral surgery privileges must have completed the number of years of residency in an oral surgery residency program approved by the American Dental Association Commission on Dental Accreditation sufficient to satisfy the specialty board requirements for eligibility to become certified, in effect at the date application for staff membership is submitted;

C. A podiatrist applicant for staff appointment seeking surgical privileges must have completed the number of years of residency in a podiatric surgery residency approved by the American Board of Podiatric Surgery.

D. The residency requirements in Paragraphs A, B and C above do not apply to practitioners with staff appointments on the date these medical staff bylaws become effective.

6.2-4 The medical staff will determine those clinical services which may be delivered via use of an electronic communications for the benefit of patient care services. Upon the recommendation of a Division Chief, Departmental
Chair, or Chief Medical Officer, the Medical Executive Committee may approve the provision of specific services to hospitalized patients by practitioners at remote sites using information obtained via electronic communications (i.e. telemedicine). The practitioner who provides treatment, diagnostic or consultative services via telemedicine will be credentialed and obtain a determination of clinical privileges by the medical center as outlined in the Bylaws of the medical staff. Credentialing information from another JCAHO approved facility may be used, when appropriate, as a basis for credentialing and privilege determination.

6.2-5 Procedures. All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article V.

6.3 SPECIAL CONDITIONS FOR DENTAL/ORAL SURGERY PRIVILEGES

Requests for clinical privileges from dentists/oral surgeons shall be processed in the manner specified in Section 6.2. Surgical procedures performed by dentists/oral surgeons shall be under the supervision of the Chair of the department of surgery. All dental/oral surgical patients shall receive the same basic medical appraisal as patients admitted to other surgical services; the chief of the division of oral and maxillofacial surgery shall recommend dentists/oral surgeons who may perform the physical examination and prepare the histories for their own patients. A physician member of the staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient. Except in the event of an emergency admission, the responsible physician member of the staff shall be identified prior to admission of the patient for surgery to be performed by a dentist/oral surgeon member of the staff.

6.4 SPECIAL CONDITIONS FOR PODIATRIC PRIVILEGES

Requests for clinical privileges from podiatrists shall be processed in the manner specified in Section 6.2. Surgical procedures performed by podiatrists shall be under the supervision of the Chair of the department of surgery. All podiatric patients shall receive the same basic medical
appraisal as patients admitted to other surgical services. A physician member of the staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient. The responsible physician member of the staff shall be identified prior to admission of the patient for surgery to be performed by a podiatrist member of the staff.

6.5 ALLIED HEALTH PRACTITIONERS

The staff may recommend to the Board the granting of clinical duties to allied health practitioners based upon investigation and evaluation of the education, training, experience and demonstrated ability and judgment of individuals requesting duties as allied health practitioners, according to procedures established in these bylaws and the rules and regulations governing allied health practitioners. An allied health practitioner, does not have delineated clinical privileges and does not have the rights and privileges of a member of the medical staff. A recommendation by or on behalf of the staff to not grant duties to an applicant as an allied health practitioner, or to suspend, to terminate, or to discontinue such duties, or such a decision by the Board, shall not give rise to any procedural rights set forth in Article VIII, unless otherwise specifically provided in the rules and regulations governing allied health practitioners.

6.5-1 Purpose. The purpose of this paragraph is to set forth the framework for the review and evaluation of the need for, and method of granting duties to categories of, allied health practitioners, to avoid ad hoc decisions, and to focus attention on the variety of factors to be taken into account in incorporating allied health practitioners within the Medical Center's organized patient services.

6.5-2 Board and Medical Staff Responsibilities - General

Allied Health Practitioners shall be divided into the following categories:

- Independent Allied Health Practitioner including but not limited to:
Clinical Psychologists

- Dependent Allied Health Practitioner including but not limited to:
  - Clinical Nurse Specialist
  - Advanced Practice Nurses and Nurse Practitioners
  - Certified Registered Nurse Anesthetists
  - Nurse Associate
  - Research Nurse
  - Physician Assistant

A. The decision to permit granting duties to any category of allied health practitioners shall be made by the Board after taking into consideration the need for its services based on review of the Medical Center's comprehensive health plan, its facilities and manpower plan, and its utilization plan, and any recommendations made by the medical staff. After the Board has approved granting duties to a category of allied health practitioners, the medical staff shall follow the procedures set forth below for granting specific clinical duties to individual allied health practitioners.

B. Each medical staff department under whose jurisdiction the duties of allied health practitioners fall, shall adopt such policies and procedures as are necessary concerning the services to be rendered by such allied health practitioners.

6.5-3 Independent Allied Health Practitioners.

CONTENT: The application form shall include such provisions as are necessary to secure information useful for evaluation of the applicant. In addition, the form shall include a statement that the applicant has been furnished a copy of the medical staff bylaws, Ethical and Religious Directives for Catholic Health Facilities, policy on Sexual Assault/Harassment by a Member of the Medical Staff, and the Allied Health Practitioners Rules and Regulations and that he/she agrees to be bound by the terms thereof during the time the application is under consideration and, if appointment is granted, while an allied health practitioner at Our Lady of Lourdes Medical Center.

A. Independent allied health practitioners are allied health practitioners who are neither employees of the
Medical Center nor of a member of the medical staff. No category of independent allied health practitioners may be recognized unless such practitioners are licensed or otherwise regulated by the State of New Jersey, and are permitted by law and the Medical Center to provide patient care services without direction and supervision. For purposes of these bylaws, "to provide patient care services without direction and supervision" means that the allied health practitioner is not limited to patient care services ordered by, and subject to the oversight of, a physician.

B. Each independent allied health practitioner shall submit his/her application for clinical duties on a form approved by the Medical Executive Committee. The applicant form must be returned the application form must be returned to the Chief Medical Officer within sixty (60) days or the credentialing process will be terminated. The applicant shall have the burden of producing adequate information for a proper evaluation of his/her experience, background, training, demonstrated ability, current competency, professional ethics, physical and mental status, and the ability to work harmoniously with medical and staff personnel, and of resolving any doubts about these or any of the other basic qualifications. The applicant shall also produce evidence of professional liability insurance coverage in an amount determined by the Board.

C. Each application and supporting materials shall first be reviewed by the department to which his/her privileges would pertain. The department may request a personal interview with the applicant and, after evaluation and review, shall transmit the application, supporting materials, and its recommendation, including the privileges to be granted and any conditions placed upon the exercise of such clinical duties, to the credentials committee.

D. The credentials committee shall review and evaluate the independent allied health practitioner's application, supporting materials, the department's recommendation and other relevant information. The credentials committee shall determine whether to approve or disapprove the department's recommendation, and forward its decision to the Medical Executive Committee which, in turn, shall review all material which was reviewed by the credentials committee and such other information as it may obtain, and make a recommendation to the Board concerning the granting of duties to the applicant. The Board shall make the final decision with respect to the
granting of duties, and shall direct the President to advise the applicant of its decision.

E. Each department under whose jurisdiction the duties of independent allied health practitioners fall shall prepare specific criteria for the evaluation of applicants for duties as independent allied health practitioners, and policies that express the relationships between physicians and independent allied health practitioners. These policies must address the nature of the physician's role in the admission to the Medical Center of patients of independent allied health practitioners, and the physician's responsibility for the medical needs of the patient that may be present at admission or arise during hospitalization.

F. Independent allied health practitioners shall comply with all requirements and responsibilities established by the medical staff bylaws and rules and regulations, departmental rules and regulations, and Medical Center policies, that would logically pertain or apply to them as providers of services to patients in the Medical Center. Each independent allied health practitioner granted duties must agree in writing, prior to the exercise of any duties, to comply with the previously mentioned documents.

G. Independent allied health practitioners may be appointed to serve on medical staff committees and may attend meetings of the department in which they have duties and the medical staff. As a condition of continued duties, independent allied health practitioners are required to attend meetings involving clinical review of patient care in which they participate.

H. The application of an independent allied health practitioner may be rejected and the duties of an independent allied health practitioner may be modified, reduced, suspended or terminated by the Board, without recourse to any procedural rights set forth in Articles VII and XVI of the medical staff bylaws. The President, and the Chair of the department under whose jurisdiction the privileges of the independent allied health practitioner fall, each may suspend the duties of an independent allied health practitioner for a period of up to thirty (30) days, without recourse to any procedural rights set forth in Articles VII and XVI of the medical staff bylaws.

I. Patients admitted by independent allied health practitioners shall receive a prompt medical evaluation by a physician member of the medical staff, and a physician member of the medical staff must have accepted
responsibility for the medical needs of the patient existing at admission or which develop during hospitalization. Except in the event of an emergency admission, the responsible physician member of the staff shall be identified prior to admission.

J. In the event that the physician member of the medical staff, who has accepted responsibility for the medical needs of a patient, as indicated in 3I. above, disagrees with diagnostic or therapeutic measures proposed by the independent allied health practitioner, the measures shall not be commenced until the Chair of the department has reviewed the proposed measures in the light of the patient's condition, and has stated in writing his/her concurrence.

6.5-4 Dependent Allied Health Practitioners.

A. Dependent allied health practitioners are allied health practitioners for whom the Board has decided that clinical duties may be granted only as employees of either a physician member of the medical staff or of the Medical Center.

B. Procedures, rules and policies for granting clinical duties to dependent allied health practitioners employed by the Medical Center or an individual physician for their performance in providing services to patients in the Medical Center are as follows:

1. After consultation with the collaborating physician, the Medical Affairs Office, in accordance with the rules and regulations for AHP, shall credential the allied health practitioner for clinical duties and obtain the Medical Executive Committee's approval.

2. The Medical Affairs Office shall obtain evidence of each applicant's current licensure or other regulatory status, if relevant, or of certification or other credential status from an appropriate voluntary organization, liability insurance coverage, as it deems appropriate. When necessary, the Medical Center personnel department shall assist helping in the preparation of documents or statements to be submitted.

C. All dependent allied health practitioners shall wear identification badges indicating their titles in words.
D. Upon receipt of a written request for temporary duties and under unusual circumstances or needs of the Medical Center, the Chief Medical Officer may conduct an expedited review with the collaboration of the Chair of the appropriate department or member of the medical staff for the purpose of approving temporary duties as locum tenens for a dependent allied practitioner. The following documentation must be submitted for review prior to approval: Completed Application and Clinical Duties Request form; Signed Agreement form; current New Jersey licensure or regulatory status, current malpractice insurance letter(s) from the practitioner's current chief(s) and/or employer(s), and current delineation of duties approved by the Board of Trustees of primary institution. The Medical Affairs Office will verify licensure status, query the National Practitioner Data Bank and Department of Health and Human Services Office of Inspector General. Temporary duties are for an initial period of 120 days and may be renewed for an additional 120 day period if needed.

6.5-5 **Relationships Between Physicians Allied Health Practitioners.**

A. Supervision. In granting clinical duties to allied health practitioners, the statements shall specify the nature and extent of the supervisory relationship. Thus, "direct supervision" is to be used when the tasks or functions of the allied health practitioner are to be performed when the supervising physician is physically available to manage directly and personally the processes of examination, diagnosis, patient treatment and care. "Limited supervision" is to be used when the supervising physician is not physically available but can communicate with the allied health practitioner by telephone or other device.

B. Collaboration. This term is to be used when the physician and the allied health practitioner perform different, but complementary, functions relating to the patient's needs for care. Any grant of duties to an allied health practitioner in which such practitioner's role will be collaborative, shall identify the circumstances and nature of the collaboration.

C. Consultation. This term is to be used when the physician, upon request, provides professional advice or opinion regarding the care or treatment of a patient to the
responsible allied health practitioner on a one-time, periodic or ongoing basis.

6.6 ADMINISTRATIVE AND MEDICO-ADMINISTRATIVE POSITIONS

6.6-1 Administrative Practitioners. A practitioner employed by the Medical Center in a purely administrative capacity with no clinical duties or privileges is subject to the regular personnel policies of the Medical Center and to the terms of any contract of employment he/she may have, and need not be a member of the medical staff.

6.6-2. Medico-Administrative Practitioners. A practitioner in a medico-administrative position is one who is employed by or otherwise serves the Medical Center on a full or part-time basis, and whose duties include the exercise of clinical responsibilities, but who is neither a department Chair or division chief. Practitioners in medico-administrative positions must be members of the medical staff, and their clinical privileges must be delineated in accordance with Articles III, V and VI.

The medical staff appointment and clinical privileges of any practitioner in a medico-administrative position shall be subject to the other pertinent provisions of these bylaws, unless otherwise provided by contract.

6.7 TEMPORARY PRIVILEGES

6.7-1 Circumstances.

A. Temporary privileges require a completed credentials file which has undergone review and approval, including interview of the candidate, by the Credentials Committee. The applicant must then receive approval from the Medical Executive Committee. Following this, the candidate may request, in writing to the Chief Medical Officer, a request for temporary privileges, pending review by the Joint Conference Professional Affairs Committee and final Board of Trustees approval. Temporary privileges are granted for a period up to (120) one hundred twenty consecutive days.

B. Special Privileges. Upon receipt of either a written or oral request from the attending physician, and of
the recommendation of the department Chair and/or division chief in response to an important patient care need, an appropriately licensed practitioner who is not an applicant for membership may be granted temporary privileges for the care of one or more specific patients for a specified period of time. An oral request for temporary privileges must promptly be reduced to a written request. Upon granting such privileges, the Chief Medical Officer shall issue a writing setting forth the specific temporary privileges to be exercised by the practitioner. In no instance may privileges be granted to a practitioner for the care of more than two (2) patients in any calendar year.

C. Locum Tenens. Upon receipt of a written request, by a current member of the medical staff to the Chief Medical Officer, in response to an important patient care need an appropriately licensed practitioner can serve as a locum tenens for a member of the staff, without applying for membership on the staff, and be granted temporary privileges. The following documentation must be submitted with request: Current NJ License, CDS, DEA, Malpractice Insurance in accordance with Section 3.2-1C, Curriculum Vitae, competency recommendation and current delineation of privileges signed by Chief and Board of Trustees of primary institution, and letter of approval from OLLMC Division/and or Department Chief. Temporary privileges can be granted by separate intervals for a maximum of 120 days per calendar year. Temporary Locum tenens privileges can be granted by separate intervals for as long as necessary for an important patient care need.

6.7-2 Conditions. In exercising such privileges defined in 6.7-1, the applicant shall act under the supervision of the Chair of the department to which he/she is assigned. Special requirements of consultation and reporting may be imposed by the Chair of the department responsible for supervision of a practitioner granted temporary, special, or locum tenen privileges.

6.7-3 Termination. Continuation of temporary privileges may be granted to allow the fully completed application to be presented to the Board of Trustees. Temporary privileges for new applicants are granted for no more than one hundred and twenty (120) days.

On the discovery of any information, or the occurrence of any event of a professionally questionable nature,
pertinent to a practitioner's qualifications or ability to exercise any or all of the temporary privileges granted, the President and/or Chief Medical Officer may, after consultation with the department Chair responsible for supervision, the Department Chairperson to which the practitioner has been assigned or the President of the Medical Staff, terminate any or all of such practitioner's temporary privileges, provided that where the life or well-being of a patient is determined to be endangered by continued treatment by the practitioner, the termination may be effected by any person entitled to impose summary suspensions under Article VII. In the event of any such termination, the practitioner's patients then in the Medical Center shall be assigned to another practitioner by the department Chair responsible for supervision. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner. The terminated practitioner shall confer with the substitute practitioner to the extent necessary to safeguard the patient.

6.7-4 Rights of the Practitioner. A practitioner shall not be entitled to the procedural rights afforded by Articles VIII and XVI because of his/her inability to obtain temporary privileges or because of any termination or suspension of temporary privileges.

6.8 EMERGENCY PRIVILEGES

For the purposes of this Section, an "emergency" is defined as a condition in which serious or permanent harm would result to a patient, or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger, or during disaster(s) in which the emergency management plan has been activated. In the case of an emergency, any practitioner, to the degree permitted by his/her license, regardless of department, staff status or clinical privileges, shall be permitted to do, and shall be assisted by Medical Center personnel in doing, everything possible to save the life of a patient or save a patient from serious harm. A practitioner utilizing emergency privileges shall promptly provide to the Medical Executive Committee, in writing, a statement explaining the circumstances giving rise to the emergency. During disaster(s) in which the emergency management plan has been activated, the Chief Executive Officer or Chief Medical
Officer or designee(s) has the option to grant emergency privileges.

6.9 DISASTER PRIVILEGES

6.9-1 When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the President, Chief Medical Officer, or designee or the President of the Medical 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.

6.9-2 Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.

A. A volunteer's identity may be verified through a valid government-issued photo identification (i.e., driver's license or passport).

B. A volunteer's license may be verified in any of the following ways: (i) current Medical Center picture ID card that clearly identifies the individual's professional designation; (ii) current license to practice; (iii) primary source verification of the license; (iv) 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 (v) identification by a current Medical Center or Medical Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

C. 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.
D. 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.

E. The Medical Staff will oversee the care provided by volunteer licensed independent practitioners. This oversight shall be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Medical Center.

6.10 TELEMEDICINE PRIVILEGES

6.10-1 Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of improving patient care, treatment, and services. The Board will determine the clinical services to be provided through telemedicine after considering the recommendations of the appropriate Department Chair, the Credentials Committee, and the Medical Executive Committee.

6.10-2 Individuals applying for telemedicine privileges shall meet the qualifications for medical staff appointment outlined in Article 3.2, except for those requirements relating to geographic residency, coverage arrangements and emergency call responsibilities.

6.10-3 Qualified applicants may be granted telemedicine privileges pursuant to a contractual agreement shall be incident to and coterminous with the agreement.

6.10-4 All individuals applying for telemedicine privileges shall be processed in accordance with the provisions of these Bylaws in the same manner as other applicants except as noted in 6.10-5.

6.10-5 If the distant site is a Joint Commission accredited organization, credentialing and the final decision to grant privileges may rely upon information obtained from the
distant site upon receipt of an attestation from the distant site indicating the information is complete, up to date and accurate. The decision to grant privileges shall be independent of the distant site in accordance with medical staff bylaws and not based on the determination of the distant site.

6.10-6 Telemedicine privileges, if granted, shall be for a period of not more than two years. Individuals seeking to renew telemedicine privileges will be required to complete an application and, upon request, provide the Medical Center with evidence of current clinical competence. This information may include, but is not limited to, a quality profile from the applicant's primary practice affiliation and evaluation form(s) from qualified supervisor(s). If all requested information is not received by dates established by the Medical Center, the individual's telemedicine privileges will expire at the end of the current term. Once all information is received and verified, an application to renew telemedicine privileges will be processed as set forth above.

6.11 CLINICAL PRIVILEGES FOR NEW PROCEDURES

6.11-1 Requests for clinical privileges to perform either a significant procedure not currently being performed at the Medical Center or a significant new technique to perform an existing procedure ("new procedure") will not be processed until (1) a determination has been made that the procedure will be offered by the Medical Center and (2) criteria to be eligible to request those clinical privileges have been established.

6.11-2 The Credentials Committee will make a preliminary recommendation as to whether the new procedure should be offered to the community. Factors to be considered by the Credentials Committee include, but are not limited to, whether there is empirical evidence of improved patient outcomes and/or other clinical benefits to patients, whether the new procedure is being performed at other similar hospitals and the experiences of those institutions, and whether the Medical Center has the capabilities, including support services, to perform the new procedure.
6.11-3 If it is recommended that the new procedure be offered, the Credentials Committee will conduct research and consult with experts, including those on the Medical Staff and those outside the Medical Center, and develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the new procedure, and (2) the extent of monitoring and supervision that should occur if the privileges are granted. The Credentials Committee may also develop criteria and/or indications for when the new procedure is appropriate. The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

6.12. CLINICAL PRIVILEGES THAT CROSS SPECIALTY LINES

6.12-1 Requests for clinical privileges that traditionally at the Medical Center have been exercised only by individuals from another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.

6.12-2 The Credentials Committee will conduct research and consult with experts, including those on the Medical Staff (e.g., department chairs, individuals on the Medical Staff with special interest and/or expertise) and those outside the Medical Center (e.g., other hospitals, residency training programs, specialty societies).

6.12-3 The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Committee may develop recommendations regarding:

A. the minimum education, training, and experience necessary to perform the clinical privileges in question;

B. the clinical indications for when the procedure is appropriate;

C. the extent of monitoring and supervision that should occur if privileges would be granted;
D. the manner in which the procedure would be reviewed as part of the Medical Center's ongoing performance improvement activities (including an assessment of outcomes data for all relevant specialties); and

E. the impact, if any, on emergency call responsibilities.

The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.
ARTICLE VII - CORRECTIVE ACTION

7.1 COLLEGIAL INTERVENTION

7.1.1 These Bylaws encourage the use of progressive steps by Medical Staff leaders and Medical Center management, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

7.1.2 All collegial intervention efforts by Medical Staff leaders and Medical Center management are part of the Medical Center's performance improvement and professional and peer review activities.

7.1.3 These efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of staff members and pursuing counseling, education, and related steps, such as the following:

(a) advising colleagues of all applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

(b) proctoring, monitoring, consultation, and letters of guidance; and

(c) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.

7.1.4 The relevant Medical Staff leader(s) will determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's credentials file. If
documentation of collegial efforts is included in an individual's file, the individual will have an opportunity to review it and respond in writing. The response will be maintained in that individual's file along with the original documentation.

7.1.5 Collegial intervention efforts are encouraged, but are not mandatory, and will be within the discretion of the appropriate Medical Staff leaders and Medical Center management.

7.1.6 The President of the Medical Staff, in conjunction with the Chief Medical Officer or CEO, will determine whether to direct that a matter be handled in accordance with an applicable Policy, such as the Policy on Practitioner Health (#AC0031MDS) or the Code of Conduct Policy (#AS0045CCP), or to direct it to the Medical Executive Committee for further determination.

7.2 INVESTIGATIONS

7.2-1 Initial Review.

A. Whenever a serious question has been raised, or where collegial efforts have not resolved an issue, regarding:

(1) the clinical competence or clinical practice of any member of the Medical Staff, including the care, treatment or management of a patient or patients;

(2) the known or suspected violation by any member of the Medical Staff of applicable ethical standards or the Bylaws, policies, Rules and Regulations of the Medical Center or the Medical Staff; and/or

(3) conduct by any member of the Medical Staff 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, including the inability of the member to work harmoniously with others,
the matter may be referred to the President of the Medical Staff, Chief Medical Officer the chair of the department, the chair of a standing committee, the CEO, or the Chair of the Board.

B. The person to whom the matter is referred will make sufficient inquiry to satisfy himself or herself that the question raised is credible and, if so, will forward it in writing to the Medical Executive Committee.

C. No action taken pursuant to this Section will constitute an investigation.

7.2-2 Initiation of Investigation.

A. When a question involving clinical competence or professional conduct is referred to, or raised by, the Medical Executive Committee will review the matter and determine whether to conduct an investigation or to direct the matter to be handled pursuant to an applicable policy, such as the Policy on Practitioner Health or the Code of Conduct Policy, or to proceed in another manner. In making this determination, the Medical Executive Committee may discuss the matter with the individual. An investigation will begin only after a formal determination by the Medical Executive Committee to do so.

B. The Medical Executive Committee will inform the individual that an investigation has begun. Notification may be delayed if, in the Medical Executive Committee's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Medical Center or Medical Staff.

C. The Board may also determine to commence an investigation and may delegate the investigation to the Medical Executive Committee, a subcommittee of the Board, or an ad hoc committee.

D. The President of the Medical Staff will keep the CEO fully informed of all action taken in connection with an investigation.
7.2-3 Investigative Procedure.

A. Once a determination has been made to begin an investigation, the Medical Executive Committee will either investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an individual or ad hoc committee to conduct the investigation. Any ad hoc committee will not include partners, associates, or relatives of the individual being investigated, but may include individuals not on the Medical Staff. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee will include a peer of the individual (e.g., physician, dentist, oral surgeon or podiatrist).

B. The committee conducting the investigation ("investigating committee") will have the authority to review relevant documents and interview individuals. It will also have available to it the full resources of the Medical Staff and the Medical Center, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the Medical Center and investigating committee that

(1) the clinical expertise needed to conduct the review is not available on the Medical Staff; or

(2) the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff; or

(3) the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.

C. The investigating committee may require a physical and/or mental examination of the individual by health care professional(s) acceptable to it. The
individual being investigated will execute a release allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee.

D. The individual will have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual will be informed of the general questions being investigated. At the meeting, the individual will be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview will be made by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings will apply. The individual being investigated will not have the right to be represented by legal counsel at this meeting.

E. The investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, will not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the investigating committee is unable to complete the investigation and issue its report within these time frames, it will inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.

F. At the conclusion of the investigation, the investigating committee will prepare a report with its findings, conclusions, and recommendations.
G. In making its recommendations, the investigating committee will strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Medical Center, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:

(1) relevant literature and clinical practice guidelines, as appropriate;
(2) all of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s);
(3) any information or explanations provided by the individual under review.

7.2-4 Recommendation.

A. The Medical Executive Committee may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the Medical Executive Committee may:

(1) determine that no action is justified;
(2) issue a letter of guidance, counsel, warning, or reprimand;
(3) impose conditions for continued appointment;
(4) impose a requirement for monitoring or consultation;
(5) recommend additional training or education;
(6) recommend reduction of clinical privileges;
(7) recommend suspension of clinical privileges for a term;
(8) recommend revocation of appointment and/or clinical privileges; or
(9) make any other recommendation that it deems necessary or appropriate.

B. A recommendation by the Medical Executive Committee that would entitle the individual to request a hearing as defined in Article 6.1-1 will be forwarded to the CEO, who will promptly inform the individual by special notice. The CEO will
hold the recommendation until after the individual has completed or waived a hearing and appeal unless the Medical Executive Committee determines that a precautionary or restriction be imposed as defined in Article 7.3.

C. If the Medical Executive Committee makes a recommendation that does not entitle the individual to request a hearing, it will take effect immediately and will remain in effect unless modified by the Board.

D. In the event the Board considers a modification to the recommendation of the Medical Executive Committee that would entitle the individual to request a hearing, the CEO will inform the individual by special notice. No final action will occur until the individual has completed or waived a hearing and appeal.

E. When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal will be monitored by Medical Staff leaders on an ongoing basis through the Medical Center's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

7.3 PRECAUTIONARY SUSPENSION

7.3.1 Criteria and Initiation. Whenever a staff member is reasonably believed to have willfully disregarded or grossly violated these bylaws, staff rules and regulations, or other Medical Center policies, or whenever his/her conduct requires that immediate action be taken to protect the life of any patient or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other person present in the Medical Center, or whenever the conduct of the staff member materially disrupts the operations of any department, division or unit of the Medical Center, the President of the Medical Staff, a Chair of a department, a chief of a division, the President, or the Medical Executive Committee or the Chief Medical Officer shall have the authority to suspend or restrict, as a precaution, the staff appointment, all, or any portion of the clinical privileges, of such
staff member. Such precautionary suspension shall promptly give special notice of suspension to the staff member, and notice to the Medical Executive Committee of such action. Such precautionary suspension shall be deemed an interim step in the professional review activity, but not a final professional review action. The individual may be given an opportunity to refrain voluntarily from exercising privileges pending an investigation.

7.3-2 Medical Executive Committee Action.

A. The Medical Executive Committee will review the matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the Medical Executive Committee. The individual may propose ways other than precautionary suspension or restriction to protect patients, employees and/or the smooth operation of the Medical Center, depending on the circumstances.

B. After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Medical Executive Committee will determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Medical Executive Committee will also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).

C. There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.

7.4 AUTOMATIC SUSPENSION

7.4-1 License. If a staff member's license to practice his/her profession in the State of New Jersey or any other state is revoked or suspended, such staff member shall
immediately and automatically be suspended from practicing in the Medical Center.

7.4-2 **Drug Enforcement Administration (DEA) Number and/or Controlled Dangerous Substance (CDS) Number.** A staff member whose DEA number and/or CDS number is revoked or suspended or voluntarily relinquished shall immediately and automatically be divested of his/her right to prescribe medications covered by such number. As soon as reasonably possible after such automatic suspension, the Medical Executive Committee shall convene to review and consider the facts under which the DEA number and/or CDS number was revoked or suspended or relinquished. The Medical Executive Committee may then take such further corrective action as is appropriate to the facts disclosed in its investigation.

7.4-3 **Failure to Satisfy Special Appearance Requirement.**

A staff member who fails to satisfy the requirements of Section 12.7-3 shall immediately and automatically be suspended from exercising all or such portion of his/her clinical privileges in accordance with the provisions of said Section 12.7-3.

7.4-4 **Conviction of a Felony.** Upon exhaustion of appeals after conviction of a felony of a staff member in any court of the United States, either federal or state, the member's staff appointment is automatically revoked. Revocation pursuant to this section of the bylaws does not preclude the staff member from subsequently applying for staff appointment.

7.4-5 **Medical Records.** An administrative suspension for incomplete records will occur at 21 days. An automatic suspension of admitting, consulting and operating privileges shall be imposed for delinquent medical records thirty (30) days after discharge, and shall remain in effect until the incomplete medical records are completed. If the medical records remain incomplete ninety (90) days after patient discharge, such failure shall constitute a resignation from the staff effective immediately. For the purpose of enforcing this Section 7.3-5, justified reasons for delay in completing medical records shall include:

A. That the staff member or any other individual contributing to the record is ill, on vacation, or otherwise unavailable for a period of time;
B. In the case of an administrative suspension the staff member who has dictated reports and is waiting for transcription, may have their suspension terminated.

7.4-6 Procedural Rights. A staff member under automatic suspension or who has resigned by operation of Section 7.3-5 shall be entitled to the procedural rights provided in Articles VIII and XVI only for the purpose of establishing justification for the delay in completing medical records.

7.4-7 Medicare and Medicaid Sanctions. Whenever a Medical Staff Member has been involuntary excluded from participation in the Medicare, Medicaid, and other federally sponsored health programs, the practitioners privileges shall be automatically suspended until evidence of the exclusion has been removed.

7.5 CONTINUITY OF PATIENT CARE

Upon the imposition of precautionary suspension or restriction or the occurrence of an automatic suspension, the President of the Medical Staff or the Chair of the department to which the affected staff member is assigned, shall provide for alternative coverage for the affected member's patients in the Medical Center. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner. The affected staff member shall confer with the substitute practitioner to the extent necessary to safeguard the patient.
8.1 INTERVIEWS

When the Medical Executive Committee or the Board receives or is considering initiating an adverse recommendation concerning a staff member, the staff member may be afforded an interview. The interview shall not constitute a hearing, shall be preliminary in nature, and shall not be conducted according to the procedural rules provided with respect to hearings. The staff member shall be informed of the general nature of the circumstances and may present information relevant thereto. A record of such interview shall be made.

8.2 HEARINGS AND APPELLATE REVIEW

8.2-1 Adverse Medical Executive Committee Recommendation.

When any staff member received special notice of an adverse recommendation of the Medical Executive Committee, as described in Section 16-1.1 and Section 16-1.2, he/she shall be entitled, upon request, to a hearing before an ad hoc hearing committee of the staff. If the recommendation of the Medical Executive Committee following such hearing is still adverse to the staff member, he/she shall then be entitled, upon request, to an appellate review by the Board before a final decision is rendered.

8.2-2 Adverse Board Decision.

When any staff member receives special notice of an adverse decision by the Board taken either contrary to a favorable recommendation by the Medical Executive Committee under circumstances where no right to a hearing existed, or on the Board's own initiative without benefit of a prior recommendation by the Medical Executive Committee under circumstances where no right to a hearing existed, such staff member shall be entitled, upon request, to a hearing by an ad hoc hearing committee appointed by the Board. If such hearing does not result in a favorable recommendation, he/she shall then be entitled, upon request, to an appellate review by the Board before a final decision is rendered.
8.2-3  Procedure and Process.

All hearings and appellate reviews shall be in accordance with the procedure and safeguards set forth in Article XVI.

8.2-4  Exceptions.

The denial, termination or reduction of temporary privileges, or any other actions, except those specified in Article XVI, shall not give rise to any right to a hearing or appellate review.
ARTICLE IX - OFFICERS OF THE STAFF AND DEPARTMENT

9.1 OFFICERS OF THE STAFF

9.1-1 Identification.

The officers of the medical staff shall be:

A. Chief Medical Officer
B. President
C. Vice-President
D. Secretary
E. Treasurer

The Chief Medical Officer shall be appointed by the Board. Unless otherwise stated, the provisions of this Article dealing with nominations, term of office, removal and vacancies do not apply to the Chief Medical Officer. All other officers shall be elected by the members of the active medical staff at the annual meeting of the medical staff.

9.1-2 Qualifications.

Officers must be physician members of the active medical staff at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

9.1-3 Nominations.

A. By Nominating Committee: The nominating committee shall convene at least sixty (60) days prior to the annual meeting and shall submit to the secretary of the staff a list of one or more qualified nominees for each office, to which is attached a statement of the Chair that each nominee has agreed to stand for election to office. The names of such nominees shall be reported to the staff at least fifteen (15) days prior to the annual meeting.

B. By Petition: Nominations may also be made by petition signed by at least ten percent (10%) of the members of the active staff with voting rights, to which is attached a statement signed by the nominee attesting to his/her willingness to stand for election to the office, and filed with the secretary of the staff at least fifteen (15 days
prior to the annual meeting. As soon after filing of a petition as is reasonably possible, the name(s) of these additional nominee(s) shall be reported to the staff;

C. By Other Means: If, before the election, all of the individuals nominated for an office pursuant to Sections 9.1-3A and B shall be disqualified from, or otherwise be unable to accept nomination, then the nominating committee shall submit one or more substitute nominees at the annual meeting, and nominations shall be accepted from the floor.

9.1-4 Election. Officers shall be elected at the annual meeting of the staff. Voting shall be by open ballot, unless closed ballot is requested by 10% of those present and voting, and voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of the votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes.

9.1-5 Term of Elected Office. Each officer shall serve a one (1) year term, commencing on the first day of the Medical Staff Year following his/her election. Each officer shall serve until the end of his/her term and until a successor is elected.

9.1-6 Removal of Officers. An officer shall be removed from office if a two-thirds (2/3) majority of the active staff vote in favor of removal, and provided that the Medical Executive Committee and the Board concur. Grounds for removal shall include, but not be limited to, mental and/or physical impairment and inability to perform the duties and responsibilities of the office. Action directed towards removing an officer from office may be initiated by submission to the Medical Executive Committee of a petition seeking removal of an officer, signed by not less than fifty (50) members of the active staff with voting rights.

9.1-7 Vacancies in Staff Offices. Vacancies in offices, other than that of President of Medical Staff, shall be filled by the Medical Executive Committee. If there is a vacancy in the office of the President of the Medical Staff, the Vice-President shall become President of the Medical Staff and serve out the remaining term.
9.1-8 Duties of Elected Officers.

A. President: The President of the Medical Staff shall serve as the Chief Executive Officer and principal elected official of the staff. As such, he/she shall:

1. Aid in coordinating the activities and concerns of the Medical Center administration and of the nursing and other patient care services with those of the staff;

2. Be accountable to the Board, in conjunction with the Medical Executive Committee, for the quality and efficiency of clinical services and performance within the Medical Center and for the effectiveness of the patient care quality assessment functions delegated to the staff;

3. Develop and implement, in cooperation with the department and committee chair, methods for credentials review and for delineation of privileges, continuing education programs, utilization review, concurrent monitoring of practice, and quality assessment techniques;

4. Appoint the medical staff representatives to Medical Staff and Medical Center-wide committees, unless otherwise expressly provided by these bylaws or Medical Center bylaws, policies or procedures and make recommendations for Medical Center wide committees;

5. Communicate and represent the opinions, policies, concerns, needs and grievances of the staff to the Board and the President;

6. Be responsible for the enforcement of these bylaws, and staff rules and regulations, for implementation of sanctions where these are indicated, and for the staff’s compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

7. Call, preside at, and be responsible for the agenda of all general meetings of the staff;

8. Serve as Chair of the Medical Executive Committee, as a staff member of the Joint Conference
Professional Affairs committee, and as an ex officio member, without vote, of all other staff committees;

B. **Vice-President:** The Vice-President shall be a member of the Medical Executive Committee, the Physician Performance Improvement Subcommittee, and a staff member of the Joint Conference Professional Affairs Committee. In the temporary absence of the President of the Medical Staff, he/she shall assume all the duties and have the authority of the President of the Medical Staff. He/She shall perform such additional duties as may be assigned to him/her by the President of the Medical Staff, the Medical Executive Committee, or the Board.

C. **Secretary:** The Secretary shall be a member of the Medical Executive Committee and shall have the following duties:

1. He/She shall keep accurate and complete minutes on all medical staff meetings, call medical staff meetings on order of the President of the Medical Staff, attend to all correspondence and perform such other duties as ordinarily pertain to his/her office;

2. He/She shall forward to the President of the Medical Staff and to members of the Medical Executive Committee a copy of the minutes of the medical staff and the Medical Executive Committee meetings. An abstract of the proceedings of the Medical Executive Committee and copy of the minutes of the meeting of the medical staff shall be sent to the members of the medical staff.

D. **Treasurer:** The treasurer of the medical staff shall have the following duties:

1. He/She shall be accountable for all funds entrusted to him/her;

2. He/She shall make a report at the Annual meeting of the medical staff.

3. He/She shall report all delinquencies and dues payment after ninety (90) days from due date to the Medical Executive Committee; and,
4. He/She shall supervise the collection and accounting for any funds that may be collected in the form of staff dues, assessments, or application fees, and maintain proper records of such funds.

9.2 DEPARTMENT AND DIVISION OFFICERS

9.2-1 Appointment Process and Qualifications

A. Chair of each department and chiefs of each division shall be appointed by the Board, in consultation with the Medical Executive Committee, and pursuant to the following provisions, and shall be subject to periodic review by both parties.

B. Appointments of chair and chiefs shall be for a five (5) year term. After serving two successive five (5) year terms, appointees shall be ineligible for reappointment in the absence of compelling circumstances. Appointment of division chiefs shall ordinarily follow by one year the appointment of the chair of the department of which the divisions are a part, but the Board may make exceptions to the timing of these appointments and the terms of incumbent division chiefs when, in its sole judgment, the best interests of the Medical Center so require.

C. Process for chair: One hundred twenty (120) days prior to the expiration of the department chair's term of appointment, the Medical Executive Committee shall appoint a search committee to submit a recommendation for the forthcoming vacancy. The search committee shall consist of one member of the Board, the President of the Medical Staff or his/her designee, and three members of the active medical staff, at least one of whom shall be the chair of another department or chief of a division in another department. The search committee shall submit its recommendation to the Medical Executive Committee no less than forty-five (45) days before the next term is due to commence. In the event a chair ceases to serve before the end of his/her term, a search committee shall be appointed as soon as possible, and it shall endeavor to recommend a replacement promptly, at the earliest opportunity, which should ordinarily be within sixty (60) days of any vacancy. The above process applies only to departments with non-contracting physicians as chair. In departments with contracting physicians as chair,
these matters are covered by the terms of the contract after consultation with the Medical Executive Committee.

D. **Process for chiefs:**

1. Department chair have the opportunity to recommend division chiefs. After the department chair selects a division chief he/she shall then present the selection to the division involved. If the majority of active medical staff within the division involved agree with the choice of the department chair, the recommendation will then go to the Medical Executive Committee for approval and finally to the Board for its approval.

2. If the department chair so desires, in lieu of appointing a division chief, he/she may ask the President of the Medical Staff to appoint a search committee for a particular division chief. If the division does not agree with the recommendation of the department chair, it may also request that the President of the Medical Staff appoint a search committee for the division chief. Finally, if the Medical Executive Committee does not approve the choice of the department chair, it may request that a search committee be formed, which will report to the Medical Executive Committee.

3. All recommendations and approvals will go to the Board for its review and approval.

E. **Qualifications for department chair and division chiefs:**

1. Board certification in relevant specialty.
2. Demonstrated administrative skills.
3. Demonstrated commitment to medical education.
4. Ability to work harmoniously with medical center staff and administration.
5. Active staff membership in good standing.

9.2-2 **Temporary Service.** Whenever a department or division staff member has not yet been approved to fill an existing chair's or chief's vacancy, the Chief Medical Officer with the concurrence of the President of the Medical Center shall designate a qualified physician to temporarily serve in that position.
9.2-3 Removal of Chair or Chief.

A. Removal of a chair or chief during his/her term of office may be recommended by a two-thirds (2/3) majority vote of all active medical staff members of the respective department or division, but no such removal shall be effective unless and until it has been ratified by the Medical Executive Committee and the Board.

B. The Medical Executive Committee may also recommend to the Board that a chair or chief be removed during his/her term of office. The Board may also remove a chair or chief on its own accord, following consultation with the Medical Executive Committee.

9.2-4 Functions of the Department Chair and Division Chiefs.

A. Each department chair shall:

1. Be accountable for all professional and administrative activities within his/her department.

2. Give guidance to the Medical Executive Committee by making specific recommendations and suggestions regarding his/her own department in order to maintain quality patient care.

3. Maintain continuing review of the professional performance of all practitioners with clinical privileges in his/her department and report regularly thereon to the Medical Executive Committee.

4. Appoint a departmental committee to conduct the initial phase of patient care review required by these bylaws.

5. Be responsible for enforcement within his/her Department of the Medical Center bylaws and policies and the medical staff bylaws, rules and regulations.

6. Be responsible for implementation within his/her department of actions taken by the Medical Executive Committee of the medical staff.

7. Transmit to the Medical Executive Committee in accordance with departmental specific criteria his/her department's recommendations concerning the staff classification, the reappointment, and the delineation of clinical privileges for all practitioners in his/her department.

8. Be responsible for the teaching, education and research program in his/her department.
9. Participate in every phase of administration of his/her department through cooperation with the nursing service and the Medical Center administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders, and techniques.

10. Assist in the preparation of such annual reports, including budgetary planning, pertaining to his/her department as may be required by the Medical Executive Committee, the President or the Board.

11. Act as presiding officer at all department meetings;

12. Perform such duties commensurate with his/her office as may from time to time be reasonably requested of him/her by the President of the Staff, the Medical Executive Committee, the President, or the Board.

13. Be responsible for the performance improvement monitoring, recommendations for continuing contracted services and annual reporting to the Chief Medical Officer of contracted patient care services not provided within the Medical Center.

14. Name a designee who will assume the Departmental responsibilities in the Chief's absence. This designation will remain in effect until changed by the Chief. In this way, all services will have on file a designee to call upon in the Chief's absence.

15. Be responsible for the integration of the department or service into the primary functions of the organization.

16. Be responsible for the coordination and integration of interdepartmental and intradepartmental services.

17. Be responsible for the development and implementation of policies and procedures that guide and support services.

18. Make recommendations for a sufficient number of qualified and competent persons to provide care or service.

19. Be responsible for the continuous assessment and improvement of the quality of care and services provided.

20. Be responsible for the orientation and continuing education of all persons in the department or service.
21. Make recommendations for space and other resources needed by the department or service.

B. Department vice-chair:

1. Each vice-chair shall have the qualifications set forth in Section 9.2-1 for department chair and shall be appointed by the chair.

2. A vice-chair shall serve a term commencing on his/her appointment and continuing until his/her successor is appointed. Removal of a vice-chair from office may be made by the chair.

3. Upon a vacancy in the office of vice-chair, the chair shall appoint a member of the department to fill the vacancy.

4. The vice-chair shall, in the absence of the chair, carry out the duties of the chair and shall perform such duties as may be assigned to him/her by the chair.

C. Each division chief shall:

1. Be accountable for all professional and administrative activities within the division.

2. Maintain continuing review of the professional performance of all practitioners with clinical privileges in the division and report regularly thereon to the department chair.

3. Be responsible for the enforcement within division of the Medical Center bylaws and policies and the Medical Staff bylaws, rules and regulations.

4. Recommend classification, initial granting of privileges, reappointment and renewal of delineation of clinical privileges for all members in division.

5. Transmit as needed, and as requested by the department chair, the division’s recommendations concerning staff classification, reappointment, and delineation of clinical privileges for all practitioners in the division.
6. Assist in teaching, education and research as requested by the department chair.

7. Participate in performance improvement of division as directed by the department chair and the Chief Medical Officer.

9.2-5 Director of Medical Education.

The director of medical education shall be appointed by the Chief Medical Officer and shall serve at its pleasure.

Such appointment may only be conferred upon a licensed physician, and when such appointment is conferred upon a physician who is the chair of a department, that individual will only have a vote on the Medical Executive Committee as chair of a department.

If the director of medical education has no other department responsibilities, he/she shall be a member of the Medical Executive Committee, with no vote.

The director of medical education will deal with problems relating to medical education and shall coordinate inter-departmental education activities. The director shall be a member of the Continuing Medical Education Committee and Affiliation Committee.

9.2-6 Chief Medical Officer

The Chief Medical Officer shall be appointed by the Board. As such, he/she shall:

1. Serve as a member of the Medical Executive Committee;

2. Supervise the functioning of the various departments; and,

3. Be the active head of the professional staff with full authority to direct properly all the professional activities of the Medical Center.

4. Must be a member of the Our Lady of Lourdes Medical Center Medical Staff.
9.2-7 Additional Officers

The Board may, after considering the advice and recommendations of the Medical Executive Committee, appoint additional practitioners to medical administrative positions within the Medical Center to perform such duties as are prescribed by the Board, or as defined by amendments to these bylaws. To the extent that any such officer performs any clinical function, he/she must become and remain a member of the staff. In all events, he/she must be subject to these bylaws and to the other policies of the Medical Center, except to the extent so provided by the Board.
ARTICLE X - STAFF DEPARTMENTS AND DIVISIONS

10.1 ORGANIZATION OF STAFF DEPARTMENTS

Each department shall be organized as a separate part of the medical staff and shall have a chair and a vice chair who are selected and have the authority, duties, and responsibilities as specified in Article IX. Within each department staff members shall be assigned to divisions, based on their areas of professional practice.

10.2 DEPARTMENTS AND DIVISIONS

10.2-1 Department of Medicine

The Department of Medicine shall have the following divisions:

1. Primary Care Medicine
2. Cardiology
3. Gastroenterology
4. Nephrology
5. Pulmonary
6. Hematology Immunology
7. Infectious Disease
8. Neurology
9. Endocrinology
10. Rheumatology
11. Oncology
12. Dermatology
13. Geriatric
10.2-2 Department of Surgery

The Department of Surgery shall have the following divisions:

1. Cardiothoracic Surgery
2. General Surgery
   Section: Pediatric Surgery
   Podiatry
3. Neurologic Surgery
4. Ophthalmologic Surgery
5. Oral Maxillofacial Surgery
   Section: Dentistry
6. Orthopedic Surgery
7. Otolaryngologic Surgery and Bronchoesophagology
8. Plastic and Reconstructive Surgery
9. Transplant Surgery
10. Urologic Surgery
11. Vascular Surgery

10.2-3 Department of Obstetrics and Gynecology

The Department of Obstetrics and Gynecology shall include those divisions which practice obstetrics, treat complications of pregnancy and puerperium, and treat diseases of the female reproductive organs, both surgical and medical. The Department of Obstetrics and Gynecology shall be divided into the following divisions:

1. Obstetrics
2. Gynecology
3. Maternal Fetal Medicine
10.2-4 **Department of Pediatrics**

The Department of Pediatrics shall be divided into three divisions:

1. General Pediatrics
2. Neonatology
3. Allergy-Immunology

10.2-5 **Department of Pathology**

The Department of Pathology shall include all physicians who perform and supervise clinical laboratory services of the Medical Center.

The Department shall provide the following laboratory services which consist of Transfusion Medicine, Clinical Chemistry, Clinical Microscopy, Laboratory Hematology, Immunohematology and Coagulation, Microbiology, Serology, and Tissue Pathology (Autopsy, Surgical Pathology, Cytology).

10.2-6 **Department of Radiology**

The Department of Radiology shall include all Physicians who are specialists in the diagnostic and therapeutic aspects of radiant energy in all its forms.

10.2-7 **Department of Psychiatry**

The Department of Psychiatry shall include those physicians who treat psychiatric illnesses and their complications.
10.2-8 **Department of Emergency Medicine**

The Department of Emergency Medicine shall include those physicians trained to treat patients requiring emergency care. The members of the Department of Emergency Medicine will be responsible for the care of Emergency Room patients. They will be under the supervision of the chair of the department and will have admission privileges to that unit only. They will not have admission privileges to the general Medical Center.

10.2-9 **Department of Physical Medicine and Rehabilitation**

The Department of Physical Medicine and Rehabilitation shall include those physicians specially trained to care for patients with special problems in rehabilitation medicine. The members of the Department of Physical Medicine and Rehabilitation will admit patients to the Rehabilitation Unit only and will not admit patients to other services.

10.2-10 **Department of Anesthesia**

The Department of Anesthesia shall include those physicians specially trained to practice anesthesiology, including the administration of anesthesia, supervision of nurse anesthetists and training of nurse anesthetists in the Medical Center.

The department and its chair shall be responsible for supervision of the Recovery Room.
10.3 **FUTURE DEPARTMENTS AND DIVISIONS**

When deemed appropriate the Medical Executive Committee and the Board, by their joint action, may create anew, eliminate, subdivide, further subdivide or combine departments and divisions.

10.4 **ASSIGNMENT TO DEPARTMENTS AND DIVISIONS**

Each member of the staff shall be assigned membership in at least one department and/or division, but may be granted membership and/or clinical privileges in one or more of the other departments, or divisions, of his/her assigned, or any other, department. The exercise of privileges within each department and division shall be subject to the rules and regulations therein and to the authority of the department chair and division chief.

10.5 **FUNCTIONS OF DEPARTMENTS**

The primary responsibility delegated to each department is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the department. To carry out this responsibility, each department shall:

A. Meet at regularly scheduled intervals for the purpose of receiving, reviewing and considering performance improvement findings and the results of the department's other review, evaluation and education activities and of performing, or receiving reports on, other department and staff functions;

B. Participate in patient care audits for the purpose of reviewing and evaluating the quality of care within the department. Each department shall review all clinical work performed under its jurisdiction;

C. Establish guidelines for the granting of clinical privileges within the department and submit recommendations regarding the specific privileges each staff member or applicant may exercise;
D. Conduct or participate in continuing education programs;

E. Monitor, on a continuing and concurrent basis, adherence to:
   1. Staff and Medical Center policies and procedures,
   2. Requirements for alternate coverage and for consultations,
   3. Sound principles of clinical practice.

F. Coordinate the patient care provided by the department's members with nursing and ancillary patient care services and with administrative support services;

G. Submit written reports to the Medical Executive Committee on a regularly scheduled basis concerning:
   1. Findings of the department's review and evaluation activities, actions taken thereon, and the results of such action,
   2. Recommendations for maintaining and improving the quality of care provided in the department and the Medical Center, and
   3. Such other matters as may be requested from time to time by the Medical Executive Committee.

H. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it.

10.6 FUNCTIONS OF DIVISIONS

Each division shall perform the functions assigned to it by the department chair. Such functions may include, without limitation, the monitoring of patient care audit, continuing education programs, and credentials review and privileges delineation as requested. Each division shall meet at the discretion of the chief, independently, or as part of the departmental meeting and shall submit reports to the department chair as needed.
10.7 ATTENDANCE AT MEETINGS

Upon the approval of the department chair, attendance at a division meeting may be considered as attendance at a department meeting for the purpose of satisfying any attendance requirements that may be imposed upon any member of the staff.
ARTICLE XI - COMMITTEES

11.1 DESIGNATION, STRUCTURE AND FUNCTION

There shall be such standing and special committees of the staff as may from time to time be necessary and desirable to perform the functions of the staff required by these bylaws or necessarily incidental thereto. All staff members to serve on committees and committee chair and all Medical Center personnel, other than staff members, to serve on committees shall be appointed by the President of the Medical Staff, except as otherwise provided in these bylaws. The President of the Medical Staff shall appoint staff members to Medical Center-wide committees if requested by the President.

All committees shall:

1. Maintain a record of attendance at their meetings;
2. Maintain a record of their proceedings;
3. Submit timely reports of their activities and/or copies of the minutes of their meetings to the Medical Executive Committee; and

Medical Staff committees shall be classified as follows:

A. Medical Staff Standing Committee:
   Medical Executive Committee
   Credentials Committee
   Joint Conference and Professional Affairs Committee
   Pharmacy and Therapeutics Committee
   Infection Control Committee
   Operating Room Committee
   Institutional Review Board
   Radiation Safety Committee
   Continuing Medical Education
   Constitution, Bylaws, Rules & Regulations
   Impaired Physicians Committee
   Cancer Committee
   Blood Utilization Committee
   Nominating Committee
   Physicians Performance Improvement Subcommittee

B. Performance Improvement Committees
All Performance Improvement committees that are directly related to clinical departments and clinical services.

11.2 MEDICAL EXECUTIVE COMMITTEE

11.2-1 The Medical Executive Committee shall consist of:

1. The Chief Medical Officer
2. The President of the Medical Staff
3. The Vice-President of the Medical Staff
4. The Secretary of the Staff
5. The Treasurer of the Staff
6. The Immediate Past President of the Staff
7. Chiefs from the four Departments of Medicine, Surgery, OB/GYN and Pediatrics
8. Chiefs from two departments other than Medicine, Surgery, OB/GYN and Pediatrics
9. Two Division Heads
10. Five members of the active staff who are neither chairperson nor chief

11. The CEO, Vice President for Patient Care Services, and all medical staff department chairs not appointed to a voting seat on the Medical Executive Committee shall be ex officio members without vote.

11.2-2 Duties of the Medical Executive Committee shall be to:

1. Act on behalf of the medical staff under such limitations as may be imposed by these bylaws.
2. Meet at least monthly and maintain a permanent record of its proceedings and actions.
3. Receive and act upon reports of medical staff committees, clinical departments, and assigned activity groups.

4. Consider and recommend action to the President on all matters of a medico-administrative nature.

5. Be responsible to the Board of Trustees for the maintenance of professional standards pertaining to the care of the sick, education, and scientific investigation, either clinical or experimental.

6. Make recommendations to the Board of Trustees on those matters that require its action.

7. Coordinate the activities and general policies of the various departments and conduct a collaborative review of departments and divisions.

8. Formulate and implement policies of the medical staff and report its work to the medical staff at each general staff meeting.

9. Inform the medical staff of the accreditation program and of the accreditation status of the Medical Center.

10. Provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agent.

11. Review the credentials of all applicants and to make recommendations for staff membership, department assignments and delineation of clinical privileges and the mechanisms for credentials review.

12. Review periodically all information available regarding the performance and clinical competence of staff members and other practitioners with clinical privileges and as a result of such reviews to make recommendations for reappointments and renewal or changes in clinical privileges.

13. Take all reasonable steps to bring about professionally ethical conduct and competent clinical performance on the part of all members of
the medical staff, including the initiation of and/or participation in medical staff corrective or review measures when warranted.

14. Establish ad hoc committees from time to time, delineate their mission, and appoint their members.

15. Make recommendations on the medical staff structure.

16. Make recommendations regarding the participation of medical staff in organization performance improvement activities.

17. Make recommendations regarding the mechanism by which medical staff membership may be terminated.

18. Make recommendations regarding fair-hearing procedures.

Members of the Medical Executive Committee shall serve no more than five (5) consecutive terms.

11.3 CREDENTIALS COMMITTEE

11.3-1 The Credentials Committee shall be composed of five members of the Active Staff who have experience in leadership roles, including where possible past Presidents of the Medical Staff and past department chairs or division chiefs, broadly representative of the major clinical specialties and the staff at large. Three of the five members constitute a quorum.

11.3-2 Duties of the Credentials Committee shall be to:

1. Review the credentials of all applicants and make recommendations for appointment and delineation of clinical privileges in compliance with Articles V and VI of these bylaws. Make a report and recommendation to the Medical Executive Committee on each applicant for medical staff membership or clinical privileges, including specific considerations from the departments in which such applicant requests privileges.

2. Review periodically all information available regarding the competence of staff members and as a result of
such reviews, make recommendations for the granting of privileges, reappointments, and the assignment of practitioners to the various departments or services as provided in Articles V and VI of these bylaws.

3. Investigate any breach of ethics that is reported to it.

4. Review reports that are referred by the Medical Executive, medical records, and utilization review committees and by the President of the Medical Staff.

5. Meet at least monthly and maintain a permanent record of its proceedings and actions and submit a written report to the Medical Executive Committee.

11.4 JOINT CONFERENCE AND PROFESSIONAL AFFAIRS COMMITTEE

11.4-1 The Joint Conference and Professional Affairs Committee shall be a standing committee composed of three members of the Medical Executive Committee of the medical staff and three members of the Board. The Chief Medical Officer and the President shall be ex-officio members without voting privileges.

The representatives from the medical staff shall be the President, Vice-President and immediate Past-President. The chairship shall be alternated between the Board and medical staff every two (2) years.

11.4-2 The Joint Conference and Professional Affairs Committee shall conduct itself as a forum for the discussion of matters of hospital policy and practice, especially those pertaining to efficient and effective patient care, and shall provide medico-administrative liaison with the Board of Trustees and the President.

11.4-3 The Joint Conference and Professional Affairs Committee shall meet at least quarterly and shall transmit written reports of its activities to the Board of Trustees.

11.5 CONTINUING MEDICAL EDUCATION COMMITTEE

11.5-1 The Continuing Medical Education Committee (CME) shall be responsible for the coordination and direction of continuing medical education for the medical staff of Our
Lady of Lourdes Medical Center. This Committee shall be responsible for assuring compliance with standards set forth by the Accrediting Agency and by the Chief Medical Officer for awarding CME credits. Members of this committee will be appointed by the President of the Medical Staff and the Chief Medical Officer and will include the Director of Medical Education.

11.6 PHARMACY AND THERAPEUTICS COMMITTEE

11.6-1 Membership shall consist of at least four representatives of the medical staff and one each from the pharmaceutical service, the nursing service and from Medical Center management. The Medical Center chief pharmacist shall be a member of and act as secretary of the committee.

11.6-2 This committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the Medical Center in order to bring about optimum clinical results and a minimum potential for hazard. The committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, adverse drug reactions, and all other matters relating to drugs in the Medical Center. It shall also perform the following specific functions:

1. Serve as an advisory group to the medical staff and the pharmacist on matters pertaining to the choice of available drugs.

2. Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.

3. Develop and review periodically a formulary or drug list for use in the Medical Center.

4. Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients.

5. Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.
6. Review antibiotic usage in conjunction with the infection control committee.

11.6-3 This committee should meet at least quarterly and send quarterly reports to the Medical Executive Committee regarding its activities.

11.6-4 The Drug Utilization Committee shall act as a subsection of the Pharmacy and Therapeutics Committee.

11.7 INFECTION CONTROL COMMITTEE

11.7-1 The committee shall consist of representation from at least: infection control, medical staff, nursing service, administration, clinical laboratory, respiratory care services, surgery, and the employee health service. The committee shall receive formal advice from all other services upon its request.

11.7-2 The Infection Control Committee shall be responsible for the surveillance of inadvertent hospital infection potentials, the review and analysis of actual infections, the promotion of a preventative and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the Medical Center's activities including:

1. Operating rooms, delivery rooms, recovery rooms, special care units.

2. Sterilization procedures by heat, chemicals or otherwise.

3. Isolation procedures.

4. Prevention of cross-infection.

5. Guidance regarding immunization procedures for Medical Center personnel.

6. Other situations as requested by the Medical Executive Committee, Medical Center management, or as required by circumstances.

7. Review antibiotic usage in conjunction with the pharmacy and therapeutics committee.
11.7-3 This committee shall meet at least quarterly and shall report thereon to the Medical Executive Committee.

11.8 OPERATING ROOM COMMITTEE

This committee shall consist of six (6) voting members with at least one representative from the Department of Surgery, Obstetrics/Gynecology, and Anesthesiology, as well as three non-voting nursing and support personnel. It shall be responsible for supervision and surveillance of the workings of the operating room, including rules, recommendations and regulations.

This committee shall meet as necessary, and not less than four (4) times per year.

11.9 INSTITUTIONAL REVIEW COMMITTEE

The Institutional Review Board shall review, approve the initiation of, and conduct continuing review of biomedical research involving human subjects in accordance with FDA regulations and hospital policy. The IRB shall have the authority to approve, require modifications of, or disapprove research conducted at the Medical Center.

This committee shall meet as necessary, and not less than four (4) times per year.

11.10 RADIATION SAFETY COMMITTEE

This committee shall consist of a staff member from the Department of Radiology, and representatives from administration and nursing. Additional members may be drawn from nuclear medicine and the medical staff at large. Its responsibilities shall be to supervise the usage and handling and storage of all radio isotopic materials as required. Also, it shall be responsible for monitoring the Radiation Exposure Badge Program.

This committee shall meet as necessary, and not less than four (4) times per year.
11.11 BYLAWS, RULES, REGULATIONS COMMITTEE

The President of the Medical Staff shall appoint members of the medical staff, the majority of whom have held medical staff office or Medical Executive Committee membership, and support personnel, to this committee. This committee shall be responsible for making recommendations for the revision and updating of the bylaws, rules and regulations of the medical staff.

This committee shall meet as necessary.

11.12 PHYSICIAN HEALTH COMMITTEE

The Impaired Physician Committee shall consist of five members of the medical staff who are appointed by the President of the Medical Staff. One member of the committee shall be the Chief Medical Officer, and when appropriate, a physician staff member who has successfully completed a drug or alcohol rehabilitation program. Each committee member's term shall be two years with not more than three members' terms ending each year. The committee will function as a peer review organization and its duties shall be:

1. To establish a program for identifying, contacting and offering rehabilitation and help to physicians who have become professionally impaired to various degrees because of drug dependence, including alcoholism, and mental, physical and aging problems.

2. When intervention by the Physician Health Committee and reasonable rehabilitation efforts fail, to refer impaired physicians to the Medical Executive Committee of the medical staff through the Chief Medical Officer and the President of the Medical Staff.

This committee shall meet as necessary.

11.13. CANCER COMMITTEE

The committee shall include representatives involved in the care of cancer patients, including but not limited to: surgery, medical oncology, gynecology, diagnostic and therapeutic radiology, and pathology, nursing, social service, cancer registry, administration, performance improvement, and a cancer liaison physician.
Additional members may also be drawn from rehabilitation service, medical records, clergy, pharmacy, and nutrition service.

Responsibilities:

1. Plan, initiate, stimulate and assess the results of cancer related activities in the institution, including the organization of regular, educational and consultative Cancer Conferences.

2. To facilitate the provision of consultative services in the major disciplines for cancer patients.

3. To plan and implement a minimum of two patient care evaluation studies annually.

4. To support the availability of cancer rehabilitation services.

5. To encourage development of a support care system for the patient dying from cancer.

6. To oversee and monitor the Cancer Registry system.

Meetings: The committee will meet as necessary, and not less than quarterly. The committee meetings will be for policy decisions and patient care evaluation as distinguished from Cancer Conference, which is for educational, consultational purposes.

11.14 Blood Utilization Committee

The committee shall include the Director of the Blood Bank and representatives from the Division of Hematology Immunology, nursing services and Medical Center administration.

Responsibilities:

1. Investigate suspected transfusion reactions.

2. Recommend policies regarding transfusion policies.
3. Strive to improve utilization of blood and blood products by the Medical Center staff.

Meetings: The Committee will meet at least quarterly.

11.15 NOMINATING COMMITTEE

The nominating committee shall consist of three members of the active medical staff, one of whom is appointed by the Chief Medical Officer, and two who are elected by the medical staff at a regular meeting in April. This committee shall offer nominees for medical staff office and for positions on the Medical Executive Committee as required by Articles IX and XI of these bylaws.

11.16 PHYSICIANS’ PERFORMANCE IMPROVEMENT SUBCOMMITTEE

The committee shall be a subcommittee of the Hospital wide Performance Improvement Committee. It shall include the President of the Medical Staff, Vice President of the Medical Staff, Chief Medical Officer, Past President of the Medical Staff, Past Chair of the Physician's Performance Improvement Subcommittee and other members of the Medical Staff as defined by the Hospital wide PI Plan.

Duties:

To monitor and develop the Performance Improvement program of the medical staff and to attempt to assure that quality-cost effective healthcare is provided, and risk of medical malpractice and general liability is minimized.

Meetings:

It shall meet monthly and submit a report to the Medical Executive Committee containing appropriate recommendations.

11.17 UTILIZATION REVIEW COMMITTEE

The committee shall include five (5) members; including two (2) representatives (Director-RN and Assistant Director-SW) from the Integrated Care Management Department, one (1)
representative from Nursing, and two (2) physicians from the Medical Staff.

Duties: This committee will provide review for Medicare and Medicaid patients with respect to the medical necessity of:

A) Admissions to the institution,
B) The duration of stays that are reasonably assumed to be outlier cases based on extended lengths of stay,
C) Professional services furnished, including drugs and biologicals that are reasonably assumed to be outlier cases based on extraordinary high costs.
ARTICLE XII - MEETINGS

12.1 GENERAL STAFF MEETINGS

12.1-1 Regular Meetings. The staff shall hold meetings on the third Tuesday of April and October of each year. The October meeting constitutes the annual meeting at which the election of officers for the following Medical Staff Year shall be conducted.

12.1-2 Special Meetings. Special meetings of the staff may be called at any time by the Board, the President of the Medical Staff, the Medical Executive Committee, or shall be called by the President of the Medical Staff within fourteen (14) days after receipt of a written request of at least twenty-five percent (25%) of the members of the active staff, and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting except that stated in the meeting notice.

12.1-3 Order of Business and Agenda. The order of business at a regular meeting shall be determined by the President of the Medical Staff. The agenda shall include at least:

A. Reading and acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting;

B. Administrative reports from the President, the President of the Medical Staff, departments and committees;

C. The election of officers and of representatives to staff committees, when required by these bylaws;

D. Reports by responsible officers, committees, and departments on the overall results of patient care audit and other quality maintenance activities of the staff and on the fulfillment of the other required staff functions;

E. Recommendations for improving patient care within the Medical Center; and
F. New business.

12.2 COMMITTEE AND DEPARTMENT MEETINGS

12.2-1 Regular Meetings. Committees, departments and divisions may, by resolution, provide for the time for holding regular meetings and no notice other than such resolution shall then be required. The frequency of such meetings shall be as required by these bylaws.

12.2-2 Special Meetings. A special meeting of any committee, department or division may be called by, or at the request of, the chair or chief thereof, the Board, the President of the Medical Staff, or shall be called by the chair or chief within fourteen (14) days after receipt of a written request of at least twenty-five percent (25%) of the group's then current members. No business shall be transacted at any special meeting except that stated in the meeting notice.

12.3 NOTICE OF MEETINGS

Written or printed notice stating the place, day and hour of any general staff meeting, of any special meeting, or of any regular committee, department, or division meeting not held pursuant to resolution shall be delivered either personally or by mail to each person entitled to be present thereat not less than four (4) days nor more than ten (10) days before the date of such meeting. Notice of department, division and committee meetings may be given orally. If mailed, the notice of the meeting shall be deemed delivered twenty-four (24) hours after deposited, postage prepaid, in the United States mail, addressed to each person entitled to such notice at his/her address as it appears on the records of the Medical Center. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

12.4 QUORUM

12.4-1 General Staff Meetings.

The quorum requirement for the General Staff Meeting shall be those members present and voting.
12.4-2 Department, Division and Committee Meetings

With the exception of the Medical Executive Committee, the Credentials Committee, and the Institutional Review Board which require fifty percent (50%) of the voting members present, the quorum requirement for Department, Division and Committee Meetings shall be those members present and voting. Ex-officio members shall not be counted in determining the presence of a quorum.

12.5 MANNER OF ACTION

Except as otherwise specified in these bylaws, the action of a majority of the members present and voting, which includes more than fifty percent (50%) active staff members, at a meeting at which a quorum is present, shall be the action of the group. Action may be taken without a meeting by a department, division or committee by a writing setting forth the action so taken signed by each member entitled to vote thereat. Members of committees appointed by the President of the Medical Staff in conformity with Section 11.1 shall have the same rights and privileges as members of the staff serving on the committees.

12.6 MINUTES

Minutes of all meetings shall be prepared by the secretary of the meeting and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer, distributed to the attendees, and made available to the medical staff. A permanent file of the minutes of each meeting shall be maintained.

12.7 ATTENDANCE REQUIREMENTS

Regular Attendance: Meeting attendance requirements for the following meetings shall be:

Medical Executive Committee, Credentials Committee, and Institutional Review Board:
Fifty percent (50%) of all meetings.
12.7-2 Absence from Meetings

Any staff member who is compelled to be absent from any staff, department, division or committee meeting shall promptly provide, in writing, to the regular presiding officer thereof, the reason for such absence. Failure to meet the attendance requirements of Section 12.7-1 shall be grounds for any of the corrective actions specified in Article VII and, in addition, removal from such department, division or committee, unless the Medical Executive Committee finds that the submitted reasons for absences are valid, and that the staff member has attended at least twenty-five percent (25%) of the meetings other than those for which valid reasons for absences were submitted. Reinstatement of a staff member whose membership has been revoked because of absence from meetings shall be made only on application, and any such application shall be processed in the same manner as an application for initial appointment.

12.7-3 Special Appearance

Whenever a pattern of suspected deviation from standard clinical or professional practice is to be reviewed at an administrative level, a performance improvement committee, or a department or division meeting, the VPMA, President of the Medical Staff, or the applicable Department or Division Chair may require the practitioner to confer with him or with a standing or ad hoc committee considering the matter. The staff member involved in the patient's treatment shall be given written special notice at least seven (7) days prior to the meeting. The notice shall (1) include a statement of the issue involved, and (2) inform the staff member that his/her appearance is mandatory. Failure of a staff member to appear at any meeting with respect to which he/she was given such special notice shall, unless excused by the Medical Executive Committee upon a showing of good cause, result in an automatic suspension of all or such portion of the staff member's clinical privileges as the Medical Executive Committee may direct. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Medical Executive Committee, or the Board, or through corrective action if necessary.

This section shall not apply to case reviews done in the usual course of utilization and quality assurance activities.
ARTICLE XIII - CONFIDENTIALITY, IMMUNITY AND RELEASE

13.1 SPECIAL DEFINITIONS

A. Information means records of proceedings, minutes, records, reports, memoranda, statements, recommendations, data and other disclosures whether in written or oral form relating to any of the subject matter specified in Section 13.5-2.

B. Malice means the dissemination of a known falsehood, or of information with a reckless disregard for whether it is true or false, or the absence of a reasonable belief that an action, statement or recommendation is warranted by the facts.

C. Practitioner means a staff member or applicant.

D. Representative means the Board and any member or Committee thereof, the President, the staff organization and any member, officer, department, service or committee thereof, and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

E. Third Parties means both individuals and organizations providing information to any representative.

13.2 AUTHORIZATIONS AND CONDITIONS

By applying for, or exercising, clinical privileges within this Medical Center, a practitioner:

A. Authorizes representatives of the Medical Center and the staff to solicit, provide and act upon information bearing on his/her professional ability and qualifications;

B. Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article; and
C. Acknowledges that the provisions of this Article are express conditions to his/her application for, or acceptance of, staff membership, or his/her exercise of clinical privileges at this Medical Center.

13.3 CONFIDENTIALITY OF INFORMATION

Information with respect to any practitioner submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of achieving and maintaining quality patient care, shall to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a representative, or used in any way except as provided herein. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's file or of the general Medical Center records.

13.4 IMMUNITY FROM LIABILITY

13.4-1 For Action Taken

No representative of the Medical Center or staff shall be liable in any judicial proceeding for damages or other relief for any action taken or statement or recommendation made within the scope of his/her duties as a representative, if such representative acts in good faith and without malice. Regardless of any provisions of state law to the contrary, truth shall be an absolute defense for a representative in all circumstances.

13.4-2 For Providing Information

No representative of the Medical Center or staff and no third party shall be liable in any judicial proceeding for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this Medical Center or staff or to any other hospital, organization of health professionals, or other health-related or educational institution or organization concerning a practitioner who is or has been an applicant to or member of the staff or who did or does exercise clinical privileges at this Medical
Center, provided that such representative or third party acts in good faith and without malice.

13.5 ACTIVITIES AND INFORMATION COVERED

13.5-1 Activities

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other educational or health-related institution's or organization's activities concerning, but not limited to:

A. Applications for appointment and clinical privileges.

B. Periodic reappraisals for reappointment and clinical privileges.

C. Corrective Action.

D. Hearings and appellate reviews.

E. Patient care audits.

F. Utilization review, and

G. Other Medical Center, department, division, committee and subcommittee activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

13.5-2 Information

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, professional ethics, ability to work cooperatively with others or any other matter that might directly or indirectly affect patient care or the efficient functioning of an institution or organization.
13.6 RELEASES

Each practitioner shall, upon request of the Medical Center, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of New Jersey, and such releases or copies thereof may be submitted to third parties from whom information as described in Section 13.5-2 is sought. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

13.7 CUMULATIVE EFFECT

Provisions in these bylaws and in application forms relating to authorizations, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.
ARTICLE XIV - GENERAL PROVISIONS

14.1  STAFF RULES AND REGULATIONS

Subject to approval by the Board, the staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these bylaws. These shall relate to the proper conduct of staff organizational activities as well as embody the level of practice that is to be required of each staff member or allied health practitioner in the Medical Center. Such rules and regulations shall be a part of the bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Board.

14.1-2 In addition to the Medical Staff Bylaws, there shall be Medical Staff Policies and Rules and Regulations.

14.1-3 The MEC and Board shall have the power to provisionally adopt urgent amendments to the Rules and Regulations that are needed in order to comply with the law or regulation without providing prior notice of the proposed amendments to the Medical Staff. Notice of all provisionally adopted amendments shall be provided to each member to the Medical Staff as soon as possible. The Medical Staff shall have 14 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 shall stand. If there is conflict over the provisional amendments, then the process for resolving conflict shall be implemented.

14.1-4 All other policies of the Medical Staff may be adopted and amended by a majority vote of the MEC. No prior notice is required.

14.1-5 Amendments to the Medical Staff Policies and Rules and Regulations may also be proposed by a petition signed by 25% of the voting members of the Medical Staff. Any such proposed amendments will be reviewed by the MEC.
14.1-6 Adoption of the changes to the medical staff rules and regulations, and other medical staff policies will become effective only upon approval by the Board.

14.2 DEPARTMENT AND DIVISION RULES AND REGULATIONS

Subject to the approval of the Medical Executive Committee and the Board, each department and division shall formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these bylaws, the general rules and regulations of the staff, or other policies of the Medical Center. A permanent file of current department and division rules and regulations shall be maintained by the President of the Medical Staff.

14.3 FORMS

Application forms and any other prescribed forms required by these bylaws for use in connection with staff appointments, reappointments, delineation of clinical privileges, corrective action, notices, recommendations, reports, and other matters shall be adopted by the Board after considering the advice of the Medical Executive Committee.

14.4 HEADINGS

The captions or headings in these bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these bylaws.

14.5 TRANSMITTAL OF REPORTS

Reports and other information which these bylaws require the staff to transmit to the Board shall be deemed so transmitted when delivered, unless otherwise specified, to the President.
14.6 **GOOD STANDING**

The prerogatives and rights provided by these bylaws to staff members to vote at staff meetings, to be nominated for and to hold staff office or serve as a member of the Medical Executive Committee, and to serve as a department or division officer or committee chair, shall be limited to members in good standing.

14.7 **CONFLICTS OF INTEREST**

14.7-1 When performing a function outlined in these Bylaws, or the Rules and Regulations, if any Medical Staff member has or reasonably could be perceived as having a conflict of interest or a bias in any credentialing or peer review matter involving another individual, the individual with a conflict shall not participate in the final discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual may provide relevant information and may answer any questions concerning the matter before leaving.

14.7-2 Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of President of the Medical Staff (or to the Vice President if the President of the Medical Staff is the person with the potential conflict), or the applicable Department or Committee Chair. The President of the Medical Staff or the applicable Department or Committee Chair will make a final determination as to whether the provisions in this Article should be triggered.

14.7-3 The fact that a Department Chair or staff member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No staff member has a right to compel disqualification of another staff member based on an allegation of conflict of interest.

14.7-4 The fact that a committee member or Medical Staff leader voluntarily chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.
ARTICLE XV - ADOPTION AND AMENDMENT OF BYLAWS

15.1 STAFF RESPONSIBILITY AND AUTHORITY

The staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend to the Board medical staff bylaws and amendments thereto which shall be effective when approved by the Board. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner.

Members of the medical staff and other individuals who have delineated clinical privileges are provided with revised texts of the written materials when significant changes are made in the bylaws, rules and regulations of policies of the medical staff.

15.2 METHODOLOGY

Medical staff bylaws may be adopted, amended, or repealed by the combined action of Sections 15.2-1, 15.2-2, 15.2-3 and 15.2-4 as cited below:

15.2-1 Staff or Medical Executive Committee

Amendments, adoptions, or repeal of Article 6 (Delineation of Privileges) 6.1 to 6.4; Article 7 (Corrective Action); Article 8 (Interviews, Hearing and Appellate Review); Article 9 (Officers of the Staff and Departments); Article 11.2-1 (Medical Executive Committee); Article 15 (Adoption and Amendment of Bylaws); or Article 16 (Fair Hearing Plan) require the action listed under 15.2-2. All other amendments, adoptions, or repeal of the bylaws may be satisfied by the action listed under 15.2-1 (a) or 15.2-1(b).

15.2-1(a) Staff

The affirmative vote of the majority of the staff members eligible to vote on this matter who are present at a meeting, provided at least fourteen (14) days written notice, accompanied by the proposed bylaws and/or alterations, has been given of the intention to take such action.
15.2-1(b) Medical Executive Committee

The affirmative vote of a majority of the voting members of the Medical Executive Committee.

15.2-2 Board

The affirmative vote of a majority of the Board. Provided, however, that in the event that the staff shall fail to exercise its responsibility and authority as required by Section 15.1, and after notice from the Board to such effect including a one-hundred and twenty (120) day period of time for response, the Board may resort to its own initiative formulating or amending medical staff bylaws. In such event, staff recommendations and views shall be carefully considered by the Board during its deliberations and in its actions which shall be pursuant to this section.

15.2-3 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 Medical Executive Committee.

All proposed amendments must be reviewed by the MEC prior to a vote by the Medical Staff. The MEC shall provide notice of all proposed amendments including amendments proposed by a petition of 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 meeting of the medical staff, or a special meeting called for such purpose.

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 members at the meeting.

15.2-4 The MEC may also present any proposed amendments to the voting staff by written or electronic ballot, returned to the medical staff office by the date stipulated by the MEC. Along with the proposed amendments, the MEC may at its discretion, provide a written report of
them either favorably or unfavorably. To be adopted an amendment must receive a majority of the votes cast.

The MEC shall 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. All amendments shall be effective only upon approval by the Board. If the Board has determined to not to accept the recommendations 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 shall be for the purpose of further communicating the Board’s rationale for this action and permitting the officers of the Medical Staff to discuss the rationale for the recommendations. Such a conference will be scheduled by the CEO within two (2) weeks after receipt of a request.

15.3 CONFLICT MANAGEMENT PROCESS

15.3-1 When there is a conflict between the Medical Staff and the MEC with regard to:

a. Proposed amendments to the Medical Staff Rules and Regulations,

b. A new policy proposed by the MEC, or

c. Proposed amendments to an existing policy that is under the authority of the MEC, a special meeting of the Medical Staff will be called in accordance with the process for calling special meetings. The agenda for that meeting will be limited to the amendment or policy at issue. The purpose of the meeting is to strive to resolve the differences that exist with respect to medical staff rules and regulations or policies.

15.3-2 If the differences cannot be resolved, the MEC shall 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.
DEFINITIONS

The following definitions, in addition to those stated in other provisions of the medical staff bylaws, shall apply to the provisions of this Fair Hearing Plan:

1. **Appellate Review Body** means the group designated pursuant to Section 16.5-4 of this Plan to hear a request for appellate review properly filed and pursued by a practitioner.

2. **Hearing Committee** means the committee appointed pursuant to Section 16.2-3 of this Plan to hear a request for an evidentiary hearing properly filed and pursued by a practitioner.

3. **Parties** means the practitioner who requested the hearing or appellate review and the body upon whose adverse action a hearing or appellate review request is predicated.

16.1 INITIATION OF HEARING

16.1-1 **Recommendations or Actions**

The following recommendations or actions shall, if deemed adverse pursuant to Section 16.1-2, entitle the practitioner affected thereby to a hearing:

A. Denial of initial staff appointment,
B. Denial of reappointment,
C. Suspension of staff appointment,
D. Revocation of staff appointment,
E. Denial of requested modification of staff category,
F. Reduction in staff category,
G. Limitation of admitting prerogatives,
H. Denial of requested department or division assignment,

I. Denial of requested clinical privileges,

J. Reduction in clinical privileges,

K. Suspension of clinical privileges

L. Revocation of clinical privileges

M. Terms of probation, and

N. Requirement of consultation

16.1-2 Actions Not Grounds for Hearing

None of the following actions will constitute grounds for a hearing, and they will take effect without hearing or appeal, provided that the individual will be entitled to submit a written explanation to be placed into his or her file:

A. issuance of a letter of guidance, counsel, warning, or reprimand;

B. imposition of conditions, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);

C. termination of temporary privileges;

D. automatic relinquishment of appointment or privileges;

E. imposition of a requirement for additional training or continuing education;

F. precautionary suspension;

G. denial of a request for leave of absence, or for an extension of a leave;

H. determination that an application is incomplete;
I. determination that an application will not be processed due to a misstatement or omission; or

J. determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract, or by virtue of their employment contract.

16.1-3 When Deemed Adverse

A recommendation or action listed in Section 16.1-1 shall be deemed adverse only when it has been:

A. Recommended by the Medical Executive Committee; or

B. Taken by the Board contrary to a favorable recommendation by the Medical Executive Committee under circumstances where no prior right to a hearing existed; or

C. Taken by the Board on its own initiative without benefit of a prior recommendation by the Medical Executive Committee.

16.1-4 Notice of Adverse Recommendation or Action

The President will promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice will contain:

A. a statement of the recommendation and the general reasons for it;

B. a statement that the individual has the right to request a hearing on the recommendation within thirty (30) days of receipt of this notice; and

C. a copy of this Article.

16.1-5 Request for Hearing

A practitioner shall have thirty (30) days following his/her receipt of a notice pursuant to Section 16.1-4 to file a written request for a hearing. Such request shall be deemed
to have been made when delivered to the President in person or when sent by registered mail to the President, properly addressed and postage prepaid.

16.1-6 Waiver by Failure to Request a Hearing

A practitioner who fails to request a hearing within the time and in the manner specified in Section 16.1-5 waives any right to such hearing and to any appellate review to which he/she might otherwise have been entitled. Such waiver in connection with:

A. An adverse action by the Board shall constitute acceptance of that action, which shall thereupon become effective as the final decision of the Board.

B. An adverse recommendation by the Medical Executive Committee shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending the final decision of the Board. The Board shall consider the committee's recommendations at its next regular meeting following waiver. In its deliberations the Board shall review all the information and material considered by the committee and may consider all other relevant information received from any source in making its final decision.

The President shall promptly send the practitioner special notice informing him/her of each action taken pursuant to this Section 16.6-1 and shall notify the president of the staff of each such action.

16.2 HEARING PREREQUISITES

16.2-1 Notice of Time and Place of Hearing

Upon receipt of a timely request for hearing, the President shall deliver such request to the president of the medical staff or to the Board, depending on whose recommendation or action prompted the request for hearing. The president of the staff or the Board, as applicable, shall promptly schedule and arrange for a hearing. At least fifteen (15) days prior to the hearing, the President shall send the practitioner special notice of the time, place, and date of the
hearing. The hearing date shall be not less than thirty (30) days nor more than forty-five (45) days from the date of receipt of the request for hearing; provided, however, that a hearing for a practitioner who is under suspension then in effect shall be scheduled to be held as soon as the arrangements for it may reasonably be made, but not later than thirty (30) days from the date of receipt of the request for hearing.

16.2-2 Statement of Reasons

The notice of hearing required by Section 16.2-1 shall contain a concise statement of the practitioner's alleged acts or omissions, a list by number of the specific or representative patient records in question, and/or the other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing.

16.2-3 Appointment of Hearing Committee.

A. By Staff

A hearing occasioned by a Medical Executive Committee recommendation pursuant to Section 16.1-2A shall be conducted by a hearing committee appointed by the President of the Medical Staff and composed of at least five (5) members of the active staff. One of the members so appointed shall be designated as chair.

B. By Board

A hearing occasioned by an adverse action of the Board pursuant to Section 16.1-2B or C shall be conducted by a hearing committee appointed by the Chair of the Board and composed of at least five (5) members. At least two (2) active staff members chosen with the advice of the President of the Medical Staff shall be included on this committee when the issues concern professional competence or performance. One of the appointees to the committee shall be designated as chair.

C. Service on Hearing Committee. A staff or Board member shall not be disqualified from serving on a hearing committee merely because he/she has heard of the case or has knowledge of the facts involved or what he/she supposes the facts to be. In any event, all members of a hearing committee shall be required to consider and decide the case with good faith objectivity.
D. Employment by, or other contractual arrangement with, the Medical Center or an affiliate shall not preclude an individual from serving on the Panel. The Panel shall not include any individual who is in direct economic competition with the individual requesting the hearing. The Panel shall not include any individual who is professionally associated with, related to, or involved in a referral relationship with, the individual requesting the hearing, and the Panel shall not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

16.2-4 Pre-hearing Procedures

A. General Procedures:

The pre-hearing and hearing processes will be conducted in an informal manner. Formal rules of evidence or procedure will not apply.

B. Provision of Relevant Information:

1. Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

2. Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with a copy of the following:

   (a) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual’s expense;
(b) reports of experts relied upon by the Medical Executive Committee;

(c) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and

(d) copies of any other documents relied upon by the Medical Executive Committee.

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

3. The individual will have no right to discovery beyond the above information. No information will be provided regarding other practitioners.

4. Prior to the pre-hearing conference, on dates set by the Presiding Officer or agreed upon by both sides, each party will provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, will be submitted in writing in advance of the pre-hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.

5. Evidence unrelated to the reasons for the recommendation or to the individual’s qualifications for appointment or the relevant clinical privileges will be excluded.

6. Neither the individual, nor his or her attorney, nor any other person acting on behalf of the individual will contact Medical Center employees appearing on the Medical Executive Committee’s witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

C. Pre-Hearing Conference:

The Presiding Officer will require the individual or a representative (who may be counsel) for the individual and for the Medical Executive Committee to participate in a pre-hearing conference. At the pre-hearing conference,
the Presiding Officer will resolve all procedural questions, including any objections to exhibits or witnesses. The Presiding Officer will establish the time to be allotted to each witness's testimony and cross-examination. It is expected that the hearing will last no more than fifteen (15) hours, with each side being afforded approximately seven and a half (7-1/2) hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing will be concluded after a maximum of fifteen (15) hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

D. Stipulations:

The parties and counsel, if applicable, will use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

E. Provision of Information to the Hearing Panel:

The following documents will be provided to the Hearing Panel in advance of the hearing: (a) a pre-hearing statement that either party may choose to submit; (b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and (c) stipulations agreed to by the parties.

16.3 HEARING PROCEDURE

16.3-1 Personal Presence. The personal presence of the practitioner who requested the hearing shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner and with the same consequence as provided in Section 16.1-5.

16.3-2 Presiding Officer. Either the hearing officer, if one is appointed pursuant to Section 16.8-1, or the chairperson of the hearing committee shall be the presiding officer. The presiding officer shall act to maintain
decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He/She shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence.

16.3-3 Representation. The practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by a member of the staff in good standing or by a member of his/her local professional society. The Medical Executive Committee or the Board, depending upon whose recommendation has prompted the hearing, shall appoint one of its members, or in the case of the Medical Executive Committee, any staff member, to represent it at the hearing, to present the facts in support of its adverse recommendation or action, and to examine witnesses. Representation of either party by an attorney at law shall be governed by the provisions of Section 16.8-2.

16.3-4 Rights of Parties. During a hearing, each of the parties shall have the right to:

A. Call and examine the witnesses,
B. Introduce exhibits
C. Cross-examine any witness on any matter relevant to the issues,
D. Impeach any witness,
E. Rebut any evidence, and/or
F. Request that the record of the hearing be made by use of a court reporter or an electronic recording unit.

If the practitioner who requested the hearing does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

16.3-5 Procedure and Evidence. The hearing shall not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party shall, prior to or during the
hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become a part of the hearing record. The presiding officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by him/her and entitled to notarize documents.

16.3-6 Evidentiary Notice. In reaching a decision, the hearing committee may take note, for evidentiary purposes, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the state of New Jersey. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be recited in the hearing record. Any party shall be given opportunity, on timely request, to request that a matter be evidentially noticed and to refute the evidentially noticed matters by evidence or by written or oral committee. The committee shall also be entitled to consider any pertinent material contained on file in the hospital, and all other information that can be considered, pursuant to the medical staff bylaws, in connection with applications for appointment or reappointment to the staff and for clinical privileges.

16.3-7 Burden of Proof

When a hearing relates to Section 16.1-lA, E, H, or I, the practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation or action lacks any factual basis or that such basis or the conclusions drawn therefrom are either arbitrary, unreasonable, or capricious. Otherwise, the body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support thereof, but the practitioner shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or action by clear and convincing evidence that the grounds therefor lack any factual basis or that such basis or the conclusions drawn therefrom are either arbitrary, unreasonable, or capricious.

16.3-8 Record of Hearing

A record of hearing shall be kept that is of sufficient accuracy to assure that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a recommendation or
decision in the matter. The hearing committee chair, unless his/her decision is reversed by a majority vote of the hearing committee, shall select the method to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceedings. A practitioner requesting an alternate method under Section 16.3-4F shall bear the primary cost thereof.

16.3-9 Postponement

Requests for postponement of a hearing shall be granted by the hearing committee only upon a showing of good cause.

16.3-10 Recesses and Adjournment

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

16.4 HEARING COMMITTEE REPORT AND FURTHER ACTION

16.4-1 Hearing Committee Report

Within fifteen (15) days after final adjournment of the hearing, the hearing committee shall make a written report of its findings and recommendations in the matter and shall forward the same, together with the hearing record and all other documentation considered by it, to the body whose adverse recommendation or action occasioned the hearing.

16.4-2 Action on Hearing Committee Report

Within thirty (30) days after receipt of the report of the hearing committee, the medical executive committee or the Board, as the case may be, shall consider the same and affirm, modify or reverse its recommendation or action in the matter. It shall transmit the result, together with the hearing record, the report of the hearing committee and all other documentation considered, to the President, and the secretary of the staff.
16.4-3 Notice and Effect of Result

A. Notice. The secretary-treasurer shall promptly send a copy of the result to the practitioner by special notice, to the president of the staff, and to the Board.

B. Effect of Favorable Result

1. Adopted by the Board - If the Board's result pursuant to Section 16.4-2 is favorable to the practitioner, such result shall become the final decision of the Board and the matter shall be considered closed.

2. Adopted by the Medical Executive Committee - If the Medical Executive Committee's result pursuant to Section 16.4-2 is favorable to the practitioner, the President shall promptly forward it, together with all supporting documentation, to the Board for its final action. The Board shall take action thereon by adopting or rejecting the Medical Executive Committee's result in whole or in part, or by referring the matter back to the Medical Executive Committee for further recommendation.

Any such referral back shall state the reasons therefor, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take final action. The President shall promptly send the practitioner special notice informing him/her of each action taken pursuant to this Section 16.4-3B.2.

Favorable action shall become the final decision of the Board, and the matter shall be considered finally closed. If the Board's action is adverse in any of the respects listed in Section 16.1-1, the special notice shall inform the practitioner of his/her right to request an appellate review by the Board as provided in Section 16.5-1 of this Plan.

C. Effect of Adverse Result. If the result of the medical executive committee or of the Board pursuant to
Section 16.4-2 continues to be adverse to the practitioner in any of the respects listed in Section 16.1-1, the special notice required by Section 16.4-3A shall inform the practitioner of his/her right to request an appellate review by the Board as provided in Section 16.5-1 of this Plan.

16.5 INITIATION AND PREREQUISITES OF APPELLATE REVIEW

16.5-1 Request for Appellate Review

A practitioner shall have fifteen (15) days following his/her receipt of a notice pursuant to Section 16.4-3B.2 or 16.4-3C to file a written request for an appellate review. Such request shall be deemed to have been made when delivered to the President in person or when sent by registered mail to the President, properly addressed and postage prepaid, and may include a request for a copy of the report and record of the hearing committee and all other material, favorable or unfavorable, that was considered in making adverse action or result.

16.5-2 Waiver by Failure to Request Appellate Review

A practitioner who fails to request an appellate review within the time and in the manner specified in Section 16.5-1 waives any right to such review. Such waiver shall have the same force and effect as that provided in Section 16.1-5.

16.5-3 Notice of Time and Place for Appellate Review

Upon receipt of a timely request for appellate review, the President shall deliver such request to the Board. The Board shall promptly schedule and arrange for an appellate review which shall be not less than twenty (20) days nor more than thirty (30) days from the date or receipt of the appellate review request; provided, however, that an appellate review for a practitioner who is under a suspension then in effect shall be held as soon as the arrangements for it may reasonably be made, but not later than twenty (20) days from the date of receipt of the request for appellate review. At least fifteen (15) days prior to the appellate review, the President shall send the practitioner special notice of the time, place and date of the review. The time for the appellate review may be extended by the appellate review body for good cause.
16.5-4 Appellate Review Body

The Board shall determine whether the appellate review shall be conducted by the Board as a whole or by an appellate review committee composed of at least seven (7) members of the Board appointed by the chair. If a committee is appointed, one of its members shall be designated as chair.

16.6 APPELLATE REVIEW PROCEDURE

16.6-1 Nature of Proceedings

The proceedings by the review body shall be in the nature of an appellate review based upon the record of the hearing before the hearing committee, that committee's report, and all subsequent results and actions thereon. The appellate review body shall also consider the written statements submitted pursuant to Section 16.6-2 and such other materials as may be presented and accepted under Section 16.6-4 and 16.6-5.

16.6-2 Written Statements

The practitioner seeking the review shall submit a written statement detailing the findings of fact, conclusions and procedural matters with which he/she disagrees, and his/her reasons for such disagreement.

This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the appellate review body through the President at least seven (7) days prior to the scheduled date of the appellate review. A written statement in reply may be submitted by the medical executive committee or by the Board and, if submitted, the President shall provide a copy thereof to the practitioner at least four (4) days prior to the scheduled date of the appellate review.

16.6-3 Presiding Officer

The chair of the appellate review body shall be the presiding officer. He/She shall determine the order of
procedure during the review, make all required rulings, and maintain decorum.

16.6-4 Oral Statement

The appellate review body, in its sole discretion, may allow the parties or their representatives to appear personally and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put to him/her by any member of the appellate review body.

16.6-5 Consideration of New or Additional Matters

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review only under unusual circumstances. The appellate review body, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.

16.6-6 Powers

The appellate review body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the appellate review shall be closed. The appellate review body shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations the appellate review shall be declared finally adjourned.

16.6-7 Action Taken

The appellate review body may recommend that the Board affirm, modify or reverse the adverse result or action taken by the Medical Executive Committee or by the Board pursuant to Section 16.4-2 or 16.4-3B.2, or, in its discretion, may refer the matter back to the hearing committee for further review and recommendation to be returned to it within seven (7) days. Within seven (7) days after receipt of such recommendation after referral, the appellate review body shall make its recommendation to the Board as provided in this Section 16.6-8.
16.6-8 Conclusion

The appellate review shall not be deemed to be concluded until all of the procedural steps provided in Section 16.6 have been completed or waived.

16.7 FINAL DECISION OF THE BOARD

16.7-1 Board Action

Within seven (7) days after the conclusion of the appellate review, the Board shall render its final decision in the matter in writing and the President shall send notice thereof to the practitioner by special notice, and to the Medical Executive Committee. If this decision is in accord with the Medical Executive Committee's last recommendation in the matter, if any, it shall be immediately effective and final. If the Board's action has the effect of changing the Medical Executive Committee's last such recommendation, if any, the Board shall refer the matter to the Joint Conference Professional Affairs committee. The Board's action on the matter following receipt of the Joint Conference Professional Affairs committee recommendation shall be immediately effective and final.

16.7-2 Joint Conference Professional Affairs Committee Review

Within seven (7) days of its receipt of a matter referred to it by the Board pursuant to the provisions of this Plan, the Joint Conference Professional Affairs committee shall submit its recommendation to the Board.

16.8 GENERAL PROVISIONS

16.8-1 Hearing Officer Appointment and Duties

The use of a hearing officer to preside at an evidentiary hearing is optional. The use and appointment of such officer shall be determined by the Board after consultation with the president of the medical staff. A hearing officer may or may not be an attorney at law, but must be experienced in conducting hearings. He/She shall act in an impartial manner as the presiding officer of the
hearing. He/She may not participate in its deliberations and shall not be entitled to vote.

16.8-2 Attorneys. If the affected practitioner desires to be represented by an attorney at any hearing or at any appellate review appearance pursuant to Section 16.6-4, his/her request for such hearing or appellate review must so state. The hearing committee or appellate review body shall, in its sole discretion, determine whether to permit counsel to present the case, or examine or cross-examine witnesses. The foregoing shall not be deemed to limit the practitioner, the Medical Executive Committee or the Board in the use of legal counsel in connection with preparation for a hearing or an appellate review.

16.8-3 Waiver. If at any time after receipt of special notice of an adverse recommendation, action or result, a practitioner fails to make a required request or appearance or otherwise fails to comply with this Fair Hearing Plan, he/she shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights to which he/she might otherwise have been entitled under the medical staff bylaws then in effect or under this Fair Hearing Plan with respect to the matter involved.

16.8-4 Number of Reviews

Notwithstanding any other provision of the medical staff bylaws or of this Plan, no practitioner shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to an adverse recommendation or action.

16.8-5 Release

By requesting a hearing or appellate review under this Fair Hearing Plan, a practitioner agrees to be bound by the provisions of Article XIII of the medical staff bylaws in all matters relating thereto.

ADOPTED: 9/24/91
REVISED: 4/20/93; 4/19/94; 9/20/94; 4/16/96; 11/5/96; 5/5/98; 5/18/99; 11/2/99; 9/18/01, 11/04/02; 10/19/04; 10/18/05; 04/18/06; 10/16/07; 04/15/08; 10/21/08; 4/5/2011, 2/7/2012, 6/11/2013, 06/10/14, 10/21/14