BYLAWS OF THE MEDICAL STAFF
OF
ST. JOSEPH’S HEALTHCARE SYSTEM

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PREAMBLE

St. Joseph's Healthcare System is a not-for-profit corporation organized under the laws of the State of New Jersey that owns and operates two (2) licensed hospitals. St. Joseph's Hospital and Medical Center d/b/a St. Joseph's Regional Medical Center and St. Joseph's Wayne Hospital (the "**Hospital**"), located in Paterson and Wayne respectively. Although each campus is separately licensed, there is a single unified Medical Staff that shall serve, for licensure and accreditation purposes, as the medical staff at each, respective licensed hospital campus of the Hospital.

These Bylaws are adopted to provide for the organization of the Medical Staff of the Hospital and shall provide a framework for self-governance to permit the Medical Staff to discharge its responsibilities in matters involving the quality and efficiency of medical care, and to govern the orderly resolution of those purposes. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Trustees to which the Medical Staff is accountable, and relations with applicants to and members of the Medical Staff. It is the intent of the Board of Trustees and the Medical Staff that these Bylaws shall be binding on any successor to the Hospital so long as the successor maintains a hospital license at either campus.

ARTICLE I – NAME AND PURPOSES

1.1 **NAME**: The name of this organization shall be the St. Joseph's Healthcare System Medical Staff (the "Medical Staff").

1.2 **PURPOSES**: The purposes of this organization are to:

a. provide all patients admitted to or treated in any of the facilities, divisions, or services of the Hospital with quality care which is efficient;
b. provide professional performance at the recognized level of quality and efficiency by all members of the Medical Staff through the appropriate delineation of privileges to practice in the Hospital and continual review and evaluation of the activities of all individuals granted clinical privileges in the Hospital;
c. provide education and maintain appropriate scientific and educational standards and an atmosphere of continuous progress of all members of the Medical Staff in professional knowledge and skill;
d. initiate and maintain Rules and Regulations for Medical Staff self-governance, consistent with the Preamble to the Bylaws;
e. review appropriate programs associated with the fulfillment of the purposes of the Hospital and make recommendations to the Board;
f. provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff and its members and by the Medical Staff with the Board and the Chief Executive Officer, and a means for reporting to the Board on the activities of the Medical Staff and on the quality of the medical care; and
g. achieve cooperation between the various Departments of the Medical Staff and personnel of the Hospital.

ARTICLE II - DEFINITIONS AND GENERAL PROVISIONS

2.1 **DEFINITIONS**: Except as specifically provided in these Bylaws, the following definitions shall apply in interpreting these Bylaws:

a. **ACADEMIC CHAIRPERSON** – the individual appointed by the Chief Executive Officer as the head of a System medical department.
b. **ALLIED HEALTH PROFESSIONAL (AHP**) – an individual, other than a licensed physician, dentist, or podiatrist, who exercise independent judgment within the areas of his professional competence and the limits established by the Board, the Medical Staff and applicable State Practice Acts; who is qualified to render direct or indirect medical, dental, or podiatric care under the supervision or direction of a Medical Staff member possessing privileges to provide such care in the Hospital; and who may be eligible to exercise practice privileges and prerogatives in conformity with the rules adopted by the Board, these Bylaws, and the Medical Staff Rules. AHPs include midwives, physician assistants, advanced practice nurses, registered nurse first assistants and individuals who are licensed in New Jersey as psychologists and/or who are holders of degrees of Ph.D. or Ed.D and who provide services in or to the Hospital. AHPs shall be appointed to a specific Department. AHPs may not admit patients unless authorized by statute and Delineation of Privileges but may provide treatment to patients within their Delineation of Privileges
c. **BOARD CERTIFICATION –** shall mean successful completion of all parts of the board certification process within five (5) years of the last educational experience unless the certifying board identifies a later time period. Board certification must be obtained from a board recognized by the American Board of Medical Specialties, American Osteopathic Association, the American Dental Association, or the American Podiatric Medical Specialties Board or are certified by a comparable, recognized board that is judged to be appropriate by the Credentials Committee
d. **BOARD ELIGIBLE –** shall mean actively engaged in the board certification process and within five (5) years of the last educational experience unless the certifying board identifies a later time period.
e. **BOARD OF TRUSTEES** ("Board") – the governing body of St. Joseph's Healthcare System.
f. **BYLAWS, RULES, AND REGULATIONS** - these Bylaws and all Medical Staff Rules, Regulations, policies and procedures duly adopted as required in these Bylaws, including general, Department, and Division Rules and Regulations.
g. **CDS** - Controlled Dangerous Substance registration
h. **CHIEF** - the head of a Division.
i. **CHIEF EXECUTIVE OFFICER** - the individual appointed by the General Superior of the Sponsor and approved by the Board to carry out its policies in the overall management of the Hospital.
j. **CLINICAL PRIVILEGES** - permission granted to Medical Staff members to provide patient care, including access to those Hospital resources (including

equipment, facilities and Hospital personnel deemed appropriate by the Board) that are necessary to effectively exercise those privileges.

k. **COMPLETE APPLICATION** – shall mean an application for either initial appointment or reappointment to the Medical Staff, or an application for increased clinical privileges. Specifically, to be complete, the application must be submitted on a form approved by the Medical Board and Board of Trustees, and include all required supporting documentation and verifications of information, and any additional information needed to perform the required review of qualifications and competence of the applicant/Member.
l. **CRIMINAL CONVICTION** – shall include the conviction of, or a plea of guilty or nolo contender for any felony, or for any misdemeanor related to the practice of a health care profession, fraud or abuse relating to any governmental health program, third party reimbursement or controlled substance, whether or not an appeal of the conviction has been filed or is pending.
m. **DEA –** Drug Enforcement Agency registration.
n. **DENTIST** - a doctor of dental surgery or dental medicine duly licensed to practice in New Jersey.
o. **DEPARTMENT CHAIRPERSON** – the individual charged with directing the medical departments at each specific site
p. **LICENSED INDEPENDENT PRACTITIONER** – a Medical Practitioner or AHP who may function independently pursuant to their respective licensing agency.
q. **MEDICAL BOARD –** the governing body of the Medical Staff
r. **MEDICAL EXECUTIVE COMMITTEE** - the executive committee of the Medical Staff at each campus.
s. **MEDICAL PRACTITIONER** - a duly licensed medical or osteopathic physician, podiatrist, oral and maxillofacial surgeon, or dentist.
t. **MEDICAL STAFF** - all Medical Practitioners and Allied Health Practitioners duly appointed to Medical Staff membership in accordance with these Bylaws.
u. **MEMBER** – any individual appointed to the Medical Staff.
v. (Any) **NOTICE, REPORT or REQUEST** - required or provided for by these Bylaws (unless a contrary provision is specifically set forth in these Bylaws) to be given, made or delivered, to any person shall be in writing and shall be deemed to have been given, made, received, or delivered when (1) delivered in person, or (2) a period of 72 hours has elapsed from the time it is placed in the United States mail, postage prepaid, certified mail, return receipt requested, or addressed to the person at (a) the Hospital, if the notice, report or request is to be given, made or delivered to the person in his official capacity, or (b) his last known post office address in all other cases.
w. **ORAL SURGEON** - an oral and maxillofacial surgeon licensed to practice oral or maxillofacial surgery in New Jersey.
x. **PEER REVIEW** - the evaluation of an individual physician's professional performance with the goal of objectively evaluating patient care to identify opportunity for improvement.

y. **PHYSICIAN** - a doctor of medicine or osteopathy duly licensed to practice medicine and surgery in New Jersey.

z. **PODIATRIST** - a graduate of Podiatric Medicine approved by the Council of Education of the American Podiatric Medical Association who is licensed to practice podiatry by the New Jersey State Board of Medical Examiners

aa. **SPONSOR** – The Sisters of Charity of Saint Elizabeth.

bb. the **"SYSTEM"** – the St. Joseph's Healthcare System

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2.2 **GENERAL PROVISIONS**: Except as specifically provided in these Bylaws, the following general provisions shall apply in interpreting these Bylaws:

a. Care of Patients:

The care of the patient is the responsibility of the Member of the Medical Staff in whose name the patient has been admitted or to whom the patient has been transferred. Members of the Medical Staff are responsible for providing for continuous care for their patients; providing appropriately credentialed professional coverage when the responsible Member of the Medical Staff is unavailable may carry out this responsibility. It shall be the obligation of the House Staff to assist and be responsible to the responsible practitioner in caring for the patient.

b. Ethics and Ethical Relationships:

Each member of the Medical Staff by acceptance of appointment to the Medical Staff pledges to (a) refrain from fee splitting or other inducements relating to patient referral, (b) refrain from delegating the responsibility for diagnosis, care or consultation of a hospitalized patient to a medical practitioner who is not qualified to undertake the responsibility or who is not adequately supervised, (d) seek consultation whenever necessary, (e) obtain proper informed consent as a prerequisite to any procedure requiring informed consent including the identity of the operating surgeon or the responsible physician, and (f) comply with the Medical Staff Policy on Confidentiality. Failure to fulfill these and other obligations imposed by these Medical Staff Bylaws, Rules and Regulations shall constitute cause for dismissal from the Staff.

c. Forms:

Application forms and any other prescribed forms required by these Bylaws for use in connection with Medical Staff appointments, reappointments, delineation of privileges, corrective action, notices, recommendations, reports and other matters shall be approved by the Medical Board and the Board of Trustees. Upon adoption, they shall be deemed part of the Medical Staff rules. They may be amended by approval of the Medical Board and the Board of Trustees.

d. Dues:

The Medical Board shall have the discretion to establish reasonable annual dues, if any, for each category of Medical Staff membership, and to determine the manner of expenditure of such funds received; however, such expenditures must be appropriate to the purposes of the Medical Staff and shall not

jeopardize the nonprofit tax-exempt status of the hospital. Funds shall be kept in System approved financial institutions.

e. Legal Counsel:
Legal Counsel shall be provided or retained by the Office of the General Counsel. The Medical Staff may, at its expense, retain and be represented by independent legal counsel only upon approval of the Chief Executive Officer and in accordance with the Bylaws of St. Joseph's Healthcare System

f. Authority to Act:
Any member who acts in the name of this Medical Staff without proper authority shall be subject to such disciplinary action, as the Medical Board may deem appropriate.

ARTICLE III - CATEGORIES OF THE MEDICAL STAFF

All appointments to the Medical Staff shall be made by the Board of Trustees upon recommendation of the Medical Board and shall be to one of the following categories of the staff. The categories are as follows:

a. Active Staff
b. Provisional Staff
c. Senior Active Staff
d. Courtesy Staff
e. Consulting Staff
f. Emeritus Staff
g. Teaching Staff
h. House Staff
i. Allied Health Professional Staff
    1. Independent Allied Health Professionals
    2. Dependent Allied Health Professionals
j. Affiliate Staff
k. Telemedicine Staff

All appointees shall be assigned to a specific department/division, but shall be eligible for clinical privileges in other departments/divisions as applied for and recommended pursuant to these bylaws and approved by the Board of Trustees. All Members shall limit the scope of their clinical activities to those specified in the signed statement delineating clinical privileges, a copy of which accompanies their official notice of appointment to the Medical Staff. The requirements and procedures for appointment and reappointment to the Medical Staff and granting and renewing of clinical privileges are set forth in Policy and Procedure on Appointment and Reappointment.

All Medical Staff Members are required to comply with their obligations under the Emergency Medical Treatment and Labor Act (EMTALA) and its corresponding regulations. The purpose of this requirement is to assure that all patients are screened and stabilized within the capability of this Hospital, as required by law. All physicians and dentist members of the Medical Staff are authorized to conduct appropriate medical screening examinations if appropriately credentialed. Other members of the Medical

Staff and members of the Allied Health Professional Staff are also authorized to conduct medical screening examinations if appropriately credentialed to do so.

Except as otherwise specified herein, no practitioner shall admit or provide services to patients in the Hospital unless he/she is a Member of the Medical Staff or has been granted temporary privileges in accordance with the procedures set forth in these Bylaws

3.1 **ACTIVE STAFF**

The Active Staff shall consist of those physicians, dentists and podiatrists who demonstrate substantial commitment to the welfare and programs of the Hospital and who specify such commitment as part of the appointment/reappointment process.

a. Qualifications. Eligibility for membership on the Active Staff is extended to practitioners who meet the following:
   1. Licensed to practice medicine, dentistry, or podiatric medicine in the State of New Jersey and maintain a valid CDS, DEA registration and current malpractice insurance;
   2. Utilization of one of the hospitals as principal site of hospital practice evidenced by performing sufficient medical services at the Hospital to ensure adequate review of clinical competence. For purposes of this ARTICLE 3, a "patient contact" is an admission, a consultation or a procedure in a surgical suite in the Hospital. A Chairperson of a Department has reasonable discretion to waive the patient contact requirement of any Department member upon that member's showing that the reason for the lack of patient contacts is his lack of patient contacts at any hospital. In such an event, that Department member has the burden to demonstrate in writing at the time of reappointment his sufficient quality-of-care by other means in order to maintain privileges. Each Department shall develop standard criteria for making such alternative quality of care determinations, which must be approved by the site Medical Executive Committee.
   3. Agree to assume all the functions and responsibilities of appointment to the Active Staff, including, where appropriate, care for unassigned patients, emergency service care (on-call), consultation;
   4. Participation in educational programs of the departments/divisions and the Hospital in order to assist with the teaching programs;
   5. Participation in quality assessment and monitoring activities, including the evaluation of provisional Members (except Department Chairpersons)
   6. Be board certified or board eligible. In the absence of a certifying board for general dentists and given the limited role of such boards in the dental specialties, dentist and other oral surgeons are exempt from this requirement. If a member of the Active Staff fails to obtain board certification within specified time limits, or is found to be ineligible for further preparation for board certification, the Active Staff appointment will terminate automatically and such physician, oral surgeon or podiatrist will not be entitled to a fair hearing as set forth in the Policy and Procedure on Hearing and Appellate Review.

      Following board certification, failure of a subsequent required board certification

examination by a member shall result in automatic suspension of Medical Staff membership until board certification is reacquired.

7. Be located close enough to the Hospital to fulfill their responsibilities and to provide timely and continuous care for their patents in the Hospital.

b. Prerogatives. Except as provided in these Bylaws, any member of the Active Staff may:
   1. Admit patients consistent with his/her privileges, unless otherwise provided in the Medical Staff Bylaws or Rules and Regulations;
   2. Vote on any matter coming before any meeting of the Medical Staff or of any Department, Division or Committee of which he is a member;
   3. Serve as an officer of the Medical Staff or of any Department or Division of which he/she is a member if the member is a Medical Practitioner and is not concurrently serving as an officer or department chairman of another hospital or competing health organization nor employed on a full-time basis by another hospital or competing health organization; and
   4. Serve on any Committee of the Medical Staff or of any Department or Division of which he is a member.

c. Duties. Each member of the Active Staff shall:
   1. Be required to attend at least 50% of all regular medical staff meetings in each year. A Member who is compelled to be absent from any regular medical staff meeting shall promptly notify the Secretary of the Medical Staff of the reason for such absence. Failure to meet the attendance requirements for regular medical staff meetings shall be grounds for loss of voting privileges. Reinstatement of voting privileges which have been revoked because of absence from staff meetings shall be made only after fulfilling the attendance requirements set forth in these bylaws;
   2. Perform all duties incident to elective or appointed offices when elected or appointed;
   3. Perform all reasonable duties, including inpatient, outpatient and clinic services and emergency and disaster plan duties, when specifically assigned by the Medical Executive Committee or his/her Department or Division;
   4. Pay all dues and special assessments levied by the Medical Staff;
   5. Agree to serve when elected or appointed to a Committee; and
   6. Report to the Vice President of Medical Affairs regarding final judgments or settlements in professional liability actions and supply to the Vice President of Medical Affairs, within thirty (30) days of receipt, a copy of any report or proposed report submitted to the National Practitioner Data Bank or the New Jersey State Board of Medical Examiners with regard to such member.

3.2 PROVISIONAL STAFF

The Provisional Staff shall consist of those Medical Practitioners who shall be considered for advancement to the Active Staff after a probationary period of one (1) year. During this period, the Medical Practitioner's clinical performance shall be evaluated to determine suitability for Active Staff Status. Reappointment to Provisional Staff may be

made for a period of one (1) additional year upon the recommendation of the Academic or Department Chairperson. A Medical Practitioner shall not be appointed to Provisional Staff for more than two (2) years. If, at the completion of this time, the Medical Practitioner has not demonstrated the clinical performance necessary for Active **or** Courtesy Staff, his/her Provisional status and clinical privileges shall automatically terminate, and the Medical Practitioner shall be given written notice of such termination and entitlement to a hearing and appellate review as set forth in the Policy and Procedure on Fair Hearing and Appellate Review.

a. <u>Qualifications.</u> Each member of the Provisional Staff shall have the same qualifications as a member of the Active Staff

b. <u>Prerogatives</u>. Except as provided in these Bylaws, any member of the Provisional Staff may:
    1. Admit patients consistent with his/her privileges, unless otherwise provided in the Medical Staff Bylaws or Rules and Regulations;
    2. **Not** vote on any matter coming before any meeting of the Medical Staff or of any Department, Division or Committee of which he is a member;
    3. **Not** serve as an officer of the Medical Staff or of any Department or Division and
    4. Serve on any Committee of the Medical Staff or of any Department or Division of which he is a member but may **not** serve as a chairperson of a committee.

c. <u>Duties</u>. Each member of the Provisional Staff shall have the same duties as a member of the Active Staff except that Provisional Staff shall not pay dues and assessments.

3.3 SENIOR ACTIVE STAFF

The Senior Active Staff shall consist of Medical Practitioners who have been members of the Active Staff for 25 years or who has attained the age of 60 years plus 10 years of service as an Active Staff member and who elect to change their status.

a. <u>Qualifications</u>. Each member of the Senior Active Staff shall have the same qualifications as a member of the Active Staff

b. <u>Prerogatives.</u> Except as provided in these Bylaws, any member of the Senior Active Staff may:
    1. Admit patients consistent with his/her privileges, unless otherwise provided in the Medical Staff Bylaws or Rules and Regulations;
    2. Vote on any matter coming before any meeting of the Medical Staff or of any Department, Division or Committee of which he/she is a member;
    3. Serve as an officer of the Medical Staff or of any Department or Division. Senior Active Staff appointees shall not be required to serve on medical staff committees, or to accept service/on-call or teaching duties. Each Senior Active Staff member shall indicate the privileges he wishes to retain to his Department Chairman.

c. Duties. Each Senior Active Staff members shall have the same duties as a member of the Active Staff to admit, consult and treat, except they will have no responsibility for clinic or emergency services of the Hospital. Senior Active Staff shall not pay dues and assessments

3.4 COURTESY STAFF

The Courtesy Staff shall consist of Medical Practitioners who qualify for appointment to the Medical Staff but who shall not have more than twelve (12) patient contacts per year.

a. Qualifications. Eligibility for membership on the Courtesy Medical Staff is extended to practitioners who:
   1. Meet the qualifications of Active Staff;
   2. Have or intend to have fewer than twelve (12) patient contacts per year.
   3. Hold an active staff appointment at another accredited hospital.

b. Prerogatives. Except as provided in these Bylaws, any member of the Courtesy Staff:
   1. May admit or treat up to twelve (12) patients per year;
   2. May serve on one (1) Committee upon request of the President of the Medical Staff but may not vote on any matter presented to the Committee;
   3. May not hold any office or vote; and
   4. May attend Medical Staff and department/division meetings.

c. Duties. Each member of the Courtesy Medical Staff shall:
   1. Attend Department or Division meetings at which a patient treated by the member is presented for discussion;
   2. Perform all duties, including outpatient and clinic services and emergency and disaster plan duties, consistent with his Courtesy Medical Staff status assigned by his Department or Division, including Committee service if requested by the President of the Medical Staff;
   3. Shall pay dues and special assessments;
   4. Accept automatic assignment to the Provisional Staff if patient contacts exceed twelve (12) in any year and accept Active Staff status for a minimum of one (1) year thereafter (patient contacts to be assessed quarterly). Medical Practitioner shall be required to pay Active Staff dues upon assignment to Active Staff.

3.5 CONSULTING STAFF

The Consulting Staff shall consist of recognized specialist Medical Practitioners appointed for the specific purpose of providing consultation in the diagnosis and treatment of patients and the administration of clinical department/divisions.

a. Qualifications. Consulting Staff members shall be
   1. Appointed by invitation of the Medical Board, or by formal application, and
   2. Must be board certified and licensed in the State of New Jersey

b. Prerogatives. Appointment to the Consulting Staff does **NOT** entitle the Appointee

1. To admit patients,
2. To vote,
3. To hold staff offices, or
4. To serve on medical staff committees.
5. Consulting Staff are encouraged to attend department/division meetings.
6. Consulting Staff shall contribute to the care of service patients, on request.

c. Duties. Consulting Staff may be called on any case in which consultation is requested or required by the Hospital or the medical staff rules, regulations or policies.

3.6 **EMERITUS STAFF**

The Emeritus Staff shall consist of members of the Medical Staff who do not actively practice at the Hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences or their previous long standing and exemplary service to the Hospital and who continue to exemplify high standards of professional and ethical conduct.

a. Qualifications. Membership on the Emeritus Staff is available (but not required) to any Active Staff or Senior Active Staff who has achieved thirty (30) years of accumulated Active or Senior Active Staff status on the medical staff of Hospital **or** who has reached the age of sixty-five (65) **or** who suffers form poor health which interferes with his ability to exercise his privileges. Emeritus Staff members do not need to reside in the community

b. Prerogatives. Members of the Emeritus Staff may:

1. Serve on committees and vote on such committees
2. Use the medical library
3. Attend meetings of the Department with which they are associated
4. Maintain parking privileges
5. Attend Medical Staff dinners and social functions
6. Received Medical Staff publications

Emeritus Staff shall not:

1. Have voting rights on Medical Staff issues
2. Pay Medical Staff dues
3. Maintain a current license to practice
4. Provide proof of liability insurances
5. Have any clinical privileges.

c. Duties. Emeritus Staff shall have no specific duties but shall be required to abide by these Bylaws, the Rules and Regulations of the Medical Staff and the policies of the Medical Staff Executive Committee as they may apply.

3.7 TEACHING STAFF

The Teaching Staff shall consist of individuals who are recommended by the Academic Chairperson to assist in the didactic teaching of medical students and residents and shall include physicians, dentists, individuals with PhD's and others who may provide required and appropriate educational information.

a. Qualifications. Individuals who are recommended by the Academic Chairman to assist in teaching medical students and residents in the Department and shall include Medical Practitioners and individuals with appropriate doctorate or acceptable graduate degree.

b. Prerogatives. Members of the Teaching Staff
   1. Shall not have admitting or consulting privileges
   2. May serve on Committees
   3. Shall not have voting rights or pay dues

c. Duties. Teaching Staff shall have no specific duties but shall be required to abide by these Bylaws, the Rules and Regulations of the Medical Staff and the policies of the Medical Staff Executive Committee as they may apply.

3.8 HOUSE STAFF

Membership on the House Staff is available to Medical Practitioners who have been engaged or employed by the Hospital to provide hospitalist services in certain of the Departments/Divisions. Members of the House staff are accountable to the Vice President for Medical Affairs and their duties shall be delineated by the appropriate Department/Division, with the approval of the Vice President for Medical Affairs.

a. Qualifications. Each member of the House Staff shall have the same qualifications as a member of the Active Staff

b. Prerogatives. Members of the House Staff
   1. Shall not have admitting or consulting privileges
   2. Shall attend Department meetings as requested
   3. May serve on Committees
   4. Shall not have voting rights or pay dues

c. Duties. House Staff shall have no specific duties but shall be required to abide by these Bylaws, the Rules and Regulations of the Medical Staff and the policies of the Medical Staff Executive Committee as they may apply.

3.9 ALLIED HEALTH PROFESSIONAL STAFF

Allied Health Professionals shall include designated health care professionals; including but not limited to audiologists, doctoral scientists, nurse anesthetists, nurse midwives, advanced practice nurses, physician assistants, physicists, psychologists, registered nurse first assistants and other Health Care Professionals certified or licensed by an appropriate

body and such other individual practitioners as shall be designated from time to time by the Medical Board with approval of the Board of Trustees. Such individuals shall be appointed to a clinical Department of the Medical Staff.

The appropriate Chairperson with the approval of the Medical Board shall delineate clinical privileges of the Allied Health Care Professionals. In each category, the Board of Trustees shall appoint them after submission of an application and recommendation by the appropriate Chairperson, the Credentials Committee and the Medical Board. Members of this Staff category are not Medical Practitioners by definition. The various provisions of these Bylaws and Rules and Regulations shall apply to the Allied Health Professionals only where specifically provided or where the context requires application. Provisions relating to hearings, appeals and appellate review shall apply to Allied Health Professionals.

Certain members of the Allied Health Professionals Staff are authorized to conduct medical screening examinations as defined under federal law. Authorization to conduct medical screening examinations is granted only through an appropriately signed and approved delineation of clinical privileges.

A member of the Allied Health Professionals who is required to have a collaborating physician may not exercise any clinical privileges if there no longer is a collaborating physician. In the event that a member of this staff who is required to have a collaborating physician is no longer sponsored by that physician, the member immediately shall notify the appropriate Chairperson and provide the name of the new collaborating physician or be deemed to have resigned from the Staff

This staff category shall have two (2) groups, the Independent Allied Health Professional and the Dependent Allied Health Professional

3.9.1 **INDEPENDENT ALLIED HEALTH PROFESSIONAL**

This category includes: licensed acupuncturists; certified clinical geneticists; certified nurse midwives; psychologists; advance practice nurses; certified nurse anesthetists; holders of clinical doctoral degrees (such as PharmD.) and other as designated by the Medical Board.

An Independent Allied Health Professional must meet those specific qualifications and may request only those specific practice privileges appropriate to his/her category, as specified by the applicable policies and procedures of the Credentials Committee and these Bylaws.

An Independent Allied Health Professional may not admit or discharge patients unless specifically authorized by an appropriately signed and approved delineation of privileges.

The Independent Allied Health Professional may, within the scope of professional licensure or certification, practice privileges and the rules, regulations, policies and procedures of the Medical Staff and the Hospital:

a. Provide specified patient care services
b. Exercise independent judgment in his/her area of competence and participate directly in the management of patients, provided that a member of the Active Staff within the appropriate department or specialty has overall responsibility for the care provided to each patients

c. Enter reports and progress notes into the medical record and write certain treatment orders for specific patients
d. Serve with voting rights on committees of the Medical Staff and attend Medical Staff and departmental meetings
e. Exercise other prerogatives as specified by the Board.

3.9.2 **DEPENDENT ALLIED HEALTH PROFESSIONAL**

This category includes: physician assistants; registered nurse first assistants and other as designated by the Medical Board.

A Dependent Allied Health Professional must meet those specific qualifications and may request only those specific practice privileges within the scope of the licensing or certification requirements applicable to the profession, and as further specified by the policies and procedures of the Credentials Committee and these Bylaws. A Dependent Allied Health Professional must have a collaboration practice agreement or supervising physician agreement with one or more of the Active Staff who will supervise and assume responsibility for his/her patient care activities and conduct appropriate periodic ongoing evaluation of his/her performance.

A Dependent Allied Health Professional may not independently admit or discharge patients from the Hospital. A Dependent Allied Health Professional may, within the scope of his/her professional licensure or certification, practice privileges and the rules, regulations, policies and procedures of the Medical Staff and the Hospital:

a. provide specified patient care services in collaboration with or under the supervision of his/her collaborating Active Staff member or Members
b. enter reports and progress notes into the medical record and write certain treatment orders for specific patients
c. serve with voting rights on committees of the Medical Staff and attend Medical Staff and departmental meetings
d. exercise other prerogatives, as specified by the Board.

3.10 **AFFILIATE STAFF**

Medical Practitioners who do not meet the qualifications for membership on the Medical Staff but who wish to have an affiliation with the Hospital may apply for and be appointed to the Affiliate Staff. Members of the Affiliate staff shall not be granted any clinical privileges and may not admit or care for patients at the Hospital. They shall be given a Hospital identification badge that shall state "Affiliate Physician".

3.11 **TELEMEDICINE STAFF**

Physicians practicing remotely but providing care via telemedicine, teleradiology or in any other specialty to patients (whether to patients of Hospital or to patients of another facility that Hospital is assisting via telemedicine technology) must apply for and be granted setting and procedure-specific telemedicine privileges. Additionally, Medical Practitioners who are not otherwise member of this Hospital's Medical Staff must apply for and be granted membership and privileges as part of the telemedicine staff in order to provide services to patients of the Hospital.

ARTICLE IV - CLINICAL PRIVILEGES

4.1 Exercise of Privileges:
Medical Staff appointment or reappointment shall not confer any clinical privileges or right to practice in the Hospital. Each Practitioner providing direct clinical services at the Hospital shall be entitled to exercise only those setting-specific procedures approved for him or her.

4.2 Criteria for Privileges:
Subject to the approval of the Medical Board and Board of Trustees, each department will be responsible for developing criteria for granting setting-specific privileges including, but not limited to, identifying and developing criteria for any privileges that may be appropriately performed via telemedicine. These criteria shall assure uniform quality of patient care, treatment, and services.

4.3 Basis for Privilege Determination:
Consideration of requests for privileges shall be based upon the applicant's education, training, experience, demonstrated current competence and judgment, references, utilization patterns, health status, availability of qualified physicians or other appropriate Members to provide medical coverage for the applicant in case of the applicant's illness or unavailability; adequate levels of professional liability insurance coverage with respect to the clinical privileges requested; the Hospital's available resources and personnel; any previously successful or currently pending challenges to any licensure or registration, or the voluntary relinquishment of such licensure or registration, information concerning any voluntary or involuntary termination of medical staff appointment or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital; and other relevant information, including a written report and findings by the chairperson of each of the clinical departments in which such privileges are sought.

The applicant shall have the burden of establishing his or her qualifications for and competence to exercise the clinical privileges requested. The reports of the chairpersons of the clinical departments in which privileges are sought shall be forwarded to the Credentials Committee and thereafter processed as a part of the initial or reappointment application for staff privileges.

4.4 Clinical Privileges for Dentists and Podiatrists:
The scope and extent of surgical procedures that a dentist or podiatrist may perform in the hospital shall be delineated and recommended in the same manner as other clinical privileges. Dentists and Podiatrists may perform a pre-surgical history and physical on their own patients subject to state law and their delineation of privileges however, a designated physician who holds an appointment to the medical staff shall be responsible for the medical care of the patient throughout the period of hospitalization. Dentists and Podiatrists may write orders within the scope of their license and consistent with the medical staff rules and regulations and in compliance with the Hospital and medical staff bylaws and this policy.

(a) The dentist shall be responsible for the dental care of the patient, including the dental history and dental physical examination as well as all appropriate elements of the patient's record.

(b) Surgical procedures performed by podiatrists shall be under the overall supervision of the Chairperson of the Department of Orthopedics. The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination as well as all appropriate elements of the patient's record.

4.5 Clinical Privileges for Allied Health Professionals

Clinical privileges for Allied Health Professionals shall be based on the applicant's training, experience, demonstrated competence and judgment. The AHP must hold a valid license to practice issued by the appropriate licensing Board. The scope of practice of the AHP is limited to the procedures and practices of the collaborating physician with the appropriate privileges and their license. The scope and extent of procedures each AHP may perform shall be specifically delineated and granted in the same manner as all other Practitioners.

4.6 Residents and Fellows:

Residents and Fellows are physicians in training in the hospital programs and are either licensed by or registered with the appropriate State of New Jersey licensing or examining board or agency, practice in the Hospital shall at all times be under the direction of appropriately credentialed members of the Medical Staff.

4.7 Interim Clinical Privileges for Applicants:

When appropriate, the Chief Executive Officer or designee may, upon receipt of an application for medical staff appointment which may reasonably be relied upon as to the licensure, certification, competence, character, ethical standing and professional liability insurance coverage, and after consulting with the Academic/Department Chairperson concerned, the President of the Medical Staff and the Chairperson of the Credentials Committee, and after obtaining the individual's signed acknowledgment to be bound by the Hospital bylaws, the Medical Staff bylaws, policies and rules and regulations then in force, and by the Ethical and Religious Directives for Catholic Health Facilities, grant interim admitting and clinical privileges to an applicant for a specific time period. The interim appointment and clinical privileges are for a limited period of time, not to exceed 120 days. Interim membership and privileges will automatically terminate if the applicant’s membership application is withdrawn. In exercising such privileges, the applicant shall act under the supervision of the chairperson of the department in which the applicant has requested primary privileges.

A determination to grant interim privileges shall not be binding or conclusive with respect to an applicant’s pending request for appointment to the Medical Staff.

4.8 Temporary Clinical Privileges for Non-Applicants:

Temporary admitting and clinical privileges for care of a specific patient or patients may be granted by the Chief Executive Officer with the concurrence of either the chairperson

of the department concerned, or the President of the Medical Staff, to a physician who is not an applicant for appointment, provided that the Chief Executive Officer shall first obtain such individual's signed acknowledgment to be bound by the Hospital bylaws, Medical Staff bylaws, policies and rules and regulations then in force, and by the Ethical and Religious Directives for Catholic Health Facilities, in all matters relating to temporary clinical privileges. Temporary privileges shall only be granted to those applicants whereby there are no questions raised and all information is complete, appropriate and in order. Such privileges shall be restricted to the specific patients for which they are granted.

This shall be done in the same manner and upon the same conditions as set forth above, providing that the Chief Executive Officer shall first obtain such individual's signed acknowledgment that the individual has received and had an opportunity to read copies of the Hospital bylaws, Medical Staff bylaws, policies and rules and regulations which are then in force, and the Ethical and Religious Directives for Catholic Health Care Facilities and agrees to be bound by the terms thereof in all matters relating to temporary clinical privileges. The individual serving as a locum tenens must also complete a request for clinical privileges form and must have in force and effect a current license to practice in this state; a license, if applicable; and professional liability insurance in an amount and term acceptable to the Hospital.

The Academic/Department Chairperson may impose special requirements of supervision and reporting upon any individual granted temporary clinical privileges.

4.9 <u>Termination of Interim/Temporary Clinical Privileges:</u>

a. The Chief Executive Officer may, at any time after receiving a recommendation from the President of the Medical Staff or the chairperson of the department responsible for the individual's supervision, terminate temporary admitting privileges. Clinical privileges shall then be terminated when the individual's inpatients are discharged from the Hospital. However, where it is determined that the care or safety of such patients would be endangered by continued treatment by the individual granted temporary privileges, a summary termination of temporary clinical privileges may be imposed by the Chief Executive Officer, the department chairperson or the President of the Staff, and such termination shall be immediately effective.
b. The appropriate department chairperson, or the President of the Medical Staff shall assign responsibility for the care of such terminated individual's patients until they are discharged from the Hospital to a medical staff appointee, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.
c. The granting of any temporary admitting and clinical privileges is a courtesy on the part of the Hospital. Neither the granting, denial or termination of such privileges shall entitle the individual concerned to any of the procedural rights provided in this policy with respect to hearing or appeals.
d. Temporary privileges shall be automatically terminated at the end of 120 days or by action of the Credentials Committee if it recommends unfavorably with

respect to the applicant's appointment to the staff. At the Credentials Committee's discretion, temporary clinical privileges shall be modified to conform to the recommendation of the Credentials Committee that the applicant be granted different permanent privileges from the temporary privileges.

4.10 Application for Increased Clinical Privileges:

Whenever, during the term of appointment to the medical staff, increased clinical privileges are desired, the appointee requesting increased privileges shall apply in writing to the appropriate department chairperson. The written request and all supporting documentation shall state in detail the specific additional clinical privileges desired and the appointee's relevant recent training and experience which justify increased privileges. There after, it will be processed in the same manner as an application for initial clinical privileges.

4.11 Emergency Clinical and Disaster Privileges

a. Emergency Clinical Privileges

1. For the purpose of this section, an "emergency" is defined as the condition that could result in serious or permanent harm to a patient and in which any delay in administering treatment would add to that harm or danger. In an emergency situation, the Chief Executive Officer, or designee, in conjunction with the department chairperson, may permit a Practitioner who is not currently appointed to the medical staff to exercise clinical privileges.
2. Similarly, in an emergency situation, a Member to act in such emergency by exercising clinical privileges not specifically granted to that Member. When the emergency situation no longer exists, such Member must request the temporary privileges necessary to continue to treat the patient. In the event such temporary privileges are denied or not requested, the President of the Medical Staff shall assign the patient to a Member with appropriate clinical privileges. The wishes of the patient shall be considered in the selection of a substitute physician.

b. Disaster Privileges

Emergency privileges of licensed independent practitioners may be granted when the Hospital's Emergency Management Plan is activated and the facility is unable to handle immediate patient needs. The Chief Executive Officer or designee may grant emergency temporary privileges to a Medical Practitioner based upon presentation of appropriate identification and licensure as outlined in medical staff policies. Formal verification of credentials and privileges will begin as soon as the immediate emergency situation is under control.

4.12 Telemedicine Privileges

Telemedicine involves the use of electronic communication or other communication technologies to prove or support clinical care at a distance. The Medical Staff shall determine which clinical services are appropriately delivered through this medium, according to commonly accepted quality standards. The Hospital may use credentialing information from another Joint Commission accredited facility in accordance with the bylaws.

4.13 Transport and Organ Harvest Teams

Properly licensed practitioners who individually, or as members of a group or entity, have contracted with the Hospital to participate in transplant and/or organ harvesting activities may exercise clinical privileges within the scope of their agreement with the Hospital.

4.14 Health and Well Being Committee

Practitioner health and well being issues are managed through a sub-committee of the Credentials Committee consisting of the individual Practitioner's department chairperson, the Vice President Medical Affairs and the President of the Medical Staff. This committee will oversee the appropriate referral of the physician in question, monitor the individual's progress and receive reports from those caring for the individual.

The committee will conduct appropriate follow up and, if indicated, will make recommendations for action to the Credentials Committee as detailed in the Policy and Procedure on Health and Well Being.

4.15 Leave of Absence

a. General:

1. Individuals appointed to the Medical Staff may, for a good cause, be granted leaves of absence for up to one year with a one-year extension. Absence for a longer period shall constitute voluntary resignation of medical staff appointment and clinical privileges unless an exception is made by the Board of Trustees.
2. Requests for leaves of absences shall be made to the chairperson of the department in which the individual applying for leave holds clinical privileges, and shall state the beginning and ending dates of the requested leave. The Academic/Department Chairperson shall transmit the request together with a recommendation to the Credentials Committee which shall make a report and a recommendation and transmit it to the Medical Board for action by the Board of Trustees.
3. At the conclusion of the leave of absence, the individual may be reinstated upon recommendation of the Credentials Committee and Medical Board, after filing a written statement with the Medical Staff Office summarizing the activities undertaken during the leave of absence. The individual shall provide such information as may be requested by each of the committees reviewing the request for reinstatement.
4. In acting upon the request for reinstatement, the Board of Trustees may approve reinstatement either to the same or a different staff category, and may limit or modify the clinical privileges to be extended to the individual upon reinstatement

b. Military: Requests for leave of absence to fulfill military service obligations shall be granted upon notice to the Medical Board. Reactivation of Membership and clinical privileges previously held shall be granted by Medical Board notwithstanding the provisions of Section (a) above.

c. Medical: Members must request a medical leave of absence from their Academic/Department Chairperson, which must then be approved by the Medical Board. The request for a medical leave of absence must state the reason for the leave and the specific period of time, which may not exceed two (2) years. During the period of leave, the Member shall not exercise privileges at the Hospital, and Membership rights and responsibilities shall be inactive.

Requests for medical leave shall not be granted if the Medical Board concludes leave is being sought to avoid reportable restrictions of privileges or any medical cause or disciplinary reason.

At least 30 days prior to the end of the leave, or at any earlier time, the Member may request reinstatement of his or her privileges and prerogatives by submitting a request along with the necessary documentation to the Academic/Department Chairperson. The Academic/Department Chairperson shall promptly forward the request to the Credentials Committee and to the Medical Board, along with written verification that the Member's health status and ability to carry out delineated clinical privileges have been reviewed and were not adversely affected as a result of the time away from clinical practice at the Hospital.

ARTICLE V - MEDICAL STAFF ORGANIZATION

5.1 OFFICERS

The officers of the Medical Staff shall be the President, Vice President, Secretary/ Treasurer.

5.2 AT-LARGE MEMBERS OF THE MEDICAL BOARD AND THE MEDICAL EXECUTIVE COMMITTEES

The Members-at-Large shall advise and support the Medical Officers and are responsible for the needs/interests of the entire Medical Staff and not simply representing the preferences of their own clinical specialty.

5.3 QUALIFICATIONS OF OFFICERS AND AT-LARGE MEMBERS

Only those Active Staff members who satisfy the following criteria shall be eligible to serve as medical staff officers, or at-large members:

(a) Be appointed to the Active Staff with no pending adverse recommendations of the Credentials Committee or the Medical Board concerning staff appointment or clinical privileges, and continue so during the term of office;
(b) Have demonstrated interest in maintaining quality medical care;
(c) Not be presently serving as a medical staff or corporate officer, department/division chief or committee chairperson at another hospital, and shall not so serve during the term of office;
(d) Have constructively participated in medical staff affairs, including peer review activities;
(e) Have actively served on at least two (2) medical staff committees;

(f) Be willing to discharge faithfully the duties and responsibilities of the position to which the individual is elected or appointed including attendance at no less than 2/3 of scheduled meetings;
(g) Be knowledgeable concerning the duties of the office;
(h) Possess written and oral communication skills; and
(i) Possess and have demonstrated ability for harmonious interpersonal relationships.

All medical staff officers and at-large members must possess at least the above qualifications and maintain such qualifications during their term of office. Failure to meet the foregoing qualifications as determined by the Medical Board may result in removal from office.

5.4 NOMINATIONS AND ELECTIONS OF OFFICERS AND AT-LARGE MEMBERS

A. Nominating Committee – at-large members:
   1) At least three (3) months before the scheduled date of the next medical staff election, the Chairpersons of the Executive Medical Committees and Medical Board shall appoint Nominating Committees consisting of at least five (5) Active Staff appointees of whom not more than two (2) shall be members of the Medical Board.
   2) The Nominating Committees shall prepare a slate of nominees for at-large members positions to be filled at that election.
   3) The Nominating Committees, in writing, shall submit nominations for at-large positions to the entire Active Staff at least two (2) weeks prior to the September medical staff meeting. Nominations may also be submitted from the floor at the September meeting and will become part of the slate when seconded. In order to be included on the ballot as a candidate, each nominee must possess all of the qualifications set forth in Section 5.3. Nominations will then be closed and submitted to the Active Staff to be voted on at its November meeting.

B. Nominating Committee – Officers:
   1) At least three (3) months before the scheduled date of the next medical staff election, the Chairperson of the Medical Board shall appoint Nominating Committee consisting of at least five (5) Active Staff appointees of whom not more than two (2) shall be members of the Medical Board.
   2) The Nominating Committee shall prepare a slate of nominees for Officers to be filled at that election.
   3) The Nominating Committee, in writing, shall submit nominations for officers to the entire Active Staff at least two (2) weeks prior to the September medical staff meeting. Nominations may also be submitted from the floor at the September meeting and will become part of the slate when seconded. In order to be included on the ballot as a candidate, each nominee must possess all of the qualifications set forth in Section 5.3. Nominations will then be closed and submitted to the Active Staff to be voted on at its November meeting

C. Elections:
   If there is more than one (1) candidate for any office, the vote shall be by written

secret ballot. The candidates who receive a majority vote of those medical staff appointees eligible to vote and present at the meeting at the time the vote is taken shall be elected. In any election, if there are three (3) or more candidates for an office and no candidate receives a majority vote there shall be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until one (1) candidate obtains a majority. Each officer shall assume office at the January meeting of the Medical Board.

All nominees for election to the Medical Staff offices shall, at least 20 days prior to the date of election, disclose in writing to the Nominating Committee those personal, professional or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. The Nominating Committee shall evaluate the significance of such disclosures and discuss any significant conflicts with the nominee and others as necessary and appropriate. If a nominee with a significant conflict remains on the ballot, the nature of his or her conflict shall be disclosed in writing and circulated with the ballot.

5.5 TERM OF ELECTED OFFICERS AND AT-LARGE MEMBERS

Each officer shall serve for a term of two (2) years unless he/she shall resigns or is removed from office. The President of the Medical Staff may not serve more than two (2) successive full terms.

Members at-large shall serve a two (2) year term but shall not serve more than three (3) consecutive terms.

5.6 REMOVAL OF OFFICERS AND AT-LARGE MEMBERS

An officer or at-large member may be removed from office by the vote of two-thirds (2/3) vote of the members of the Active Staff present and voting at any regular meeting or special meeting of the Medical Staff.

A medical staff officer or at-large member may be removed for conduct detrimental to the interests of the Hospital or the Medical Staff, or if the officer or at-large member is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of that office, providing that notice of the meeting at which such action shall be decided is given in writing to such officer at least ten (10) days prior to the date of the meeting. The officer or at-large member shall be afforded the opportunity to speak prior to the taking of any vote on such removal.

Any member of the Medical Board or campus specific Medical Executive Committee who fails to attend at least 2/3 of Medical Board/Medical Executive Committee meetings during the term of service shall be ineligible for a period of three (3) years.
An officer shall be automatically removed if the officer becomes ineligible to serve as described in Section 5.7 of this ARTICLE.

5.7 VACANCY IN OFFICE

(a) Causes: A vacancy shall occur if an officer dies, resigns or is removed from his office; resigns or ceases to be a member of the Active Staff; is granted a leave of absence; or if a final decision of the Board is made to deny his reappointment to the Active Staff, expel him from the Medical Staff or suspend his clinical privileges. If a vacancy occurs in the office of the President, the Vice-President shall succeed to that office and shall serve for the unexpired term. The office of the Vice-President shall become vacant if the Vice-President succeeds to the office of President as provided in paragraph (b) of this Section.

(b) Succession in Case of Vacancy; If a vacancy occurs in any office, other than in the office of President, a successor shall be elected at the next regular or special meeting of the Medical Staff in the same manner as provided in paragraph (c) of Section 5.4 of this ARTICLE. Prior to that meeting, the Nominating Committee shall select one or more nominees for such office, who have indicated their willingness to serve if elected, at least two (2) weeks prior to the meeting of the Medical Staff. At that meeting the nominations of the Nominating Committee shall be presented by the chairman of the Nominating Committee. Nominations may also be submitted from the floor at the meeting and will become part of the slate when seconded. Election will be held at that meeting in a manner provided for under the regular election procedure. Until an election, the President of the Medical Staff may appoint an appointee pro-tem to the office that is vacant. The appointee must meet the criteria set forth for this office.

5.8 DUTIES OF THE OFFICERS

5.8.1 PRESIDENT

The President shall have been appointed to the Active Staff for at least five (5) years, and shall have served on the Medical Board or a Medical Executive Committee within the three (3) years preceding election as President. The President of the Medical Staff shall:

a. Act in coordination and cooperation with the Chief Executive Officer in matters of mutual concern involving the Hospital;
b. Call, preside at and be responsible for the agenda of all regular and special meetings of the medical staff and of all regular and special meetings of the Medical Board;
c. Appoint and remove members to all standing and special medical staff committees;
d. Chair the Medical Board and serve as ex officio member, without vote, on all medical staff committees except the Medical Board;
e. Represent the views, policies, needs and grievances of the medical staff and report on the medical activities of the staff to the Board of Trustees and to the Chief Executive Officer;
f. Enforce the medical staff bylaws, rules and regulations and Hospital policies and assure compliance with due process procedures outlined in the Medical Staff Policy on Appointment, Reappointment and Clinical Privileges when an unfavorable recommendation is made by the Medical Board concerning an applicant for initial appointment or a current appointee to the medical staff;

g. Receive and interpret the policies of the Board of Trustees to the medical staff and report to the Board of Trustees on the performance and maintenance of quality with respect to the delegated responsibility of the medical staff to provide medical care; and
h. Be the spokesperson for the medical staff in its professional and public relations.
i. Accept, if offered in accordance with the corporate Bylaws, an appointment to the Board for a term which coincides with his term of office as President and, if offered in accordance with the corporate Bylaws, to serve as a member of the executive committee of the Board during his term as President; and
j. Receive compensation for his services in an amount to be determined each year by the Medical Staff based on the recommendation of the Medical Board.

5.8.2 **VICE-PRESIDENT**

The Vice President of the Medical Staff serves on the Medical Board. The Vice President shall have been appointed to the Active Staff for at least five (5) years and shall have served on the Medical Board or a Medical Executive Committee for at least one (1) year. The Vice President shall:

a. Assume all duties and have the authority of the President of the Medical Staff in the event of the President's temporary inability to perform due to illness, absence from the community or unavailability for any other reason;
b. Automatically succeed the President, should the office of President become vacated for any reason during the President's term of office; and
c. Perform such duties as are assigned by the President

5.8.3 **SECRETARY/TREASURER**

The Secretary/Treasurer shall:

a. Serve as a member of the Medical Board;
b. Cause to be kept accurate and complete minutes of all Medical Board and medical staff meetings;
c. Send out notices of Medical Board and medical staff regular and special meetings when requested to do so by the President of the Medical Staff;
d. Be responsible for all correspondence of the Medical Board and the medical staff; and
e. Receive, hold, record and dispense all funds of the medical staff; all funds must be deposited in a System approved financial institution
f. Submit an annual financial report at the November meeting of the medical staff
g. Provide monthly financial reports to the Medical Board
h. Collect dues submitted by members of the Medical Staff;
i. Perform such other duties as ordinarily pertain to the office of Secretary.

ARTICLE VI - MEDICAL STAFF MEETINGS

6.1 PROVISIONS COMMON TO ALL MEETINGS

6.1.1 NOTICE OF MEETINGS

Notice of all meetings of the Active staff and regular meetings of departments/divisions and committees shall be posted on the medical staff bulletin board and delivered, either in person or by mail, fax or email to each Medical Staff Member, not less than seven (7)

working days in advance of such meetings.
Such notice shall state the date, time and place of the meeting. The attendance of any individual at any meeting shall constitute a waiver of that individual's notice of said meeting.

6.1.2 RULES OF ORDER

When they do not conflict with these bylaws, the *21st Century Robert's Rules of Order* shall govern all meetings and elections.

6.1.3 VOTING

Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one (1) vote.

(a) Formal Action: Except as provided in these Bylaws, the action of a majority of the members who are entitled to vote and who are present and voting at a meeting at which a quorum is present shall be the action of a Department, Section or Committee. There is no proxy voting.

(b) Informal Action: Except as provided in these Bylaws, any action which may be taken at a meeting of a Department, Section or Committee may be taken without a quorum if a consent in writing, setting forth the action taken, is signed by all the members of the Department, Section or Committee who are entitled to vote and recorded in the minutes of the next regular meeting.

6.2 MEDICAL STAFF MEETINGS

Regular meetings of the medical staff will be held quarterly in February, May, September and November, for the purpose of reviewing and evaluating medical staff committee reports and recommendations, and to act on any other matters placed on the agenda by the President. The November meeting shall be the annual meeting during which officers and at-large members shall be elected as the first order of business following the approval of minutes; annual reports of all Departments and Committees shall be presented and such other business shall be conducted as provided in these Bylaws or as may be brought before the meeting. Written notice of each meeting shall be transmitted to each member of the Active Staff in good standing not less than seven (7) days before the date of such meeting.

6.2.1 SPECIAL MEDICAL STAFF MEETINGS

The President of the Medical Staff may, at the written request of the Board, the Medical Board, or at least twenty-five percent (25%) of the members of the Active Staff, call a special meeting of the Medical Staff by giving notice as provided in Section 6.1.1 of this ARTICLE. No business shall be transacted at any special meeting except that which is stated in the notice calling the meeting.

The President of the Medical Staff shall designate the time and place of any special meeting. Written notice of the place, day, and hour of any special meeting of the medical staff shall be sent to each member of the Active Staff not less than seven (7) days before the date of such meeting. No business shall be transacted at any special meeting except that stated in the meeting notice.

In the event that it is necessary for the Medical Staff to act on a question without being able to meet, the voting medical staff, with the approval of two-thirds of the Medical Board, may be presented with the question by mail and their votes returned to the President of the Medical Staff by mail. Such a vote shall be valid so long as the question is voted on by the majority of the staff eligible to vote.

6.2.2 **QUORUM**

A quorum for any regular or special meeting of the medical staff shall be defined as the presence of (as signified by the signatures of those attending the meeting) the lower of (i) thirty percent of persons eligible to vote or (ii) 100 persons eligible to vote. Once a quorum is established, the business of the meeting may continue; and all actions taken shall be binding even if less than a quorum exists at a later time in the meeting.

6.2.3 **AGENDAS**

(a) Regular Staff Meetings:

The agenda at any regular staff meeting shall be:

1) Call to order;
2) Acceptance of minutes of the last regular and all intervening special meetings;
3) Reports from Hospital administration and the Medical Board;
4) Unfinished business;
5) Reports from medical staff committees;
6) New business; and
7) Adjournment.

(b) Special Staff Meetings:

The agenda at special staff meetings shall be:

1) Call to order
2) Reading of the notice detailing the reason for the meeting;
3) Transaction of the business for which the meeting was called; and
4) Adjournment.

6.2.4 **ATTENDANCE**

Each Active and Provisional Staff Member shall be required to attend at least 50% of all regular medical staff meetings in each year. A Member who is compelled to be absent from any regular medical staff meeting shall promptly notify the Secretary of the Medical Staff of the reason for such absence. Failure of any Active Staff Member to meet the attendance requirements for regular medical staff meetings shall be grounds for loss of voting privileges. Reinstatement of voting privileges which have been revoked because of absence from staff meetings shall be made only after fulfilling the attendance requirements set forth in these bylaws. Provisional Staff Members who fail to meet the attendance requirement may not be eligible for Active Staff status.

6.2.5 MINUTES

Minutes of each annual, regular and special meeting of the Medical Staff shall be prepared and shall include a record of the attendance of members, of the recommendations made and of the votes taken on each matter. The minutes shall be approved at the next regular meeting of the Medical Staff, signed by the Secretary of the Medical Staff and a copy thereof shall be promptly forwarded to the Medical Staff Office who shall maintain a permanent file of the minutes of the Medical Staff.

6.3 DEPARTMENT/DIVISION AND COMMITTEE MEETINGS

All regular meetings of Departments, Divisions and Committees shall be held with such frequency as is provided in these Bylaws or where these Bylaws do not provide for the frequency of meetings, as the Medical Executive Committee or Medical Board may determine.

6.3.1.1 DEPARTMENT MEETINGS

Members of each department shall meet as a department at least quarterly at a time set by the chairperson of the department to review and evaluate the clinical work of the department, to consider the findings of ongoing quality assessment, monitoring and evaluation activities, and to discuss any other matters concerning the department. The chairperson shall set the agenda for the meeting and its general conduct. A majority of the members at a meeting will be allowed to put a matter on the agenda. Each department shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof, after prior approval of those members attending the meeting, to the Medical Board and the Chief Executive Officer.

6.3.1.2 DIVISION MEETINGS

Members of each division shall meet as a division at least quarterly at a time set by the chief of the division to review and evaluate the clinical work of the division, to consider the findings of ongoing quality assessment, monitoring and evaluation activities, and to discuss any other matters concerning the division. The chief shall set the agenda for the meeting and its general conduct. A majority of the members at a meeting will be allowed to put a matter on the agenda. Each division shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof, after prior approval of those members attending the meeting, to the Chairperson, the Medical Board and the Chief Executive Officer.

6.3.1.3 COMMITTEE MEETINGS

All committees shall meet at least quarterly, unless otherwise specified in these bylaws, at a time set by the chairperson of the committee. The chairperson shall set the agenda for the meeting and its general conduct. A majority of the members at a meeting will be allowed to put a matter on the agenda. Each committee shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof, to the Medical Board.

6.3.1.4 SPECIAL DEPARTMENT/DIVISION AND COMMITTEE MEETINGS

(a) A special meeting of any department/division or committee may be called by or at the request of the appropriate chairperson, the President of the Medical Staff, or by a petition signed by not less than one-fourth of the members of the

department/division or committee.

(b) In the event that it is necessary for a department/division or committee to act on a question without being able to meet, the voting members may be presented with the question, in person or by mail, and their vote returned to the appropriate chairperson of the department/division or committee. Such a vote shall be binding so long as the question is voted on by a majority of the department/division or committee eligible to vote and passed by a majority of those voting.

6.3.2 **QUORUM**

Each Department or Division shall determine the quorum required for meetings in their Department Rules and Regulations. Committees of the Medical Staff shall require 50% of the membership of the Committee for a quorum. Only Members who are eligible to vote in accordance with ARTICLE 3 of these Bylaws, if present at the beginning of any meeting shall be counted in the quorum. No business may be transacted unless a quorum is present. A quorum shall be considered to be present for the entire duration of any meeting that commenced with such a quorum, notwithstanding the actual number present at the time of a vote.

6.3.3 **MINUTES**

Minutes of each meeting of each department and each committee shall be prepared and shall include a record of the attendance of members, of the recommendations made and of the votes taken on each matter. The minutes shall be approved by staff members attending the various meetings, shall be signed by the presiding chairperson and copies thereof shall be promptly forwarded to the Medical and to certain committees as specified elsewhere in these bylaws. The Medical Staff Office shall maintain a permanent file of the minutes of each department and each committee meeting.

6.3.4 **ATTENDANCE**

Each Active and Provisional Member shall attend at least 50% of all applicable committee and department/division meetings. The meeting attendance record of each of these individuals is a factor to be considered during the reappointment process.
Persons appointed to the Senior Active, Courtesy, Consulting, Emeritus and Teaching Staff are entitled and encouraged to attend and participate in the department/division meetings.

6.3.5 **VOTING**

Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one (1) vote.

(a) Formal Action. Except as provided in these Bylaws, the action of a majority of the members who are entitled to vote and who are present and voting at a meeting at which a quorum is present shall be the action of a Department, Division or Committee. There is no proxy voting.

(b) Informal Action. Except as provided in these Bylaws, any action which may be taken at a meeting of a Department, Division or Committee may be taken without a meeting if a consent in writing, setting forth the action taken, is signed by all the members of

the Department, Division or Committee who are entitled to vote and recorded in the minutes of the next regular meeting.

ARTICLE VII - CLINICAL DEPARTMENTS

The Departments of the Medical Staff shall be the Departments of:

1. Anesthesiology
2. Cardiovascular Services, including Divisions of Cardiology and Cardiothoracic Surgery
3. Dentistry, including Division of Oral Maxillofacial Surgery
4. Emergency Medicine
5. Family Medicine
6. Medicine, including Divisions of Allergy and Immunology, Dermatology, Endocrinology, Gastroenterology, Geriatrics, Internal Medicine, Hematology/Oncology, Infectious Disease, Nephrology, Neurology, Pulmonology, and Rheumatology
7. Obstetrics and Gynecology
8. Ophthalmology
9. Orthopedics, including Division of Podiatry
10. Pathology
11. Pediatrics
12. Psychiatry
13. Radiology
14. Rehabilitation Medicine
15. Surgery, including Divisions of Thoracic Surgery, General Surgery, Craniofacial Surgery, Neurosurgery, Otolaryngology, Plastic Surgery, Urology, Vascular Surgery and Trauma

7.1 DEPARTMENTS AND DIVISIONS

a. Structure. Each Department shall be organized as a separate part of the Medical Staff and may be divided into Divisions as provided in these Bylaws.
b. Department Officers. Each Department shall have an Academic Chairperson appointed by the Chief Executive Officer and shall have a campus specific Clinical Department Chairperson who shall be recommended to the Chief Executive Officer by the clinical department subject to the approval of the Board of Trustees. The Academic Chairman may serve as the Department Chairman at the site where he/she sits or may request the appointment of a Department Chairman for that site.
c. Departments. Departments may be established or eliminate pursuant to Article 7.3.
d. Divisions. Divisions may be established or eliminated pursuant to Article 7.3.
e. Division Officers. Each Division shall have a Chief who shall be appointed by the Chief Executive Officer and approved by the Medical Board and Board of Trustees.

7.2 FUNCTIONS OF DEPARTMENTS

a. After consultation with the department, each Academic/Department Chairperson shall recommend to the Credentials Committee written criteria for the assignment of

clinical privileges within the department and each of its divisions. Such criteria shall be consistent with and subject to the bylaws, policies, rules and regulations of the Medical Staff and the Hospital.
These criteria shall be effective when approved by the Medical Board and the Board of Trustees. Clinical privileges shall be based upon demonstrated competence, training and experience within the specialties covered by the department/division

b. Each department shall establish a medical care evaluation process or similar mechanism to monitor and evaluate medical care on a retrospective, concurrent and prospective basis in all major clinical activities of the department. This monitoring and evaluation must at least include
    1. the routine collection of information about important aspects of patient care provided in the department and about the clinical performance of its members; and
    2. the periodic assessment of this information to identify opportunities to improve care and to identify important problems in patient care.
c. Each department shall adopt, subject to approval by the Medical Board and Board of Trustees, objective criteria that reflect current knowledge and clinical experience. These criteria shall be used by each department or by the Hospital's performance improvement program in the monitoring and evaluation of patient care. When important problems in patient care and clinical performance or opportunities to improve care are identified, each department shall document the actions taken and evaluate the effectiveness of such actions. Departments shall review patient incident reports that reflect issues of patient safety and care as reported by the Risk Management Department
d. Each relevant department shall also conduct a comprehensive review to examine justification of surgery performed, whether tissue was removed or not, and to evaluate the acceptability and the quality of the procedure chosen for the surgery. Specific consideration shall be given to cases involving complications and to the agreement or disagreement of the pre-operative and post-operative (including pathological) diagnoses. The department shall maintain written reports reflecting the results of all evaluations performed and actions taken.
e. In discharging these functions, each department shall report after each meeting to the Performance Improvement Committee its analysis of patient care, and to the appropriate department chairperson and/or the Credentials Committee whenever further investigation and action is indicated, involving any individual member of the department. Copies of these reports shall be filed with the Medical Board and the Chief Executive Officer.
f. Each Department and Division may adopt Rules and Regulations provided the department/division Rules and Regulations do not conflict with the Rules and Regulations of the Medical Staff.
g. Each Department may organize a Division Chiefs Committee which shall:
    1. consist of the Chiefs of each Division with vote;
    2. act for the Department between times of the regular meetings;
    3. discuss requests from the Divisions for consideration by the Department;
    4. direct the actions of the Divisions; and

5. perform any other activity which the entire Department, by majority vote, shall request it to perform.

h. Divisions. Each Division shall:
   1. establish its own criteria for the recommendation of clinical privileges, subject to the approval of the Department, the Medical Executive Committee, and the Board;
   2. participate in quality improvement activities, as appropriate; and
   3. hold periodic meetings.

7.3 MODIFICATIONS OF DEPARTMENTS AND DIVISIONS

When deemed appropriate, the Medical Board and the Board of Trustees, by their joint action, may create, eliminate, subdivide, further subdivide or combine departments, divisions and/or clinical services.

a. Creation of a Department or Division: If (i) a sufficient number of practitioners are available for appointment to and will be appointed to and /or actively participate in the new organizational component to enable accomplishment of the functions generally assigned to such components in these Bylaws and relevant Rules and regulations adopted pursuant hereto; and (ii) the patient or service activity to be associated with the new component is substantial enough to warrant imposition on the members thereof the responsibility to accomplish such functions, a division may be created.
b. Eliminations: If the number of members available is no longer adequate and will not be so in the foreseeable future to accomplish assigned functions, or the patient or service activity associated with the component to be dissolved is no longer substantial enough to warrant imposition of the responsibility to accomplish those assigned functions on the members of such section, a division may be eliminated.
c. Combination: If the union of the two or more organizational components will result in more effective and efficient accomplishment of assigned functions, and the patient or service activity to be associated with the combination is substantial enough, without being unwieldy, to warrant imposition of the responsibility to accomplish those assigned functions on the member of such combined components, the subdivisions may be combined. In all instances of modification, the Hospital's written plan of development, as currently being implemented, and any constraints or mandates imposed by external planning authorities, shall also be considered.

7.4 DEPARTMENT OFFICERS

7.4.1 ACADEMIC CHAIRPERSON

a. Each clinical department/service line shall have an Academic Chairperson. The Academic Chairperson must qualify for appointment to the Active Staff and be qualified by training, experience and demonstrated ability to direct the department. The Academic Chairperson shall be Board certified by the appropriate specialty and shall not be an officer or department chairperson at another hospital. The Board of Trustees, upon recommendation of the Medical Board, shall appoint/reappoint the Academic Chairperson every three (3) years.
b. Resignation, death or removal of an Academic Chairperson will result in the

temporary appointment of acting Academic Chairperson. The Chief Executive Officer and the Credentials Committee shall make such designation at emergency session within three (3) days. The Medical Board and the Board of Trustees shall subsequently approve such designation.

c. At its next regular meeting, the Credentials Committee shall recommend to the Medical Board an Ad Hoc Search Committee for the purpose of finding and choosing a chairperson. The President of the Medical Staff may make such additions to/or deletions from the Ad Hoc Search Committee, with the approval of the Medical Board, as may be appropriate; however the Ad Hoc Search Committee must include two (2) members of the Credentials Committee, one (1) practicing member of the department, two (2) members of an allied department and the Chief Executive Officer or his designee.
d. Final approval of the appointment of Academic Chairperson shall be subject to the approval of the Board of Trustees.

Each Academic Chairperson shall:

a. be a member of the Medical Board and be responsible for implementation within the department/clinical service line of actions taken by the Medical Board and the Board of Trustees
b. be responsible for the professional, educational, research and administrative activities within the department/clinical service line;
c. recommend to the Credentials Committee criteria for clinical privileges in the department/clinical service line;
d. make a report to the Credentials Committee concerning the appointment, reappointment and delineation of clinical privileges for all applicants seeking privileges in the department/clinical service line;
e. maintain continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the department/clinical service line, and report thereon to the Credentials Committee as part of the reappointment process and at such other times as may be indicated;
f. make recommendations to the administration regarding the sufficient number of qualified and competent persons to provide care, treatment and services and encourage the recruitment of new members for the department/clinical service line as appropriate and as needed;
g. determine the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services;
h. maintain quality control programs, as appropriate and oversee the analysis and improvement of patient satisfaction, the continuous assessment and improvement of the quality of care, treatment and services and the compilation of data relative to the clinical experiences of the department/ clinical service line and shall report on these activities annually to Organizational Performance Improvement Committee (OPIC);
i. report and recommend to the administration when necessary with respect to matters affecting patient care in the department, including space, personnel, supplies, special regulations, standing orders and special techniques as well as off-site sources for needed patient care services not provided by the department or the organization;

j. appoint committees to conduct patient care review, as required by these bylaws;
k. be responsible for enforcement within the department of the Hospital policies and bylaws and the medical staff bylaws, policies, rules and regulations;
l. assist the Administration in the preparation of annual reports and such budget planning pertaining to the department as may be required by the Medical Board, the Chief Executive Officer or the Board of Trustees;
m. have the option to request the appointment of a Department Chairperson at the campus where the Academic Chairperson sits;
n. delegate to the Department Chairperson the authority to appoint committees to conduct patient care review, as required by these bylaws;
o. establish divisions or services within the department appoint committees to conduct patient care review, as required by these bylaws; and appoint chiefs thereof, subject to the approval of the Medical Board and the Board of Trustees.
p. after consultation with the department/clinical service line, recommend rules and regulations and policies and procedures which shall be effective when approved by the Medical Board and Board of Trustees.
q. coordinate intradepartmental and interdepartmental services and oversee the integration of the department/clinical service line into the primary functions of the institution;
r. have the option to delegate other functions and duties as indicated in these Bylaws or as necessary fort he functioning of the clinical service line.

7.4.2 **DEPARTMENT CHAIRPERSON**

Each clinical department that operates at more than one (1) campus may have a Department Chairperson designated at each campus who shall report to the campus specific MEC. The Department Chairperson must qualify for appointment to the Active Staff and be qualified by training, experience and demonstrated ability to direct the department at that campus. The Department Chairperson shall be Board certified by the appropriate specialty and shall not be an officer or department chairperson at another hospital. The Department Chairperson shall be elected/selected by the department, recommended to the Chief Executive Officer and shall be approved by the Medical Board and Board of Trustees.

When the Hospital contracts with a group of practitioners to provide a department clinical service, the Department Chairperson must be a principal officer of that group and must maintain the authority within that group to appropriately direct all issues that relate to the group's activities at the Hospital. For clinical purposes, a different clinical group of practitioners may be contracted at each campus in such case the Department Chairperson shall be a principal officer of the group with authority to appropriately direct the group's activities

The Chief Executive Officer may remove a Department Chairperson for failure to meet the responsibilities of the position.

Each Department Chairperson shall:

a. be accountable to the campus Medical Executive Committee for all professional and medical staff administrative activities within the Department/clinical service line, including compliance with the Joint Commission accreditation duties required of Chairpersons;
b. maintain surveillance of the professional performance of all individuals having clinical privileges in the Department/clinical service line, and when necessary report thereon to the;
c. make recommendations and suggestions regarding the policies and procedures in the Department/clinical service line to the Academic Chairperson in order to assure quality patient care;
d. be responsible within the Department for enforcement of the Hospital Bylaws, the Medical Staff Bylaws, Rules and Regulations, and the Departmental Rules and Regulations;
e. be responsible for Department implementation of actions taken by the Medical Executive Committee;
f. transmit to the Credentials Committee through the Credentials Committee liaison to the campus specific MEC, his/her recommendations concerning the delineating of clinical privileges for practitioners and AHPs in the Department at the specific campus; and
g. participate in the administration of the Department, including working in close cooperation with the nursing service and the Hospital administration in matters affecting patient care such as personnel, supplies, special regulations, standing orders and techniques at the specific campus.

7.4.3 **DIVISION CHIEF**

Each Division Chief shall be a member of the Active Staff and a member of the Division that he/she is to head, be qualified by training, experience, interest, and demonstrated current ability in the clinical area by the Division and be willing and able to discharge the administrative responsibilities of this position.

The Academic/Department Chairperson shall appoint the Division Chief. The Academic/Department Chairperson may consult with members of the clinical section. The Chief Executive Officer shall approve the appointment.

Each Division Chief shall be accountable to the Academic/Department Chairperson of the Department/clinical service line for all professional and medical staff administrative activities within the Division and, subject to the overall authority of the Academic/Department Chairperson of the Department/clinical service line, shall:
a. maintain regular surveillance of the professional performance of all individuals having clinical privileges in the Division;
b. make specific recommendations and suggestions regarding the Division to the Academic/Department Chairperson of the Department in order to assure quality patient care;
c. be responsible within the Division for enforcement of the Hospital Bylaws, the Medical Staff Bylaws and Medical Staff, Department and Division Rules and Regulations;

d. be responsible for Division implementation of actions taken by the Medical Executive Committee, the Medical Board or the Department/clinical service line;
e. transmit to the Academic/Department Chairperson of the Department/clinical service line the recommendations concerning the delineation of clinical privileges for all practitioners in the Division;
f. have responsibility for teaching, education and research programs in the Division;
g. participate in the administration of the Division, including working with the nursing services and Hospital administration in matters affecting patient care such as personnel, supplies, special regulations, standing orders and techniques; and
h. participate, if requested, with the Academic/Department Chairperson in preparing such annual reports pertaining to the Department and Division, including budgetary planning.

7.4.5 **MEDICAL DIRECTORS**

The Chairperson may appoint Medical Directors for special units such as critical care units or procedural departments. The Medical Director shall be a member of the Active Staff and be qualified by training, experience, interest, and demonstrated current ability in the clinical area that is to be overseen. This appointment shall be made with the approval of the Chief Executive Officer.

Each Medical Director shall be accountable to the Academic/Department Chairperson for the medical oversight of a specific Hospital unit or procedural department and shall:
a. maintain regular surveillance of the professional performance of all individuals having clinical privileges in the Unit or procedural department;
b. give guidance on the medical policies of the Unit or procedural department to the Academic/Department Chairperson of the Department/clinical service line in order to assure quality patient care;
c. transmit to the Academic/Department Chairperson of the Department/clinical service line any recommendations and/or concerns regarding clinical privileges of practitioners in Unit or procedural department;
d. have the responsibility for teaching, education and research programs in the Unit or procedural department;
e. participate in the administration of the Unit or procedural department, including working in cooperation with nursing services and administration in matters affecting patient care such as personnel, supplies, special regulations, standing orders and techniques; and
f. make suggestions to the Academic/Department Chairperson regarding equipment or supplies necessary for the proper functioning of the unit/procedural department.

ARTICLE VIII - COMMITTEES OF THE MEDICAL STAFF

8.1 **General**

a. Designation: The Medical Board and the other committees described in these Bylaws or Policies shall be the standing committees of the Medical Staff. The Medical Board or a department may create special or ad hoc committees to perform specified tasks. Any committee—whether of the Medical Staff or of a department or other clinical unit, whether standing or ad hoc—that is carrying out all or any portion of a function

or activity required by these Bylaws, is deemed a duly appointed and authorized committee of the Medical Staff.

b. Appointment of Members:
   1. Unless otherwise specified, the chair and members of all committees shall be appointed by, and may be removed by, the President of the Medical Staff, subject to consultation with and approval by the Medical Board. Medical Staff committees shall be responsible to the Medical Board, some directly and others through each campus' Medical Executive Committee.
   2. A Medical Staff committee created in these Bylaws is composed as stated in the description of the committee in these Bylaws or Policies. Except as otherwise provided in the Bylaws, committees established to perform Medical Staff functions required by these Bylaws may include any category of Medical Staff members; house staff, allied health professionals; representatives from Hospital departments such as administration, nursing services, or health information services; representatives of the community; and persons with special expertise, depending upon the functions to be discharged. Each Medical Staff Member who serves on a committee participates with a vote unless the statement of committee composition designates the position as nonvoting.
   3. The President of the Medical Staff, or his or her designee, in consultation with the Chief Executive Officer, shall appoint any non-Medical Staff members who serve in non-ex officio capacities.
   4. The committee chair, after consulting with the President of the Medical Staff, may call on outside consultants or special advisors.
   5. Each committee chair may appoint a vice chair to fulfill the duties of the chair in his or her absence and to assist as requested by the chair. Each committee chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

c. Representation on Hospital Committees and Participation in Hospital Deliberations: The Medical Staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management and physical plant safety by providing Medical Staff representation on Hospital committees established to perform such functions.

d. Ex Officio Members: The President of the Medical Staff, Chief Executive Officer, and the Vice President, Medical Affairs or their respective designees are ex officio members of all standing and special committees of the Medical Staff and shall serve with vote unless provided otherwise in the provision or resolution creating the committee.

e. Action through Subcommittees:
   Any standing committee may use subcommittees to help carry out its duties. The Medical Board shall be informed when a subcommittee is appointed. The committee chair may appoint individuals in addition to, or other than, members of the standing committee to the subcommittee after consulting with the President of the Medical Staff regarding Medical Staff members, and the Chief Executive Officer or designee regarding Hospital staff.

f. Terms and Removal of Committee Members: Unless otherwise specified, a committee member shall be appointed for a term of three years and shall serve until

the end of this period and until his or her successor is appointed, unless he or she resigns sooner or is removed from the committee. Any committee member who is appointed by the President of the Medical Staff may be removed by a majority vote of the Medical Board. Any committee member who is appointed by the department chair may be removed by a majority vote of his or her department committee or the Medical Board. The provisions pertaining to removal of such officer or official shall govern the removal of any committee member who is automatically assigned to a committee because he or she is a general officer or other official;

g. Vacancies: Unless otherwise specified, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided however, that if an individual who obtains membership by virtue of these Bylaws is removed for cause, the President of the Medical Staff may select a successor.

h. Conduct and Records of Meetings: Committee meetings shall be conducted and documented in the manner specified for such meeting in Article 6, Meetings.

i. Attendance of Nonmembers: Any Medical Staff Member who is in good standing may ask the chair of any committee for permission to attend a portion of that committee's meeting dealing with a matter of importance to that Member. The committee chair shall have the discretion to grant or deny the request and shall grant the request only if the Member's attendance will reasonably aid the committee to perform its function. If the request is granted, the invited member shall abide by all Bylaws and rules applicable to that committee

j. Accountability: All committees shall be accountable to the Medical Board.

8.2 **Standing Committees**

The Standing Committees are as follows:

Ambulatory Care Committee
Blood Utilization Committee
Bylaws Committee
Cancer Committee
Conflicts of Interest Committee
Clinical Resource Utilization Committee
Credentials Committee, including Multidisciplinary Peer Review Committee and Health and Well-being Committee
Critical Care Committee
Infection Control Committee
Medical Education Committee
Medical Executive Committee
Medical Records Committee
Patient Safety Committee
Pharmacy & Therapeutics Committee
Radiation Safety Committee
Tissue Committee

Committee charges are detailed in the Policies of the Medical Staff.

ARTICLE IX - CORRECTIVE ACTION

9.1 Criteria for Action

A corrective action investigation or focused review may be initiated whenever reliable information indicates a Member may have acted in a manner, either within or outside of the Hospital, which is of is reasonably likely to be deemed:

a. detrimental to patient safety or to the delivery of quality patient care within the Hospital;
b. contrary to the principles of ethics adopted by the Medical Staff or the Ethical and Religious Directives for Catholic Health Care;
c. contrary to the Bylaws, Policies, Rules and Regulations of the Medical Staff or the Bylaws and policies of the Hospital;
d. evidences total or partial lack of professional qualifications or performance or is otherwise below the applicable professional standards of the Medical Staff;
e. an improper use of Hospital resources; or
f. disruptive of or to Medical Staff or Hospital operations.

9.2 Nature of Corrective Action

Corrective Action may include written censure, reduction or suspension of privileges, or expulsion from the Medical Staff.

At any time during the investigation, the Credentials Committee may recommend summary suspension of all or a part of the clinical privileges of the individual being investigated. The recommendation shall be considered pursuant to Section 9.4.3 Summary Suspension of Clinical Privileges.

9.3 Initiation

a. Any person who believes that corrective action may be warranted may provide information to the Vice President Medical Affairs, President of the Medical Staff, Academic/Department Chairperson of a specific department, Chief Executive Officer, Chairperson of the Board of Trustees and/or Multidisciplinary Peer Review Committee. The information shall be presented in writing to the Vice President Medical Affairs, President of the Medical Staff or Chief Executive Officer stating in detail the allegations against the Medical Staff Member and any information, including the names of witnesses, supporting the allegations.
b. If the Vice President Medical Affairs, President of the Medical Staff or Chief Executive Officer determines that corrective action may be warranted under Article 9 of these Bylaws, he/she shall request that the Credentials Committee initiate a formal investigation or focused review of the allegations or may recommend particular corrective action.
c. The Chairperson of the Credentials Committee shall promptly notify the Medical Board in writing of all requests for action regarding an individual received by the Credentials Committee and keep the Chief Executive Officer and Medical Board fully informed of all action taken in connection therewith.

d. Normal performance improvement activities, which apply to all Medical Staff Members having the same privileges, shall not be considered an "investigation" or "focused review" under this Article.

9.4 Investigative Procedure

9.4.1 Expedited Review:

When the allegation and supporting information suggests that corrective action may be warranted, the Vice President Medical Affairs, or designee, may, on behalf of the Credentials Committee, immediately investigate and conduct whatever interviews may be indicated. The information obtained during this process shall be presented to the Credentials Committee and/or the Executive Committee of the Medical Board, which may decide whether or not to initiate a corrective action investigation, focused review or recommend corrective action.

9.4.2 Investigation:

If the Executive Committee of the Medical Board determines that a corrective action or focused review is warranted, it shall direct the Vice President Medical Affairs to either conduct the investigation or designate a committee or an individual to conduct the investigation. The investigation is to be completed within 30 days unless exigent circumstances arise.

a. The Investigating Committee shall consist of up to three (3) persons, who may or may not hold appointments to the medical staff, and shall not include partners, associates or relatives of the affected individual.
b. The Credentials Committee, the Investigating Committee or the individual charges with the investigation shall have available to them the full resources of the medical staff and the Hospital, as well as the authority to use outside consultants as required. The committee may also require a physical and mental examination of the appointee by a physician or physicians satisfactory to the committee and shall require that the results of such examination be made available for the committee's consideration.
c. The Member being investigated shall have an opportunity to meet with the Investigating Committee/individual. At this meeting (but not, as a matter of right, in advance of it) the Member shall be informed of the general nature of the allegation, evidence supporting the allegation and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing, and none of the procedural rules provided in this policy with respect to hearings shall apply. The Member may confer with an attorney prior to the meeting however the attorney shall not be present at the meeting. A summary of such interview shall be prepared by the Investigating Committee/individual and included with the final report to the Credentials Committee.
d. If an Investigating Committee/individual performs the investigation, the Credentials Committee may accept, modify or reject the recommendation it receives from that committee/individual. Prior to recommending any corrective action, the Credentials Committee shall notify the individual of the general tenor of the possible recommendation and ask the individual if he or she desires to meet with the Credentials Committee prior to the final recommendation to the Medical

Board. At such meeting, the Member shall be informed of the nature of the evidence supporting the action contemplated and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing and none of the procedural rules provided in this policy with respect to the hearing shall apply nor shall minutes of the discussion in the meeting be kept. The Member may confer with an attorney prior to the meeting however the attorney shall not be present at the meeting. However, the Credentials Committee shall indicate as part of its report to the Medical Board whether such a meeting occurred.

e. The Credentials Committee shall make a report of the investigation or focused review within 90 days of initiating the process and may recommend to the Medical Board the following:
   1. determine that no action is justified;
   2. issue a written warning;
   3. issue a letter of reprimand;
   4. impose terms of probation;
   5. impose a requirement for consultation;
   6. recommend reduction of clinical privileges;
   7. recommend suspension of clinical privileges for a term;
   8. recommend revocation of staff appointment; or
   9. make such other recommendations as it deems necessary or appropriate.

   The Chairman of the Credentials Committee shall be available to the Medical Board to answer any questions that may be raised with respect to the recommendation.

   a. If the action of the Medical Board does not entitle the individual to a hearing, the action shall take effect immediately without action of the Board of Trustees and without the right of appeal to the Board of Trustees.
   b. When the Medical Board has determined it shall make a recommendation contrary to the recommendation of the Credentials Committee, it shall either:
      1. remand the matter to the Credentials Committee for its further investigation and preparation of responses to specific questions raised by the Medical Board, prior to the Medical Board's final recommendation; or
      2. set forth in its report and recommendation to the Board of Trustees the specific reasons for the Medical Board's disagreement with the Credentials Committee's recommendation, supported by reference to particular aspects of the individual's record or the Credentials Committee's report
   c. A Medical Board recommendation that would entitle the Member to the procedural rights provided in these Bylaws shall be notified by the Chief Executive Officer by certified mail, return receipt requested within 7 days. The Chief Executive Officer shall hold the recommendation pending the decision of the individual to exercise or waive the right to a hearing. The Member shall have 14 days to notify the Chief Executive Officer of his/her intent to request a Fair Hearing. If the Member does not respond within 14 days, he/she will have been deemed to have waived the right to a hearing.

The Chief Executive Officer shall then forward the recommendation of the Medical Board, together with all supporting documentation, to the Board of Trustees. The President of the Medical Staff shall be available to the Board of Trustees or its appropriate committee to answer any questions that may be raised with respect to the recommendation.

d. If the Board of Trustees determines that it may consider a modification of the action of the Medical Board and such modification would entitle the Member to a Fair Hearing, The Board of Trustees shall direct the Chief Executive Officer to notify the Member, and shall take no final action thereon until the Member has exercised or has been deemed to have waived his/her procedural rights to a Fair Hearing. The Member shall have 14 days to respond.

9.4.3 Summary Suspension of Clinical Privileges

a. When, in the best interest of patient care and safety, action must be taken to suspend summarily all or any portion of the clinical privileges of a Member, if circumstances permit, there shall be an emergency meeting of the Academic Chairperson and/or, Department Chairpersons of the Department in which the Member has privileges, the President of the Medical Staff, and the Chief Executive Officer, or their designees. The Chief Executive Officer shall have the authority to invoke suspension of all or any portion of such privileges until a special meeting of the Credentials Committee can be convened. Such special meeting shall take place within seventy-two (72) hours of the emergency suspension. When there is clear and present danger to the health or safety of patient(s), the hospital or its personnel, any one of the above three individuals or the Vice President Medical Affairs, may suspend summarily the Member, pending the emergency meeting. At the time of the suspension, the physician must be immediately informed of the reasons for the suspension. These must be confirmed in writing prior to the emergency meeting of the Credentials Committee.

b. The Credentials Committee, after considering the facts, shall continue the suspension, or terminate it and shall make a report to the Medical Board, which shall convene a special meeting within 7 days of the report of the Credentials Committee. The Member shall be invited to attend the Medical Board meeting and may present his/her reasons and rationale for the care and treatment being reviewed. The Member may not have attorney representation present at this meeting.

c. Summary suspension is a preliminary action, and does not become a final action reportable to an appropriate agency or board until after the action has been upheld by the Medical Board.

d. The Medical Board may, by a majority vote of duly constituted quorum terminate the suspension, continue the suspension of privileges, or, if applicable, reinstate the suspension, until a meeting of the Board of Trustees. The Medical Board may recommend to the Board of Trustees that the practitioner's privileges be terminated, modified, or that the practitioner's staff membership be revoked.

e. If the disciplinary action involves an Academic or Department Chairperson, or the President of the Medical Staff, the Chief Executive Officer the Vice President Medical Affairs and the Chairperson of the Credentials Committee shall have the power to act jointly, pending emergency meetings of the Credentials Committee and the Medical Board, as in Paragraphs (b) and (c) of this Section.

f. Immediately upon the imposition of a summary suspension, the suspended Member must provide for alternative coverage for his/her patient(s) still in the Hospital at the time of the suspension. In the event that the Member does not make such provision, the Chairperson of the Department (or in his/her absence, the Associate Chairperson or the President of the Medical Staff) shall have the authority to provide appropriate coverage. The wishes of the patient(s) shall be considered in the selection of such alternative Members.

9.4.4 Confidentiality and Reporting

Actions taken and recommendations made pursuant to this Article shall be treated as confidential in accordance with such policies regarding confidentiality as may be adopted by the Board of Trustees.

9.4.5 Peer Review Protection

(a) All minutes, reports, recommendations, communications, and actions made or taken pursuant to this policy are deemed to be covered by the provisions of N.J. Stat. Ann. 24:84A-22.10 (West 1979, amended 1986) or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to this policy shall be considered to be acting on behalf of the hospital and its Board of Trustees when engaged in such professional review activities and thus shall be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986.

(b) All medical staff officers, department and committee chairpersons, committee members, and individual staff appointees who are acting on behalf of the hospital shall be indemnified by the hospital to the fullest extent permitted by law.

9.5 OTHER ACTIONS:

9.5.1 Failure to Complete Medical Records:

All the clinical privileges of an individual shall be administratively suspended for failure to complete medical records in accordance with applicable medical staff rules and regulations governing the same after notification by the Medical Records Department of such delinquency. Such suspension shall continue until all the records of the individual's patients are no longer delinquent.

Any physician who has been suspended for delinquent medical records three (3) times during a calendar year will have all privileges at the Hospital revoked. If the individual wishes to reinstate his/her privileges as a member of the Medical Staff, he/she will be required to pay the full initial application fee. Any patient who has been admitted under that particular attending shall receive the care under that attending until discharge. Since

this is an administrative suspension for delinquent medical records, it will not be reported to outside agencies.

9.5.2 Action by State or Federal Agency:

a. Revocation, Suspension, Expiration, Surrender or Relinquishment: Action by the appropriate state licensing board or agency revoking or suspending a Member's professional license, or loss or expiration/lapse, surrender or relinquishment of a of state license to practice for any reason, shall result in an automatic suspension/revocation of all Hospital clinical privileges as of that date, until the matter is resolved.
b. Restriction: In the event the Member's license is only partially restricted, the clinical privileges affected by the license restriction shall be similarly restricted.
c. Probation: whenever a Member is placed on probation by the appropriate state licensing board or agency, his/her status and privileges shall automatically become subject to the same terms and conditions of the probation as of the data such action becomes effective and throughout its term.

9.5.3 Failure to be Adequately Insured:

If at any time a Member's professional liability insurance coverage lapses, falls below the required minimum, is terminated or otherwise ceases to be in effect (in whole or in part), the Member's clinical privileges shall be suspended as of that date adequate professional liability insurance coverage is restored.

9.5.4 Failure to Attend Meetings or Satisfy Continuing Medical Education Requirements:

a. Failure to attend required meetings or failure to satisfy prescribed continuing education requirements may be considered as a reason for sanctioning the Member. Medical Practitioners shall satisfy the continuing education requirements as set forth by their respective boards. Members of the Allied Health Staff must satisfy the continuing education requirements of their respective disciplines. Such failure shall be documented and specifically considered by the Credentials Committee and Medical Board when making their recommendations for reappointment and by the Board of Trustees when making its final decisions.
b. If reappointment is refused by the Board of Trustees for failure to attend meetings or to satisfy continuing education requirements, the Member shall be eligible to reapply for staff appointment and the application shall be processed in the same manner as if it were an initial application, provided that for those physicians who held appointments or had applications on file as of December 31, 2009, the Board Certification Requirement contained herein shall not be applied to the reapplication.

9.5.5 Suspension or Exclusion from Medicare, Medicaid, Federal or State Health Care Programs

Whenever a Member of the Medical Staff has been suspended or excluded from participation in the Medicare or Medicaid program, and/or any other Federal or State

health care program, the medical staff privileges of the Member shall immediately and automatically be suspended until such time as the Member is reinstated by the Medicare/Medicaid programs.

ARTICLE X - ADOPTION AND AMENDMENT OF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF THE MEDICAL STAFF

10.1 BYLAWS

a. Medical Staff Responsibility**.** The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt and recommend Medical Staff bylaws and amendments, which shall be effective when approved by the Board of Trustees, whose approval shall not be unreasonably withheld. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, taking into account the provision of patient care quality, and efficiency, consistent with the mission of St. Joseph's Healthcare System..

b. Periodic Review**.** The Bylaws shall be reviewed periodically and amended, as necessary, to reflect the System's current practices with respect to the Medical Staff organization and functions.

c. Initiations of Amendments**.** Proposals for amendments may be initiated by: (a) the Medical Board, Medical Executive Committee or any standing committee of the Medical Staff; or (b) a Medical Staff member by petition signed by at least ten percent [10] percent of the Medical Staff's voting members. All proposed amendments shall be submitted to the Chairman of the Bylaws Committee. With the exception of technical and/or editorial changes as described in Section 10.3 below, the Chairman of the Bylaws Committee shall refer all such suggested changes to the Medical Board for review.

c. Referral to Medical Board**.** The Medical Board shall submit all proposed amendments for approval at a meeting of the Medical Staff. The Medical Board shall provide notice to the Medical Staff as to the time and place of the meeting shall include the subject of the proposed amendment(s) in the notice.

d. Vote of Medical Staff**.** Medical Staff Bylaws may be adopted, amended or repealed by the following combined actions:

   1. The affirmative vote of a majority of the Medical Staff members provided that, at least seven (7) days' advance written notice, accompanied by the proposed Bylaws and/or alterations, has been given; and
   2. The approval of the Board of Trustees that shall not be unreasonably withheld. If approval is withheld, the reasons for doing so shall be specified by the Board of Trustees in writing, and shall be forwarded to the President of the Medical Staff, the Medical Board and the Bylaws committee.

e. No Unilateral Amendment**.** The Bylaws may not be unilaterally amended by the Medical Staff, Medical Staff officers, Medical Board or Board of Trustees, or in a manner that is inconsistent with the Bylaws and/or mission of St. Joseph's Healthcare System.

f. Required Conditions. In recognition of the ultimate legal and fiduciary responsibility of the Board of Trustees, the organized Medical Staff acknowledges that, in the event the Medical Staff has unreasonably failed to exercise its responsibility and, after notice from the Board of Trustees to such effect, including a reasonable period of time for response, the Board of Trustees may impose conditions on the Medical Staff that are required for continued state licensure, approval by accrediting bodies, or to comply with law or a court order. In such event, the Board of Trustees in its actions shall carefully consider Medical Staff recommendations and views.

10.2 POLICIES, RULES AND REGULATIONS

a. Overview and Relation to Bylaws. These Bylaws describe the fundamental principles of Medical Staff self-governance and accountability to the Board of Trustees. Accordingly, the key standards for Medical Staff membership, appointment, reappointment and privileging are set out in these Bylaws.
The Medical Board shall, in consultation with the Vice President for Medical Affairs, adopt such rules and regulations ("Rules") and Medical Staff Administration Policies and Procedures as may be necessary to assure the proper conduct of Medical Staff activity. Such rules and regulations and Medical Staff Administration Policies and Procedures shall be consistent with these Bylaws and may be amended without advance notice at any meeting of the Medical Board.
Additional provisions, including but not limited to, administrative procedures for implementing the Medical Staff standards may be set out in Medical Staff or department rules, or in policies adopted or approved as described below.
Upon proper adoption, as described below, all such rules and policies shall be deemed an integral part of the Medical Staff Bylaws.

b. General Medical Staff Rules. The Medical Staff shall initiate and adopt such rules as it may deem necessary and shall periodically review and revise its rules to comply with current Medical Staff practice. Recommended changes to the rules shall be submitted to the Medical Board for review and approval as described below. Following approval by the Medical Board, a rule shall become effective following approval of the Board of Trustees, which approval shall not be withheld unreasonably or automatically within 60 days if the Board of Trustees takes no action. If there is a conflict between the Bylaws and the rules, the Bylaws shall prevail.

c. Departmental Rules. Subject to the approval of the Medical Board and Board of Trustees, each department may formulate its own rules for conducting its affairs and discharging its responsibilities. Such rules shall not be inconsistent with the Medical Staff or hospital Bylaws, rules or other policies.

d. Division Rules. Subject to the approval of the committee of the department that oversees the section, the Medical Board and Board of Trustees, each section may formulate its own rules for conducting its affairs and discharging its responsibilities. Such rules shall not be inconsistent with the Medical Staff or hospital Bylaws, rules, or policies.

e. Medical Staff Policies**.** Policies shall be developed as necessary to implement more specifically the general principles found within these Bylaws and the Medical Staff rules. The policies may be adopted, amended or repealed by majority vote of the Medical Board and approval by the Board of Trustees. Such policies shall not be inconsistent with the Medical Staff or hospital Bylaws, rules or other policies.

10.3 TECHNICAL AND EDITORIAL AMENDMENTS

The Medical Board shall have the power to adopt such amendments to the Bylaws and Rules that are, in its judgment, technical modifications or clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression or inaccurate cross-references. The action to amend may be made by motion and acted upon in the same manner as any other motion before the Medical Board subject to final approval by the Medical Board and Board of Trustees. The Medical Board or Board of Trustees shall communicate such changes in writing to the Medical Staff.