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Bylaws of the Medical Staff

As recently amended and approved by the Board of Trustees of Hunterdon Medical Center on:

2/24/2022

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PREAMBLE

Since the basic objectives of the Medical Staff of Hunterdon Medical Center are to provide quality medical care for patients, promote the education of doctors, nurses and paramedical personnel, contribute to the development of medical knowledge and to insure the advancement of appropriate community services, the licensed practitioners practicing in the Hunterdon Medical Center are hereby organized as a single medical staff in order to discharge the responsibilities and duties entrusted and delegated to it by law and custom. This shall be under the authority of the Board of Trustees of the Hunterdon Medical Center and further subject to the Bylaws of the Hunterdon Medical Center and in conformity with the Bylaws hereinafter set forth.

ARTICLE I
NAME

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

ARTICLE II
DEFINITIONS

For the purpose of these Bylaws:

Board of Trustees: means the Board of Trustees or governing body of the Hunterdon Medical Center.

Medical Staff: means the following licensed practitioners (Doctors of Medicine, Doctors of Osteopathy, Doctors of Medical Dentistry, Doctors of Podiatric Medicine) holding appointments from the Board of Trustees of Hunterdon Medical Center.

Medical Executive Committee: means the Executive Committee of the Medical Staff as defined in Article 10.3 of these Bylaws.

Medical School: means the Robert Wood Johnson Medical School.

Department Chairperson: means the elected head of a clinical department (Article 8.1).

Division Director: means the elected head of a specialty group within a specialty area (Article 8.1).

Bylaws: Documents, which define the structure, rights and governance of the Medical Staff.

Rules and Regulations: Compilation of policies and procedures for providing patient care and for carrying out Medical Staff responsibilities.

Manuals: Documents, which detail administrative or operational guidelines and processes.

He: "He" will represent either "he" or "she" throughout the document.

ARTICLE III
PURPOSE

The purpose of this Medical Staff organization shall be:

3.1 To ensure that all patients treated at the Hunterdon Medical Center receive care according to recognized quality standards.

3.2 To provide high-quality education and research within the framework of the Hunterdon Medical Center.

3.3 To initiate and maintain rules and regulations for governance of the Medical Staff.

3.4 To provide methods for discussion of matters of a medical administrative nature by the Medical Staff with the Board of Trustees and the administration of the hospital and to participate in any hospital deliberation affecting the discharge of medical staff responsibilities.

3.5 To function in continual dialogue with the hospital staff, the Board of Trustees, and the community to provide joint planning and effective execution of programs for patient care, teaching and research.

ARTICLE IV
ETHICS

The Principles of Medical Ethics as adopted or amended by the American Medical Association, American Dental Association, American Osteopathic Association and American College of Podiatric Surgeons, as appropriate, shall guide the professional conduct of the Medical Staff.

Upon appointment and reappointment to the Medical Staff, each member shall sign a written agreement of professional responsibility, a copy of which is appended to these Bylaws (Appendix A).

ARTICLE V
APPOINTMENTS

5.1 Appointments

The Board of Trustees shall appoint a Medical Staff of licensed practitioners (Doctors of Medicine, Doctors of Osteopathy, Doctors of Medical Dentistry, Doctors of Podiatric Medicine) permitted by law to independently provide patient care in the hospital. The appointments shall be in categories under rules and regulations as described in this Article 5 and more fully set forth in the Medical Staff Credentialing Manual. All appointments shall be for a period of not more than two years. All appointees shall be licensed to practice in the State of New Jersey. New appointees shall be either board certified by a specialty board recognized by the American Board of Medical Specialties (ABMS) or American Osteopathic Association specialty boards (AOA) or American Board of Podiatric Medicine also known as American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABOPOPPM) or American Board of Foot and Ankle Surgery (ABFAS) previously known as American Board of Podiatric Surgery (ABPS) or American Board of Oral and Maxillofacial Surgery (ABOMS) or board qualified and required to achieve board certification within five (5) years of initial appointment or the maximum allowed by their certifying board.

5.2 Procedure for Appointment

5.2 (a) A completed application for Medical Staff appointment shall include:

(1) Submission of a completed application for Medical Staff appointment.

(2) Documentation of current New Jersey license.

(3) Evidence of adequate malpractice insurance, at least equal to the acceptable minimum, which shall be set by the Board of Trustees from time to time after consultation with the Medical Staff.

(4) A statement detailing any successful or currently pending challenges to any licensure or registration (State, district or Drug Enforcement Administration) or the voluntary or involuntary relinquishment of such licensure or registration. Also, voluntary or involuntary termination of medical staff membership, or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital; and an explanation of any payment or settlement involvement, professional malpractice or current involvement in a professional liability action. The National Practitioner Data Bank will be queried to verify this information.

(5) Statement of health status adequate to meet practice and Staff responsibilities.

(6) Demonstration of training and current competence by records of postgraduate training, including references concerning ability, judgment and specialty status.

(7) Three references from peers demonstrating that the applicant manifests a positive attitude and functions in a manner that cooperates in supporting good patient care.

(8) Submission of a list of specific privileges requested.

All information contained in the application shall be verified from the primary source wherever possible.

5.2 (b) The applicant shall receive a copy of these Bylaws and of the Rules and Regulations of the Medical Staff. The applicant shall signify in writing agreement to abide by these Bylaws and Rules and Regulations. A copy of the latter is appended (Appendix B).

5.2 (c) The application shall be submitted to the President of the Medical Center or to such officer as may from time to time be designated by the Board of Trustees.

(1) At the time an application is requested, the applicant will receive, in writing, an explanation of how the application process will occur.

(2) It should be determined at that time if adequate facilities and services are available at the hospital to accommodate the applicant's practice.

(3) The applicant shall also be made aware that practice location must be in Hunterdon County or in such portions of neighboring counties as may be determined by the Board of Trustees to allow the member to service a significant number of Hunterdon County residents. Also, members of the Active and Community Active Staffs shall not hold an appointment on the Active Staff of any other hospital or on such staff unit as corresponds to the Active Staff at Hunterdon Medical Center (see Article 7.2(a)). Exception to this limitation is as detailed in Article 7.1(a).

5.2 (d) No application for appointment to the Active, Community Active, Courtesy or Consulting Staff of the Hunterdon Medical Center shall be acted upon until the Medical Staff Needs Committee of the Board of Trustees determines whether or not there is a need for such addition to the Medical Staff (as provided for in the Bylaws of Hunterdon Medical Center).

5.2 (e) Prior to these further determinations regarding an application, the applicant shall indicate in writing acceptance of Article 12 of these Bylaws (Confidentiality, Immunity and Releases).

5.2 (f) Following the action by the Board of Trustees taken on the Needs Committee recommendations, one of the following actions shall occur:

(1) Should there be determined that there is a need for such a position, all applications pending at that time shall be referred to the Selection and Credentials Committee and the appropriate department chairperson shall be notified. The petitioner and medical staff shall be notified of this action in writing by the Chair of the Needs Committee or designee. Any subsequent action by the Selection and Credentials Committee may be appealed under Article 6 of these Bylaws.

(2) If the determination is that there is no need for such a position, those who had petitioned for said Need shall be notified, in writing, by the Chair of the Needs Committee or designee as will the Chair of the appropriate department of the decision.

5.2 (g) Application for appointment to categories other than the Active, Community Active, Courtesy and Consulting Staff shall proceed directly to the Selection and Credentials Committee except that the Department Chairperson, Executive Committee, or President of the Medical Center may request the Medical Staff Needs Committee to determine if there is a need for such position.

5.2 (h) Applicants for positions approved by the Medical Staff Needs Committee and others not requiring such approval shall be acted upon by the Selection and Credentials Committee, which shall forward its recommendation to the Medical Executive Committee. The Medical Executive Committee shall forward its recommendation to the Board of Trustees. Final decision of the Board of Trustees shall be communicated in writing by the Secretary of the Board to the applicant.

5.2 (i) After identification of need and upon receipt of completed application, processing of the completed application shall be accomplished within 120 calendar days, unless the application becomes incomplete. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period.

5.3 Privileges

Each member of the Medical Staff shall have only such privileges allowing the member to admit or to treat as are granted by the Board of Trustees upon recommendation of the President of the Medical Center or designee and the Selection and Credentials and Medical Executive Committees after consultation with the appropriate Department Chairperson. The member shall receive a written statement of staff privileges and responsibilities. These privileges may be changed from time to time by the Board of Trustees upon recommendation of the President of the Medical Center or designee and the Selection and Credentials and Medical Executive Committees after consultation with the appropriate Department Chairperson. Such privileges shall terminate biennially with the reappointment cycle. Requests for additional privileges in areas present at Hunterdon Medical Center shall be evaluated, based upon the practitioner's training, experience and current competence, by the relevant Department Chairperson who shall make a recommendation to the Selection and Credentials and Medical Executive Committees, the President of the Medical Center and the Board of Trustees. Requests for privileges new to Hunterdon Medical Center shall be

accompanied by evidence of appropriate training, competence and experience. It is the responsibility of the relevant Department Chairperson(s) to ensure the completion of all necessary changes to procedure manuals, personnel instructions and departmental policies; and that appropriate provisions have been made regarding equipment, personnel and space. An appropriate quality review process shall be established.

In an emergency, any medical staff member with clinical privileges is permitted to provide any type of patient care, treatment or services necessary as a life-saving measure or to prevent serious harm within the scope of the practitioner's license.

5.4 Provisional Appointment

5.4 (a) Practitioners newly added to the Medical Staff shall serve a provisional term of at least one year. The practitioner's Department Chairperson shall be responsible for establishing and ensuring a quality assessment evaluation of the individual during the provisional term. After one year of provisional status, the appropriate Department Chairperson shall make all inquiries into the practitioner's performance and compliance with Medical Staff Bylaws requirements (meeting requirements, medical record completion, etc.) and shall make one of three recommendations to the Selection & Credentials Committee of either (1) appointment to the appropriate staff, (2) one additional year of provisional status, after which appointment to staff or denial of appointment must occur, or (3) denial of appointment. The Committee's recommendation shall be forwarded to the Medical Executive Committee which shall then make recommendation to the Board of Trustees.

Privileges shall be determined utilizing references from training institutions and/or current affiliations, experience, quality assessment evaluation, and other documentation. In the instance of procedures and/or treatments new to Hunterdon Medical Center, the Chairperson shall see that all pertinent alterations or additions to procedure manuals, personnel instructions and department policies have been completed prior to the institution of said procedure; and that appropriate provisions have been made regarding needed equipment, personnel and space. Appropriate quality assessment evaluation shall be included in the evaluation process at the end of the provisional year.

5.4 (b) Such provisional appointment will not be required for the Honorary Staff and may be waived by the Board of Trustees for those changing category in other areas of the Medical Staff.

5.5 Reappointment

Recommendations for biennial reappointments shall be made by the President of the Medical Center or designee and the Selection and Credentials and Medical Executive Committees of the Medical Staff after consultation with the appropriate Department Chairperson. They shall evaluate each member for satisfactory completion of requirements for Staff membership, as detailed in the Credentials Manual of the Medical Staff, and in Article 5.2 and this Article 5.5 of these Bylaws of the Medical Staff.

Applications for reappointment shall also include the appropriate Department Chairperson's review and approval of professional and clinical performance, as well as adherence to the rules and regulations of the Medical Staff, a statement of satisfactory health status, and if requested by the Selection and Credentials and/or Medical Executive Committees reasonable evidence thereof, attestation of completion of continuing medical education credit hours over a three two year period; and a peer reference designed to evaluate the applicant's ability to function with other practitioners and health care personnel in such a way that patient care is not compromised. Medical Staff members initially credentialed after 2005 shall also submit evidence of on-going recertification by at least one specialty board or sub-specialty board recognized by the ABMS, AOA, ABOMS, ABPM or ABOPOPPM, or ABFAS. Exceptions to this may be petitioned and reviewed by the Medical Executive Committee on an individual basis. Physicians initially credentialed prior to 2005 will be grandfathered and will not be required to submit evidence of recertification at time of reappointment. Physicians, whose board certification has lapsed subsequent to their most recent reappointment, must become certified within two years. The Medical Staff members shall also specify any final judgments or settlements in professional liability action that have occurred since the last appointment.

Proposed changes in privileges (if any) shall be recommended at this time. Appropriate evidence of training, experience and current competence will be required for evaluation of any additional privileges requested at the time of reappointment. In addition, a period of focused professional practice evaluation (FPPE) will be assigned as required by Joint Commission standards, these Bylaws and the Medical Staff Credentials Manual.

In the event that any question is raised regarding the reappointment of any individual practitioner, this shall be evaluated by the President of the Medical Staff and the Selection and Credentials and Medical Executive Committees, using the process described in Article 6.4.

5.6 Denial of Reappointment

A biennial reappointment can be denied for deficiencies in any of the categories in Article 5.2 and 5.5. The hearing and appellate procedures described in Article 6 shall apply if requested by the applicant.

5.7 Withdrawal of Privileges

Privileges of any member of the Medical Staff can be suspended, canceled or modified in accordance with the procedures outlined in Article 6 of the Bylaws.

5.8 Temporary Privileges

The President of the Medical Center shall have the authority to grant temporary privileges to a licensed practitioner who is not a member of the Medical Staff after consultation with the appropriate Department Chairperson. They shall make a determination that the competence and ethical standing of the practitioner who desires such temporary privileges are acceptable. In the exercise of such clinical privileges, practitioners shall be under the immediate supervision of the appropriate Department Chairperson.

Temporary privileges will extend for a specific time not to exceed 90 days. Any extension beyond this must be reviewed and approved by the Medical Executive Committee with no temporary appointment to exceed a total of 120 days. Candidates for appointment to the Medical Staff shall not receive temporary privileges prior to evaluation by the Selection and Credentials Committee.

In extraordinary circumstances when the Hospital's emergency management plan has been activated, or under a patient emergency as defined in the Credentials Manual, temporary, emergency or disaster privileges may be granted to non-staff physicians as set forth in the Medical Staff Credentials Manual.

Notwithstanding these provisions, a temporary appointment may be summarily withdrawn upon due cause by the President of the Medical Center at any time after consultation with the Department Chairperson, Assistant Chairperson or in their absence, the President of the Medical Staff.

5.9 Leave of Absence

A practitioner wishing a leave of absence shall make such a request in writing to the appropriate department chairperson, stating the reason and length of time requested. The latter shall not exceed one year. A request for a period of time up to three months may be approved by the Department Chairperson and the Chief Medical Officer/Vice President Medical Affairs. On a request for a longer period of time the Department Chairperson will forward the recommendation to the Medical Executive Committee, who will, in turn, forward their recommendation to the Board of Trustees. All rights and obligations of Medical Staff membership are suspended during a granted leave of absence (meeting attendance, committee service, emergency call, etc.)

The practitioner will be required to maintain current appointment to the staff by completing standard reappointment processes. If a practitioner's current appointment were to expire during the leave, the practitioner's appointment and clinical privileges would expire at the end of the appointment period, and the individual will be required to reapply for appointment.

The leave of absence will be reviewed by the Medical Executive Committee at the end of the time allowed. At that time, the practitioner shall request either reinstatement to the Medical Staff or a renewal of the leave. If the leave has exceeded one (1) year, the practitioner will be subject to the FPPE process in order to be reinstated as a member of the Medical Staff. The Department Chairperson shall forward this request with recommendations to the Medical Executive Committee. The Medical Executive Committee will send their recommendation to the Board of Trustees regarding action on this request. Any adverse decision to the request may be appealed by the practitioner under the procedures in Article 6 of these Bylaws. Failure of the practitioner to request reinstatement or renewal of leave of absence shall be considered resignation from the Medical Staff.

5.10 Dues

Medical Staff dues shall be determined from time to time by the Active and Community Active Medical Staffs at the recommendation of the Medical Executive Committee. Members of the Medical Staff will be required to pay full dues. Dues will be prorated quarterly for new members according to the month of their appointment. Members of the Honorary and Emeritus Staffs will not be required to pay dues.

Any staff member who is more than six (6) months in arrears in the payment of dues may have their staff membership suspended at the recommendation of the Medical Executive Committee.

Any physician who is unable to pay their dues because of extenuating circumstances must present their circumstances to the Medical Executive Committee for their recommendation for exception.

ARTICLE VI
CORRECTIVE ACTIONS AND RIGHT TO HEARING AND APPELLATE REVIEWS

6.1 Trustees' Final Decision

The Board of Trustees reserves the right at all times to take corrective action with respect to the Medical Staff appointment and clinical privileges of any practitioner and to deny reappointment to the Medical Staff because of failure of the practitioner to

fulfill the qualifications set forth in Articles 5.2 and 5.5 as the case may be; and the same is, or is reasonably likely to be detrimental to patient safety or delivery of quality medical care, or is disruptive to the operation of the hospital or an impairment to the community's confidence in the hospital. Such corrective action may include, but shall not be limited to, reprimand, the reduction, suspension or termination of privileges and/or membership, or a requirement that the practitioner be supervised or obtain consultation. Such action shall be taken in accordance with the procedure prescribed in this Article 6.

6.2 Right to Hearing

Except as provided in Articles 6.11, 6.12 and 6.13, neither an appointment to the Medical Staff nor clinical privileges shall be altered, reduced, suspended or terminated, nor shall reappointment be denied, without the affected practitioner having the right to one evidentiary hearing before a Review Committee of the Medical Staff, provided for in Article 6.6, and one appellate review before an Appeals Committee of the Board of Trustees, provided for in Article 6.7, as he may request in writing. If such request is made, the hearing and appellate review shall proceed in accordance with Article 6. The affected practitioner specifically agrees to be bound by the immunity provisions set forth in Article 12 hereof.

6.3 Duty to Report

It shall be the responsibility of each member of the Board of Trustees, the Medical Staff, the Administrative Staff, and the Nursing Staff to place before the President of the Medical Center, in writing, any significant questions as to the medical staff competence, ethical qualifications, or conditions of health of any member of the Medical Staff, when they are seen to endanger patient safety, or the quality of care. Such an issue may also arise from utilization review or quality control evaluations, which appear to demonstrate failure to provide good patient care.

6.4 Investigation by the Medical Staff President and Executive Committee

6.4 (a) Any such question as referred to in Article 6.3 shall be referred to the President of the Medical Staff who shall meet with practitioner within fourteen (14) calendar days for the purpose of discussion of the accusations. If the President of the Medical Staff finds no cause for further action this shall be so reported to the President of the Medical Center and to the Medical Executive Committee within fourteen (14) days.

6.4 (b) In cases of suspected impairment due to drug or alcohol abuse, the President of the Medical Staff may defer further action pending the referral to the Physician Health Advisory Committee.

6.4 (c) If the President of the Medical Staff finds that there is reason for further investigation into the accusations, or if the practitioner fails to meet with the President of the Medical Staff, the matter shall be referred for investigation by the Medical Executive Committee. Such meeting shall take place within thirty (30) days from receipt of the question or from the meeting with the practitioner, if such occurred. The affected practitioner shall be afforded the right to appear at a meeting of the Medical Executive Committee upon notice as required in Article 6.9(a). The meeting shall proceed as an informal conference. Minutes shall be taken but limited to a recital of the events at issue and the conclusions and recommendations of the Medical Executive Committee. There shall be no record of the discussions at the informal conference. The affected practitioner shall have the right to introduce evidence in her/her behalf and may be accompanied by medical associates (all of whom shall be members of the Medical Staff of Hunterdon Medical Center) to participate in the conference. No attorneys, for either the affected practitioner or the hospital, shall be present. The procedural rules provided for in Article 6.10 shall not apply to this conference.

6.4 (d) If the Medical Executive Committee finds insufficient grounds for further action, the matter shall be closed except for a report to the President of the Medical Center and the chairperson of the Board of Trustees sent within fourteen (14) days.

6.4 (e) Should the Medical Executive Committee believe there to be sufficient justification for further action, it shall make a written report to the President of the Medical Center within fourteen (14) calendar days after completion of the investigation, which report shall be serviced upon the affected practitioner and distributed in accordance with Articles 6.9(b) and 6.9(c).

6.4 (f) In the case of an emergency suspension of privileges (6.11) the President of the Medical Staff shall proceed under 6.11(a) of this Article.

6.5 Temporary Conditions

With the concurrence of a majority of the Medical Executive Committee, the President of the Medical Center may suspend the privileges of the affected practitioner or may impose conditions on the extent of his/her privileges and activities at the hospital, including supervision, pending completion of the entire procedure prescribed in this Article 6.

6.6 Hearing before the Review Committee of the Medical Staff

6.6 (a) Within thirty (30) calendar days of the receipt of the report and recommendations of the Medical Executive Committee, Article 6.4(e), the President of the Medical Staff shall appoint an ad-hoc Review Committee composed of five (5) impartial members of the Medical Staff. The Review Committee shall conduct a hearing and may either accept, reject, or modify the report and recommendations of the Medical Executive Committee. The affected practitioner shall receive notice of the hearing as provided for in Article 6.9(a) and may request to be present at the hearing, in which event the hearing shall be held in accordance with Article 6.10. The affected practitioner shall make such a request in writing to the President of the Medical Center within fourteen (14) calendar days of receiving the report and recommendations of the Medical Executive Committee.

6.6 (b) The Review Committee shall, within fourteen (14) calendar days after the completion of the hearing, make its written report and recommendations, which shall be served upon the affected practitioner and distributed in accordance with Article 6.9(b) and 6.9(c). If the report of the Review Committee is adverse to the practitioner, and if the practitioner so requests by written notice to the President of the Medical Center, received within fourteen (14) calendar days of the practitioner's receipt of the report of the Review Committee, there shall be appellate review by the Board of Trustees as provided in Article 6.7. If appellate review is not requested by the affected practitioner, the report and recommendations of the Review Committee shall be made directly to the Board of Trustees for final action. In the event that the Review Committee rejects the recommendations of the Medical Executive Committee, its report and recommendations shall, nevertheless, be furnished to the Board of Trustees for final action.

6.7 Appellate Review before the Appeals Committee of the Board of Trustees

6.7(a) If requested by the affected practitioner as provided in Article 6.6(b), there shall be an appellate review before an ad-hoc Appeals Committee of the Board of Trustees. The Appeals Committee shall consist of five (5) members selected from the Boards of Trustees of the Medical Center and of Hunterdon Health Services. They shall be chosen by the Chairperson of the Board. There shall be three (3) medical advisors to the Appeals Committee who shall be the resident of the Medical Staff, the Chairperson of the Credentials Committee and the Chairperson of the affected practitioner's department, or such alternate advisors as may be chosen by the Chairperson of the Board in consultation with the President of the Medical Staff.

6.7(b) The Appeals Committee shall have the power to accept, reject, or modify the report and recommendations of the Review Committee of the Medical Staff. The deliberations of the Appeals Committee shall be commenced within thirty (30) calendar days of the receipt of the report and recommendations of the Review Committee of the Medical Staff and upon written notice to the affected practitioner as provided for in Article 6.9(a). The report and recommendations of the Appeals Committee shall be made to the Board of Trustees for final action within thirty (30) calendar days after completion of the appellate review and shall be served upon the affected practitioner and distributed in accordance with Article 6.9(b) and 6.9(c).

6.7(c) The management and control of the appellate review shall rest with the Chairperson of the Appeals Committee who shall be named by the Chairperson of the Board. The appellate review shall be limited to the written record produced before the Review Committee of the Medical Staff, supplemented only by written reports submitted (in accordance with the time schedule announced by the presiding officer) by the affected practitioner and the hospital, if the right to do so is requested by either party, detailing findings of fact, conclusions of law, and procedural matters to which the party takes exception. The affected practitioner and the hospital shall be entitled to receive a copy of the entire record produced for the Review Committee of the Medical Staff. New or additional matters or evidence not raised or presented during the Article 6.6 hearing and not otherwise reflected in the record may be introduced only at the discretion of the Chairperson or, if the Chairperson so deems it appropriate, the party requesting consideration of the matter of evidence shows that it could not have been discovered in time for the Article 6.6 hearing. All members of the Appeals Committee shall review the written record of the hearing before the Review Committee of the Medical Staff, as supplemented. The medical advisors shall not participate in the final determination by the Appeals Committee.

6.8 Final Action by the Board of Trustees

6.8(a) Upon receipt from either the Review Committee of the Medical Staff or the Appeals Committee of a report and recommendations (depending upon whether the affected practitioner has requested appellate review pursuant to Article 6.7) the Board of Trustees shall take final action and either accept, reject or modify such recommendations within forty-five (45) calendar days of receipt. All members of the Board of Trustees shall be entitled to participate in the final action, including those Trustees who served on the Appeals Committee. Members of the Board of Trustees shall be free to review the written record, but shall not be required to do so. The final report of the Board of Trustees shall be issued within fourteen (14) calendar days of its adoption and shall be served upon the affected practitioner and distributed in accordance with Article 6.9(b) and 6.9(c). The affected practitioner shall not be entitled to a hearing or appellate review before the full Board of Trustees.

6.8(b) In the event that the final decision of the Board of Trustees is contrary to the recommendations of the Executive Committee or the Review Committee of the Medical Staff, the matter shall be referred to an ad hoc Committee comprised of two (2) members of the Medical Staff appointed by the President of the Medical Staff and two (2) members of the Board of Trustees appointed by the Chairman of the Board of Trustees for further consideration. The affected practitioner shall not be entitled to a hearing or to appear before this Committee. The Committee Shall report to the Board of Trustees within fourteen (14) days its recommendations, and which shall be served upon affected practitioner and distributed in accordance with Articles 6.9(b) and 6.9(c).

6.8(c) The Board of Trustees shall then take final action and either accept, reject or modify such recommendations within fourteen (14) calendar days of receiving the report of the ad-hoc Committee. The action of the Board of Trustees shall be final in accordance with Article 7.1.

6.9 Notice and Distribution of Reports: Extension of Time; Waiver

6.9(a) The President of the Medical Center shall notify the affected practitioner of the date and place of the informal conference of the Medical Executive Committee (Article 6.4), the hearing before the Review Committee of the Medical Staff (Article 6.6) and the appellate review before the Appeals Committee (Article 6.7) by certified mail (return receipt requested) mailed at least seven (7) days prior to the hearing date.

6.9(b) The President of the Medical Center shall notify the affected practitioner of any decision of the Medical Executive Committee, the Review Committee of the Medical Staff, the Appeals Committee, the Board of Trustees, or the ad- hoc committee by certified mail (return receipt requested) within fourteen (14) days of any such decision, and the affected practitioner shall be provided with a copy of any written report within such time period.

6.9(c) Copies of all reports and recommendations required hereunder shall be provided by the President of the Medical Center to the President of the Medical Staff, the Medical Executive Committee, the chairperson of the department to which the affected practitioner is assigned, and the Chairperson of the Board of Trustees, provided that failure to do so shall not affect the right of the affected practitioner.

6.9(d) Any and all time limitations set forth in this Article 6 may be extended by mutual agreement of the affected practitioner and the hospital.

6.9(e) Failure of the affected practitioner to request either a hearing or appellate review or both within the time period set forth in this Article 6 shall be deemed a waiver of the practitioner's rights to said hearing and appellate review.

6.10 Hearing Procedure

If the affected practitioner requests to participate in the hearing before the Review Committee of the Medical Staff, the following procedures shall apply:

6.10(a) There shall be at least a majority of the members of the Review Committee of the Medical Staff present when the hearing takes place and no member may vote by proxy.

6.10(b) As required by Article 6.9(b), the affected practitioner shall have received, in advance of the hearing, a copy of the written report of the Medical Executive Committee. This report shall state concisely the charges against the practitioner with reference to specific patient charts or other relevant and material documentary material.

6.10(c) The proceedings shall be transcribed by a stenographer with expense to be paid by the hospital.

6.10(d) Either the affected practitioner or the hospital, or both, may be represented by legal counsel, with counsel's participation being subject to reasonable rules promulgated by the Board of Trustees or the Chairperson of the Review Committee of the Medical Staff, or both.

6.10(e) The management and control of the hearing shall rest with the Chairperson of the Review Committee of the Medical Staff who shall be the presiding officer. The Chairperson shall maintain decorum and assume that all participants have a reasonable opportunity to present relevant oral and documentary evidence. The Chairperson shall further determine the order of procedure during the hearing and make all rulings on matters of law, procedure, and the admissibility of evidence. The Review Committee may be assisted by an independent legal advisor if deemed necessary.

6.10(f) Both the affected practitioner and the hospital shall have the right to call and examine witnesses, introduce written evidence, meet and explain adverse data, and present argument to the Review Committee of the Medical Staff. Neither party shall have the right to confront and cross-examine adverse witnesses, except as may be specifically allowed by the

presiding officer and except that should the affected practitioner not testify in his or her own behalf, he may nevertheless be called and examined as if under cross examination. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or the presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs may be considered, regardless of the admissibility of such evidence in a court of law.

6.10(g) The hearing may be postponed or adjourned beyond the time limitation set forth in Article 6.6 for good cause, upon the mutual agreement of the practitioner, the hospital, and the Review Committee of the Medical Staff.

6.10(h) The Review Committee of the Medical Staff shall, following the presentation of evidence and argument, conduct its deliberation outside of the presence of the affected practitioner and the hospital.

6.10(i) In the event that the affected practitioner fails, without good cause, to appear at a scheduled hearing, the practitioner shall be deemed to have waived his right to hearing and appellate review.

6.11 Emergency Suspension

Notwithstanding the above, if at any time a member of the Medical Staff shall, in the opinion of the President of the Medical Center (or in the President's absence, the Chief Medical Officer/Vice President Medical Affairs) become unqualified to care for any patient because of either physical or mental illness, or because of the influence of alcohol or drugs, or on action or conduct that threatens the safety of patients, employees or others, the following action shall be pursued:

6.11(a) The President of the Medical Center shall call an emergency meeting of all available members of the Executive Committee which will meet in executive session, all members of which are to be notified and given at least one hour's notice of such meeting. Pending such meeting, the practitioner's privileges shall be temporarily withheld and the President of the Medical Center or designee shall be responsible for assigning care of the suspended practitioner's patients. At the expiration of one hour, after notification of Executive Committee members, the President of the Medical Center shall hold a meeting provided there are, in addition to the convener, at least two (2) members of the Executive Committee present to determine the action to be taken. By a majority affirmative vote of those present, this emergency committee may order the immediate temporary suspension of the practitioner's privileges without hearing.

6.11(b) The President of the Medical Staff or designee shall be immediately notified, in writing, of the temporary suspension. The President shall then proceed under Article 6.4 of these Bylaws. In no event shall the emergency suspension be for longer than fourteen (14) calendar days before further action is taken.

6.12 State Board of Examiner Revocation of License

In the event of revocation of a practitioner's license by the appropriate State Board of Examiners, suspension of hospital privileges is automatic. Should the license later be restored, reapplication for privileges as per Article 5 of these Bylaws is required.

In the event of suspension of a practitioner's license, clinical privileges will be suspended automatically. If the underlying matter leading to suspension is resolved within 90 days, the practitioner may request reinstatement. Requests for reinstatement will be reviewed by the relevant Department Director, the VPMA/Chair of the Selection & Credentials Committee, the President of the Medical Staff and the CEO. If all these individuals make a favorable recommendation on reinstatement, the practitioner may immediately resume clinical practice at the Medical Center. This determination will then be forwarded to the Selection & Credentials Committee, the Medical Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee and Board for review and recommendation.

Failure to resolve the matter within 90 days of the date of license suspension will result in the practitioner's automatic resignation from the Medical Staff. Application to the medical staff will be required as per Article 5 of these Bylaws.

When a practitioner fails to renew a license prior to its expiration, clinical privileges will be temporarily suspended until primary source verification of current licensure can be obtained. Failure to renew a license for a period greater than 30 days following expiration will constitute voluntary resignation from the medical staff.

6.13 Loss of Malpractice Insurance

In the event of loss of adequate malpractice coverage, suspension of hospital privileges is automatic. Appointment and clinical privileges will be reinstated once the provider has submitted evidence of current adequate malpractice coverage. Failure to provide evidence of restored malpractice coverage within 30 days of the original date of expiration date will result in the practitioner's automatic resignation from the Medical Staff. Application to the medical staff will be required as per Article 5 of these Bylaws.

6.14 Temporary Suspension for Failure to Complete Medical Records

Notwithstanding the above, members of the Medical Staff may have their privileges temporarily suspended by the Chairperson of the Medical Executive Committee for failure to complete medical records in accordance with the Rules and Regulations of the Medical Staff. In the case of a temporary suspension, the practitioner is not entitled to a hearing as provided above. The practitioner shall be allowed to complete the care of any current patients.

ARTICLE VII
CATEGORIES OF THE MEDICAL STAFF

7.1 Active Staff

7.1(a) Definition

The Active Staff shall consist of members of several departments of the Medical Center. All members of the Active Medical Staff shall the right to vote. The President of the Medical Center and the Chief Medical Officer/Vice President Medical Affairs may be members of the Active Medical Staff provided they have completed all requirements for appointment as detailed in Article 5.2. However, they shall not have the right to vote as members of the Active Staff or to hold representative office. Having completed all requirements for appointment to the Active Staff, appointments of such employed practitioners shall not be affected by resignation from or termination of the employed position unless termination of the staff appointment is called for in the employment contract.

Each member of the Active Staff shall, subject to the provision of Article 5, practice here in Hunterdon County or in such portions of neighboring counties as may be determined by the Board of Trustees to allow the practitioner to serve a significant number of Hunterdon County residents. Members of the Active Staff shall not hold an appointment on the Active Staff of any other hospital or such staff unit as corresponds to the Active Staff of Hunterdon Medical Center. Exceptions to this provision may be made for individuals and/or specialties (i) where it is not practical, for reasons of 24-hour coverage and/or limitation in number of cases, to have the members of that specialty concentrate their in-hospital activities at this institution, or (ii) in accordance with the following terms and conditions:

(1) Applicant for waiver must be a member of the Active Staff or a new applicant for Active Staff privileges joining an existing practice on the Active Staff.

(2) Applicant must have a bona fide office outside of Hunterdon County in the service area defined by HMC's Board of Trustees.

(3) Applicant must practice in a specialty that requires the ability to provide services to existing patients of Hunterdon Healthcare System (HHS) affiliated practices when they are admitted to another hospital in HMC's service area through the hospital's Emergency Department. As used here, "requires" means it is not feasible to conduct a practice in this specialty in the geographic area without the ability to see patients at the other hospital in these circumstances. The Medical Executive Committee and the Board of Trustees will make this determination.

(4) Applicant must agree that she/she will only exercise privileges at the other hospital as necessary to admit patients to that hospital on an emergent basis, provide emergent consultation to inpatients at that hospital, or provide consultation in accordance with the Medical Staff Bylaws of that hospital, and not to admit patients electively. For purposes hereof, the elective admission of an Applicant's patient to the service of a hospitalist with subsequent consultation by the Applicant shall not be considered an "emergent consultation." The Applicant must sign an acknowledgement of this condition and periodically provide an attestation that no elective admissions or non-emergent consultations have been done at another hospital.

(5) If granted, the waiver would be time-limited to the Applicant's (2-year) credentials period, and then subject to review.

(6) Applicant must agree that any violation of the above conditions of the waiver would result in the immediate ineligibility for continued privileges at HMC, such action to be deemed an administrative termination, and not reportable to the New Jersey Board of Medical Examiners or the National Practitioner Data Bank. In the event of such a termination of privileges, the Applicant's rights under Article VI of these Medical Staff Bylaws would be limited to the question of whether he or she had admitted and/or treated a patient (or patients) at another hospital in violation of the terms and conditions stated above.

The Medical Executive Committee and Board of Trustees shall determine to what individuals and/or specialties these exceptions apply. Exceptions are anticipated to be rare, and the grant of an exception is not intended to set a precedent for any other individual or specialty. There is no entitlement to an exception.

7.1(b) Minimum Activity Required

Appointees to the Active Staff are expected to participate in patient care activities at the Medical Center. No appointee to the Active Staff shall be eligible for reappointment unless he or she has had at least ten (10) documented patient encounters at the Medical Center or at an HMC-affiliated outpatient surgery center during the preceding two year appointment period. An exception to this rule may be made in the discretion of the appointee's Department Chair upon a finding that continued appointment of the practitioner is in the best interest of the Medical Center.

7.2 Community Active Staff

7.2(a) Definition

The Community Active Staff shall consist of those practitioners, primarily community based, who desire to be associated with the Hunterdon Medical Center but who do not provide inpatient care. Members of the Community Active Staff shall not hold an appointment on the Active Staff of any other hospital or such staff unit as corresponds to the Active Staff of Hunterdon Medical Center.

7.2(b) Privileges

Community Active Staff members do not hold clinical privileges at Hunterdon Medical Center. They may request "Refer and Follow", which will give them access to the patient's record without the ability to write orders or to make any entries in the medical record.

They may not admit patients, attend patients, write orders or progress notes, may not make any notations in the medical record, or actively participate in the provision or management of care to patients in the Hospital. They shall have access to inpatient Hospital services for their patients by referral to members of the Active, Affiliate, Courtesy or Consulting Staffs. They may visit their hospitalized patients, access their Hospital medical records and communicate with the treating physicians.

7.2(c) Community Active Staff members shall have the right to vote. They shall be able to hold office, serve on committees and shall be particularly encouraged to attend any educational programs.

Community Active Staff members shall pay application fees, dues and other assessments.

Since there are no clinical privileges granted, FPPE/OPPE is not applicable.

7.3 Affiliate Staff

7.3(a) Definition

The Affiliate Staff shall consist of dentists who occasionally carry on professional activities within the Medical Center. Appointment to the Affiliate Staff shall be made by the Board of Trustees after considering the recommendations of the President of the Medical Center and the Executive Committee in regard to the individual's privileges and responsibilities. The appointment shall originate with the Director of the Department or the Medical Staff Needs Committee and pass through the Selection and Credentials Committee.

7.3(b) Privileges and Responsibilities

Privileges and responsibilities for each individual shall be determined by the President of the Medical Center in consultation with the appropriate Department Chairperson and shall be appropriate to the applicant's credentials. They shall then be specified to the applicant in writing upon appointment to the Affiliate Staff. Patients whose admission to the hospital is initiated by a member of the Affiliate Staff must be under the overall medical supervision of a member of the Active Staff named at the time of admission. These patients must receive a medical history, physical exam and other basic medical appraisal similar to that given to patients admitted to other services. The member of the Active Staff shall be responsible for the overall medical care of the patient. A member of the Affiliate Staff may write orders consistent with the scope of his or her professional license and credentials. The practitioner may serve on appropriate hospital committees and shall not be eligible to vote or hold office.

7.4 Consulting Staff

7.4(a) Definition

The Consulting Staff shall consist of 1) members of the full-time faculty of the affiliated medical school; and 2) practitioners from outside the area normally served by Hunterdon Medical Center who fill a vacancy not otherwise filled and benefit Hunterdon Medical Center by their appointment.

7.4(b) Privileges

Each member of the Consulting Staff shall have only such privileges to consult in the treatment of patients as are granted by the Board of Trustees upon recommendation of the President of the Medical Center or designee and the Executive Committee after consultation with the appropriate Department Chairperson.

7.4(c) They shall not be eligible to hold office or to vote. They may serve on appropriate committees.

7.5 Courtesy Staff

7.5(a) Definition

The Courtesy Staff shall consist of licensed practitioners from this and neighboring counties who occasionally wish to admit or treat their patients on one of the services of the Hunterdon Medical Center.

7.5(b) Privileges

Each member of the Courtesy Staff shall have only such privileges to admit or treat as are granted by the Board of Trustees on recommendation of the President of the Medical Center or designee and the Executive Committee after consultation with the appropriate Department Chairperson. A written statement as to his privileges shall include the maximal privileges, if any, allowed.

7.5(c) They shall not be eligible to vote. They shall be expected to serve on appropriate committees.

7.5(d) Minimum Activity Requirement

Appointees to the Courtesy Staff are expected to participate in patient care activities at the Medical Center. No appointee to the Courtesy Staff shall be eligible for reappointment unless he or she has had at least ten (10) documented patient encounters at the Medical Center or at an HMC-affiliated outpatient surgery center during the preceding two year appointment period. An exception to this rule may be made in the discretion of the appointee's Department Chair upon a finding that continued appointment of the practitioner is in the best interest of the Medical Center.

7.6 Telemedicine Privileges

7.6(a) Definition

Practitioners with Telemedicine Privileges shall consist of those physicians with offices at a distant site who provide medical care via a telemedicine link (either direct care or interpretative services).

7.6(b) Privileges

Each member providing Telemedicine Services shall be granted such privileges as are necessary to provide the services required by the Medical Staff Department needing such services. They will be subject to quality review through their privileging Department, including Focused and Ongoing Professional Practitioner Evaluations. Their privileges will be renewed on a biennial basis.

7.6(c) They shall not be considered members of the medical staff. They will not pay dues or be able to vote or to hold office.

7.7 Honorary Staff

The Honorary Staff shall consist of practitioners who have served on the Active or Community Active Staffs for at least twenty (20) years and who no longer wish to maintain an Active or Community Active Staff position on the Medical Staff. The Honorary Staff may also consist of those practitioners who are recognized for their noteworthy contributions to patient care, or their outstanding reputations, but who may not reside in the geographic area serviced by the Medical Center.

Members of the Honorary Staff may have only such privileges to admit or treat as are granted by the Board of Trustees on recommendation to the President of the Medical Center or designee and the Medical Executive Committee after consultation with the appropriate Department Chairperson, and which shall be reviewed biennially concurrent with staff reappointments. Members of the Honorary Staff shall not be eligible to vote or hold office, shall not be required to pay dues, and shall have no assigned duties.

Attendance at meetings shall be determined by the Department Chairperson consistent with the privileges granted.

7.8 Emeritus Staff

Those members of the Medical Staff who have served in this capacity for a period of at least ten (10) years, who are recognized for their noteworthy contributions to patient care, or their outstanding reputations, and who have retired from the practice of medicine may be appointed by the Board of Trustees to the Emeritus Staff upon the recommendation of the Medical Center Executive Committee. Members of the Emeritus Staff shall have no clinical privileges, shall not be eligible to vote or hold office, and shall not be required to pay dues or attend meetings. They can be appointed to committees with their consent.

ARTICLE VIII
CLINICAL DEPARTMENTS

8.1 Composition

The Medical Staff shall consist of the following departments:

- Anesthesiology
- Emergency Medicine
- Family Medicine
- Internal Medicine (Divisions of Cardiology, Dermatology, Endocrinology, Gastroenterology, General Internal Medicine, Hematology/Oncology, Infectious Disease, Nephrology, Neurology, Physical Medicine, Pulmonary/Critical Care and Radiation Oncology)
- Medical Imaging
- Obstetrics/Gynecology
- Pathology
- Pediatrics
- Psychiatry
- Surgery (Divisions of General Surgery, Neurosurgery, Ophthalmology, Oral and Maxillofacial Surgery, Orthopedic Surgery, Otorhinolaryngology, Plastic Surgery, Podiatry, Thoracic Surgery and Urology)

8.2 Chairperson

Each Department shall have a chairperson who shall be selected by the members of their respective department for a two-year term, subject to the approval of the Board of Trustees. The chairperson shall be certified by an appropriate specialty board or possess comparable competence, documented by education, training or experience. In the event that the Board of Trustees does not approve the recommendation of the department members, a committee shall be appointed consisting of three (3) trustees and three (3) members of the Active or Community Active Staffs (at least one (1) of whom shall be a member of the department involved). The recommendation of the committee shall be submitted to the Board of Trustees for its final decision subject to the approval of the affiliated medical school.

In the event that the Department Chairperson is felt to fail in his role, he may be replaced by majority vote of the department members, subject to review and approval by the Executive Committee and the Board of Trustees.

The Department Chairperson shall be responsible to the President of Hunterdon Medical Center through the Chief Medical Officer/Vice President Medical Affairs.

In the event that no department chairperson is elected, the Executive Committee shall interview the department members and then make the selection of a chairperson. The selection will be subject to the same approval mechanism as a newly elected chairperson.

In the event that any department chairperson dies, resigns or is, for any reason, unable to finish the term, the President of the Medical Staff may appoint a member of that department to serve as department chairperson for the duration of said term unless the department Bylaws provide for an elected successor. This candidate will be presented subject to the same approval mechanism as a newly elected chairperson.

8.2(a) Division Directors

Division Directors shall be elected by the members of their respective divisions for a two-year term, subject to the approval of the Board of Trustees. In the event of a tie, the decision will be deferred to the department chair.

The Division Directors will be responsible to consult with and provide recommendation to Department Chairs on all matters regarding credentialing and privileging of medical and advanced practice professional staff members within their respective divisions.

8.3 Authority and Responsibility of Department Chairperson

Each department chairperson shall be responsible for the supervision of the department in conformance with these Bylaws and the Rules and Regulations of the Medical Staff. The responsibility shall include, but not be limited:

8.3(a) to assure the continuous assessment and improvement of the quality of medical care services provided within the department and the professional performance of department members, including those individuals who are not licensed independent practitioners who provide patient care, by investigating any matter that arises about an individual practitioner during quality review (10.6), and by selecting cases for discussion at the monthly departmental meetings;

8.3(b) to provide administrative liaison for the department; and be responsible for all administratively related activities of the department, unless otherwise provided by the hospital;

8.3(c) to direct all educational and research programs in the department under the supervision of the Director of Medical Education and to direct the orientation, and monitor the continuing medical education of all persons in the department to ensure that the education requirements of the Bylaws are being met;

8.3(d) to coordinate, assign and schedule members of the department, residents and interns assigned to the department to their appropriate share of hospital facility, in-hospital physician coverage, administrative and committee assignments, indigent care, involvement in community programs and teaching responsibilities;

8.3(e) to recommend to the Medical Staff Needs Committee as to the need for new appointments;

8.3(f) in consultation with appropriate division directors on independent and dependent practitioners within the department, to recommend to the Executive Committee as to appointments, reappointments, promotions, criteria for and scope of privileges;

8.3(g) to appoint an assistant chairperson to serve in his/her absence unless an alternative mechanism is specified in the Bylaws of the department;

8.3(h) to confer with other department chairpersons under the direction of the President through the Chief Medical Officer/Vice President Medical Affairs and subject to the ultimate authority of the Board of Trustees; to provide professional guidance and supervision of all medical programs in the Medical Center, for the recognition of the primary responsibility and dedication to the goals of the Medical Center;

8.3(i) to make recommendations concerning space and resources needed by the department;

8.3(j) to advise in the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services within the department; and

8.3(k) to assess and recommend off-site sources for needed patient care services not provided by the department or organization.

8.3(l) The coordination and integration of interdepartmental and intradepartmental services.

8.4 Department Meetings and Bylaws

8.4(a) Regular meetings of the department will be held in accordance with departmental bylaws or rules and regulations, not less than four times per year.

8.4(b) These meetings shall include a review of the management and treatment of patients by members of the department. Selection of these cases shall emphasize those in which different forms of management or treatment might have been considered, those of particular complexity and those of unusual outcome.

8.4(c) Each department shall adopt Bylaws or Rules and Regulations after review by the Executive Committee and approval of the Board of Trustees.

ARTICLE IX
ORGANIZATION OF THE ACTIVE AND COMMUNITY ACTIVE STAFFS OF HUNTERDON MEDICAL CENTER

9.1 Meetings

9.1(a) <u>Annual Meeting</u>
The annual meeting shall be held in December. It shall be called by the President of the Medical Staff for the purpose of reviewing Executive Committee activities during the preceding year; hearing reports of officers, department and committee chairpersons, for other business as needed, and for announcing the elections of Staff Officers and members of the Selection and Credentials Committee.

9.1(b) <u>Regular Meetings</u>
Regular meetings shall be held quarterly. These shall be business meetings at which reports from the Executive Committee shall be heard. Any actions taken by the Executive Committee in regard to Staff functions may be reviewed. Such actions are subject to reversal by the Medical Staff upon proper motion and majority vote.

9.1(c) Special Meetings

Special meetings may be called by the President of the Medical Staff or, in the President's absence, the Vice President. A special meeting may also be called upon written request, signed by at least ten members of the Active or Community Active Staffs. Business to be transacted at the special meeting shall be limited to the subject described in the call of the meeting. Such call shall be mailed to all members of the Active and Community Active Staffs at least seven (7) days before the date of the meeting.

9.1(d) Quorum

A quorum for action at any meeting shall be 50% plus one of the Active and/or Community Active Staffs.

9.1(e) Board of Trustees Attendance

Two (2) members of the Board of Trustees of Hunterdon Medical Center as designated by the Chairperson of that Board and serving for a term of three years, may attend all meetings of the Active and Community Active Staffs without vote.

9.1(f) The current edition of "Robert's Rules of Parliamentary Procedure" shall guide the proceedings of the Medical Staff meetings.

9.2 Governance

9.2(a) Officers

The Officers of the Medical Staff shall consist of the President, Vice President, Secretary and Treasurer. They shall be selected from Active and/or Community Active Staff members who are in good standing (9.1 (a)).

9.2(b) Terms of Office

They (Medical Staff Officers) shall serve for a two (2) year term of office and be eligible for re-election once. Subsequently, they may not serve in the same office until a period of two (2) years has elapsed.

9.2(c) Vacancies

In the event of a vacancy, the following shall apply:

(1) In the vacancy of the office of President, the Vice President shall serve the balance of the term. The replacement for the Vice President shall be nominated by a three person nominating committee, appointed by the President, at the next regular staff meeting.

(2) In the case of the Secretary or Treasurer, election to complete the term shall be made from nominations from the floor.

(3) All such partial terms shall not apply to the term or qualifications for re-election.

(4) All elections to fill vacancies shall be by majority vote at a regular or special meeting.

9.2(d) Duties of Officers

(1) President of the Medical Staff

The President shall call and preside at all meetings of the Active and/or Community Active Staffs and of the Executive Committee.

The President is a member of all Medical Staff committees, ex-officio without vote. The President shall attend meetings of the Board of Trustees of Hunterdon Medical Center and Hunterdon Healthcare System to present the view, policies, needs and grievances of the Medical Staff before the governing body and to the President of the Medical Center.

(2) Vice President

The Vice President shall be considered the President-elect. In the absence of the President, the Vice President shall assume all duties and authority of the President. The Vice President shall be expected to perform such duties as may be assigned by the President.

(3) Secretary

The Secretary shall keep accurate and complete minutes of all meetings, call meetings on order of the President, attend to all correspondence, perform such other duties as ordinarily pertain to the office.

(4) Treasurer

The Treasurer is responsible for the collection and disbursement of all dues and funds as authorized by the Medical Staff. The treasurer shall report the current status of the Treasury at each business meeting.

9.2(e) Recall of Officers

Officers shall be subject to recall by a vote of two-thirds of the Medical Staff upon regular motion at any regular Staff meeting.

(1) Action for removal of a Medical Staff Officer may be brought for a valid and serious cause including, but not limited to, failure to fulfill the qualifications for Medical Staff membership as set forth in Article 5.2 and 5.5, professional conduct which is or reasonably likely to be detrimental to patient safety or the delivery of quality medical care; disruptive to the operation of the hospital or an impairment to the community's confidence in the hospital.

(2) Action may be initiated by the petition of three (3) Active or Community Active Staff members who carefully detail in writing the charges and circumstances leading to the petition. The petition will be directed to the voting members of the Medical Executive Committee who will thoroughly examine the matter or designate a group of Medical Staff members to do so. At the conclusion of the investigation, the Executive Committee may, by two-thirds vote, recommend to the entire Active Staff that the officer be removed from office.

The Executive Committee will present their recommendation at a special meeting of the Active and Community Active Staffs called for this sole purpose. The affected officer may attend the meeting to speak on his or her behalf. Minutes of the meeting will be recorded and filed.

Removal from office will require an affirmative vote of two-thirds of the entire Active and Community Active Staffs. Voting will be by email, fax or mail ballot with a return date of two (2) weeks from date of issue. The minutes of the special Medical Staff meeting at which the charges were announced will be circulated with the ballot. The office will be considered vacant immediately following the affirmative vote for removal.

(3) Vacancies will be filled according to Article 9.2(c).

9.3 Voting

9.3(a) Obligation to Vote

Each member in good standing of the Active and Community Active Staff shall be expected to vote in Medical Staff elections and when Bylaws and Rules and Regulations are proposed for adoption, amendment or repeal.

9.3(b) Voting shall take place by electronic, email, fax or mail ballot with the exception of those votes taken to fill vacancies in staff officer positions, which shall be majority vote at a regular or special meeting of the staff pursuant to Article 9.2(c)(4).

9.3(c) Elections

Candidates to fill vacancies in the positions of President, President-Elect, Secretary and Treasurer of the Medical Staff, representatives to the Selection and Credentials Committee, physician members of the Board of Trustees and the Needs Committee shall be proposed by a Nominating Committee appointed by the President of the Medical Staff. The Nominating Committee shall publish in writing the names of candidates they propose at least two (2) weeks prior to the staff meeting at which the slate is presented for approval. Other nominations may be made from the floor. If necessary, an electronic, email, fax or mail ballot will then be provided to each member of the Medical Staff with a specified return deadline of one (1) month following the issuance of the ballots.

9.3(d) Valid Election

A valid election shall consist of votes of a minimum of 33% of the members of the Active and Community Active Staffs eligible to vote that are received within 30-days. The candidate who receives the majority of votes will be elected.

9.3(e) Resolution of Ties

At both the department and medical staff level, resolution of the ties shall be decided by confidential ballot at a meeting of the Medical Executive Committee. All voting members of the Executive Committee shall be eligible to vote, including those members who might be candidates in the election. The vote shall be decided by simple majority. If a tie remains after voting, the election shall be decided by the President of the Medical Staff.

9.3(f) Reporting of Results of Elections

Results of elections shall be announced at the next regular meeting of the Active and Community Active Staffs.

9.3(g) Removal from Office

Officers shall be subject to recall by approval of two-thirds of the entire Active and Community Active Staffs eligible to vote as set forth in Article 9.2(e).

9.3(h) Adoption, Repeal, Amendment of the Medical Staff Bylaws and Rules and Regulations

Bylaws and Rules and Regulations shall be subject to adoption, amendment or repeal by vote of the Active and Community Active Medical Staffs as described below. This vote shall be by electronic, email, fax or mail ballot provided to each member of the Medical Staff only after presentation of the proposed changes at a regular or special business meeting, provided that two-week notice of such meeting has been made in writing to each member. Thirty (30) percent of the Medical Staff eligible to vote must cast ballots within sixty (60) days for it to be a valid election. Two-thirds of those voting must vote in assent to make a change to the Bylaws or Rules and Regulations. The notice shall specify the proposed amendment, repeal or new bylaw.

When new or amended Rules and Regulations are proposed for the purpose of complying with State and/or Federal law or standards mandated by the Joint Commission on Accreditation of Healthcare Organizations or other accrediting organizations, the Medical Executive Committee is authorized to approve, at a regular meeting, such amendments upon recommendation of the Bylaws Committee so long as the proposed amendment is circulated for comment to all members of the Active and Community Active Staffs in advance of the meeting of the Medical Executive Committee. Passage of such amendments shall be announced in writing to all members of the Medical Staff and also at the next quarterly meeting of the Active and Community Active Staffs. Such amendments will be binding only upon subsequent approval of the Board of Trustees of Hunterdon Medical Center.

ARTICLE X
COMMITTEES

10.1 Standing Committees

These shall be the Medical Executive, Selection and Credentials, Medical Records, Pharmacy and Therapeutics, Radiation Safety, Graduate Medical Education, Continuing Medical Education, Diabetes Management, Intensive Care Unit (ICU), Operating Room, Utilization Review, Blood Use, Infection Prevention, Medical Staff Performance Improvement, Perinatal Care, Physician Health Advisory, Bylaws and Medical Staff Charitable Donations Committees.

10.2 Committee Appointments

All appointments will be made by the Executive Committee with the exception of the Medical Staff Needs Committee, the Selection and Credentials Committee, and representatives of the Board of Trustees.

Non-physician members of these Medical Staff committees shall be selected by the President of the Medical Center. Any Board of Trustee member shall be appointed by the Chairperson of the Board of Trustees. Other individuals may be appointed by the Chairperson of the Board of Trustees. Other individuals may be invited to attend or serve on committees without vote, at the discretion of the chair.

10.3 Medical Executive Committee

10.3(a) The Medical Executive Committee shall consist of the elected Chairperson of each department and a Hospitalist representative selected by vote. Members may send a designee when unable to attend. The President and Vice President shall also serve. In the event that one of these is also a Department Chairperson, this individual shall represent both positions.

Ex-officio members without vote shall be the President of Hunterdon Medical Center and/or Chief Operating Officer, the Chief Medical Officer/Vice President Medical Affairs, the Vice President of Patient Care Services, the Chairperson of the Quality Assessment and Improvement Committee, and the Director of the Family Medicine Residency Program, and the elected Medical Staff members of the HHS/HMC Board of Trustees. Other resource persons may be present by invitation of the Chairperson.

The Committee shall meet monthly.

10.3(b) Functions

(1) To formulate and recommend to the Board of Trustees policies, rules and regulations pertaining to medical care within the Medical Center. Such policies, rules and regulations, or changes thereof, may be proposed by voting members of the Medical Staff. When the Medical Executive Committee adopts a rules and regulations or a policy (including changes to the Credentials Manual), or amendment thereto; it is communicated to the Medical Staff. Any member of the Medical Staff may petition the Medical Executive Committee within three months when in disagreement of an adopted rules and regulation or policy. If 10% of the Medical Staff disagrees in writing with the adoption of a rule and regulation or policy by the Medical Executive Committee, it

will be taken to the Medical Staff for a vote. After the vote by the Medical Staff, the policy will be repealed as long as the majority of the Medical Staff agrees. Policies or rules and regulations that were adopted or amended to comply with State and/or Federal law or standards mandated by accrediting organizations cannot be repealed by a Medical Staff vote.

(2) To serve in an advisory capacity to the Board of Trustees in matters of the medical staff s structure and professional credentials.

(3) To supervise the continuous assessment and improvement of the quality of the medical care provided in the Medical Center.

(4) To review and comment upon to the Board of Trustees (through the President of the Medical Staff), the recommendations of the various department chairpersons regarding biennial staff appointments and the privileges allowed to each member, and to recommend mechanisms by which Medical Staff membership may be terminated.

(5) To review and comment upon to the Board of Trustees (through the President of the Medical Staff), the recommendations of the Medical Staff Needs Committee and the Selection and Credentials Committee.

(6) To advise on or deal with (subject to Article 6) disciplinary problems within the Medical Staff.

(7) To receive and act on reports and recommendations from Medical Staff Committees, clinical departments, and assigned activity groups.

(8) Subject to review by the Medical Staff, to act on behalf of the Medical Staff in the intervals between regular meetings. Individual decisions of the Medical Executive Committee can be overturned as referenced in Section 10.3(b)(1).

10.4 Selection and Credentials Committee

10.4(a) Membership

The Selection and Credentials Committee shall be a standing committee composed of two (2) members of the Board of Trustees and four (4) members of the Active or Community Active Staffs, of whom two (2) shall be members of the Department of Family Medicine and two (2) members of Departments other than Family Medicine. The Chairperson of the Department involved shall also serve as a member of the committee on an ad-hoc basis. Committee members shall serve two (2) year terms, with one (1) member of each class retiring each year. Members may be re-elected to serve a maximum of three (3) consecutive two (2) year terms. Attendances at a minimum of two-thirds (2/3) of meetings held during each two (2) year terms shall be prerequisite for re-election. The President of the Medical Center or designee shall serve as Chairperson without vote. Nominations for open positions on the Committee will be announced and accepted at the September Medical Staff meeting. Election results will be reported at the Annual Meeting of the Medical Staff.

10.4(b) Responsibilities

The Selection and Credentials Committee shall participate in the review and evaluation of credentials and shall make recommendations regarding Medical Staff appointments, reappointments, provisional evaluations and revisions to clinical privileges. They shall develop, maintain and comply with the Medical Staff Credentials Manual, which shall be adopted and amended as needed by the Medical Executive Committee subject to the approval of the Board of Trustees.

10.4(c) Credentialing Procedure

The recommendation for appointment may include contingencies and shall include an effective date of appointment based on the candidate's individual circumstances. Contingencies must be resolved before the application is presented to the Board of Trustees for final approval. Failure of the candidate to resolve contingencies or assume the responsibilities of Medical Staff membership within six (6) months of the recommended appointment date shall result in the withdrawal of the recommendation for appointment and the search for additional candidates will reopen. This time-frame may be extended for special circumstances by the Medical Executive Committee.

10.5 Medical Staff Performance Improvement

The Medical Staff Performance Improvement Committee shall consist of the quality assessment reviewers for each department and the family health centers, and the Director of the Family Medicine Residency Program. The Chief Medical Officer/Vice President Medical Affairs, Vice President of Patient Care, and Director of Quality Improvement and Patient Safety shall attend.

The primary function of the committee shall be to resolve problems regarding quality evaluation in an expeditious and multidisciplinary manner. This objective shall be obtained by setting and enforcing standards related to transfers within the service of the hospital, appropriateness of treatment given and drugs prescribed, the use of blood and blood products, review of services rendered within the hospital, and other such matters that will bear directly on the effective, efficient and economical delivery of health care. To aid in this management and review function, the Utilization Review, Pharmacy and Therapeutics, Medical Record Review, Blood Usage, Diabetes Management, Intensive Care Unit (ICU), Antibiotic Utilization Subcommittee and Perinatal Care committees shall be a part of Quality Assessment. They shall report to this Performance Improvement Committee who shall review reports, making recommendations to these subcommittees for their action, and then forward reports and comments to the Executive Committee as part of the Performance Improvement report.

10.6 Utilization Review

The Utilization Review Committee shall meet at least quarterly, and shall consist of at least four (4) members. The committee shall manage the entire utilization review program so as to assure that the most efficient use is made of the Medical Center facilities and the medical care be provided as necessary and delivered in the most economic manner, and in conformity to criteria of optimal use. This management shall include the following functional elements: 1) admission request program; 2) preadmission testing program; 3) admission certification program; 4) length of stay review program; 5) discharge planning program; and 6) retrospective review program. The Committee shall report to the Medical Staff Performance Improvement Committee.

10.7 Pharmacy and Therapeutics

The voting members of this committee shall consist of at least four (4) physicians. One (1) member should be from either the Department of Pediatrics or Internal Medicine. Additionally, the Chief Pharmacist and/or designee shall be a member ex-officio with vote.

The committee shall supervise the operation of the Pharmacy and make recommendations to the Medical Executive Committee as to the formulary and the use of prescribed medications. It shall be responsible for the review of appropriateness of drug use through analysis of patterns of practice. It shall review significant untoward drug reactions. It shall review and approve protocols of investigational or experimental drug use.

The committee shall meet at least quarterly. It shall report to the Medical Staff Performance Improvement Committee.

10.8 Medical Records

Medical Records Committee shall meet at least quarterly and shall consist of at least four (4) Medical Staff members. Other representatives may include representatives of the Nursing Department, Medical Records Department and Administration as appropriate.

The Committee shall supervise and appraise the adequacy and completeness of medical records by appropriate review procedures. It shall review and recommend forms, format, media and systems applicable to the records. It shall report to the Medical Staff Performance Improvement Committee.

10.9 Blood Usage

This committee shall consist of at least four (4) members of the Active or Community Active Staffs and the Blood Bank Director. It shall meet at least quarterly. It shall review the appropriateness of the use of blood and blood components, evaluate confirmed transfusion reactions, develop or approve policies and procedures relating to ordering practices, handling, use and administration of blood or blood components, and review adequacy of the transfusion service. It shall report to the Medical Staff Performance Improvement Committee.

10.10 Radiation Safety

It shall conform to the regulations of the Nuclear Regulatory Commission. It shall consist of at least four (4) members who shall include: 1) a licensed physician; 2) the Radiation Safety Officer; 3) a representative from Administration; and 4) a representative from Nursing. It shall meet as often as necessary to conduct its business and not less than once each calendar quarter. The Radiation Safety Officer and the Administrative representative must be present. Two (2) members shall be a quorum for conducting business.

The Committee shall: 1) ensure that radioactive materials and radiation producing equipment are used safety (this includes review as needed of training programs, equipment, facilities, supplies and procedures); 2) ensure compliance with Federal and State regulations; 3) ensure the personal radiation doses are maintained as low as possible; and 4) identify problems within the Radiation Protection Program, implementing solutions.

It shall report to the Medical Executive Committee.

10.11 Infection Control

The Infection Prevention Committee shall consist of at least four (4) members of the Medical Staff, one of whom shall be chairperson, the Vice President of Patient Services or designee, and the hospital's Infection Prevention Officer.

Representatives of other hospital departments may be present by invitation as needed. The Committee shall meet not less than every two (2) months, making its report to the Medical Staff Performance Improvement Committee.

This committee shall review records and reports of infections and infection potentials among patients and hospital personnel, recommending corrective action; it shall carry out surveillance of nosocomial infections and promote preventable and corrective programs to eliminate or minimize infection in the hospital. In carrying out these functions it may recommend the policies and procedures for hospital services. Such policies and procedures are subject to approval of the Medical Executive Committee.

10.12 Operating Room

The Operating Room Committee shall consist of not less than seven (7) members; four (4) members of the Active or Community Active Staffs from departments normally utilizing the operating room, a member of the Department of Anesthesia, the President of the Medical Center or designee, the Assistant Director in charge of Nursing, or designee. The committee shall meet at least quarterly and review the operations of the Operating Room and report to the Medical Executive Committee on the quality of care provided, making such recommendations as it deems advisable as to rules, regulations, procedures and management.

10.13 Graduate Medical Education

The Graduate Medical Education Committee shall consist of the President of the Medical Center or designee, the ACGME Designated Institutional Official and the Osteopathic Director of Medical Education who shall function as co-chairpersons of the committee. Program directors from each residency or fellowship; peer selected representatives from each residency program; the Patient Safety Officer or designee; representative from Nursing Administration; four (4) other family physicians; and other Medical Staff members as designated by the President of the Medical Staff.

The Committee shall monitor and advise in matters concerned with graduate education, including curriculum, the selection of candidates, assignment of responsibilities, the scheduling by departments, salaries, benefits, living conditions and duty hours.

This Committee shall met at least ten (10) months per year and maintain written minutes. It shall report to the Medical Executive Committee.

10.14 Perinatal Care Committee

The Perinatal Care Committee shall consist of the members of the Department of Pediatrics and all staff members who practice obstetrics. It shall review the quality of perinatal infant care and specific cases as indicated.

It shall meet at least quarterly and shall report to the Medical Staff Performance Improvement Committee.

10.15 Bylaws Committee

The Bylaws Committee shall consist of four (4) members of the Active or Community Active Staffs. It shall meet at least annually and report to the Medical Executive Committee.

It shall complete an annual review of both the Bylaws of the Medical Staff and the Rules and Regulations of the Medical Staff.

It shall respond to requests from the Medical Executive Committee and other committees as well as members of the Medical Staff regarding proposals of changes and/or additions to both of these documents.

10.16 Continuing Medical Education Committee

The Continuing Medical Education Committee shall consist of interested physicians with at least representation from the Departments of Family Medicine and Pediatrics. The Chief Medical Officer or his/her designee shall serve as Chairperson. It shall assist in the preparation, coordination and direction of hospital-sponsored educational activities relating to the type and nature of care encountered at Hunterdon Medical Center; the findings of the Medical Staff Performance Improvement program and requests from specific members of the Medical Staff. It shall meet at least quarterly and report to the Medical Executive Committee.

10.17 Cancer Care Committee

The composition of the Cancer Care Committee shall be in accordance with the guidelines and requirements set forth by the American College of Surgeons. All members shall be appointed by the Medical Executive Committee.

The Cancer Care Committee will meet quarterly and report to the Medical Executive Committee. Minutes will be forwarded to the Executive Committee.

10.17(a) Responsibilities of the Cancer Care Committee

(1) Develops and evaluates the annual goals and objectives for the clinical educational and programmatic activities related to cancer.

(2) Promotes a coordinated, multidisciplinary approach to patient management.

(3) Ensures that educational and consultative cancer conferences cover all major sites and related issues.

(4) Ensure that an active supportive care system is in place for patients, families and staff.

(5) Monitors quality management and improvement through completion of quality management studies that focus on quality, access to care and outcomes through the Quality Improvement Subcommittee of the Cancer Care Committee.

(6) Promotes clinical research.

(7) Supervises the cancer registry and ensures accurate and timely abstracting, staging and follow-up reporting.

(8) Performs quality control of registry data, encourages data usage and regular reporting.

(9) Ensures content of the annual report meets requirements and publishes the annual report by November 1 of the following year.

(10) Upholds medical ethical standards.

10.18 Physician Health Advisory Committee

10.18(a) Purpose

The purpose of the practitioner health advisory committee is to provide a forum where information and concerns about potentially impaired practitioners, including issues related to behavior as described in the Medical Staff and Governing Body Bylaws may be taken for consideration; to detect, intervene upon, promote rehabilitation for and monitor practitioners who are identified as impaired; to provide assistance and recommendations to the practitioner in question and to those persons contacting the committee about possible impairment; to educate the medical staff about practitioner health, well-being and impairment, to provide appropriate responses to different levels of concern; and to help restore impaired physicians to an optimal level of functioning.

10.18(b) The practitioner health advisory committee shall be comprised of no less than three (3) members of the Active or Community Active Medical Staffs appointed by the President of the Medical Staff, one of whom shall be a member of the Department of Psychiatry. The Department Chairperson of any individual physician who is being investigated or assisted by the Committee shall also be a member, ad-hoc with vote. The Chief Medical Officer/Vice President Medical Affairs shall be a member, ex-officio, without vote. Except for initial committee appointments, each member shall serve a term of three (3) years, and the terms shall be staggered as deemed appropriate by the president to achieve continuity, with one-third (1/3) of the appointments changing each year. Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assurance committees while serving on this committee.

10.18(c) Responsibilities

The practitioner health advisory committee shall receive reports related to the health, well-being, or impairment of medical staff appointees and, as it deems appropriate, in cooperation with the Physician Health Program of the Medical Society of New Jersey, similar program or healthcare provider, may investigate such reports immediately. With respect to matters involving individual medical staff appointees, the committee may, in cooperation with the Physician Health Program of the Medical Society of New Jersey, on a voluntary basis, provide advice, counseling, or referrals as it may determine to be appropriate. Such activities shall be confidential; however, in the event information received by the committee clearly demonstrates that the health or known impairment of a medical staff appointee poses a risk of harm to patients, that information may be referred for corrective action under Article 6 of the Medical Staff Bylaws. The committee may, in its discretion, request that a practitioner voluntarily submit to an evaluation and follow any recommendations made by the treating professional, treatment staff and staff of the Physician Health Program or similar program or healthcare providers who have treated or evaluated the practitioner. If a practitioner follows this course of action following an intervention, and can demonstrate to the committee that he is capable of caring for patients safely and competently, no suspension of clinical privileges or any other disciplinary action shall be taken. In the event that a practitioner should refuse to submit to a requested evaluation, and there is a reasonable belief that the practitioner may represent a danger to his or her own health or safety, or to the safety of patients, the committee shall immediately refer the practitioner to any of those individuals identified in these bylaws who are authorized to initiate a request for corrective

action and shall so inform the others named in Article 6 for consideration of the initiation of corrective action. Upon completion of any rehabilitation, which is deemed necessary, the committee shall make a recommendation concerning reinstatement of the practitioner's privileges, were they suspended.

The committee shall also consider general matters related to the health and well-being of the medical staff and, with the approval of the executive committee, develop educational programs or related activities concerning illnesses and impairment recognition issues specific to physicians. It shall provide at least annually an educational session for physicians on physician health issues and will publicize its availability for assistance.

10.18(d) Meetings

The committee shall meet as often as necessary. It shall maintain a record of its proceedings.

10.19(e) Records: Confidentiality

Records shall be kept on individual practitioners who are being followed by the committee. Records shall be kept locked with only the members of the committee and the President of the Medical Staff and President of the Governing Body having access. At no time will the identity of the practitioner nor the nature of the impairment be released to anyone other than the committee, the staff of the Physician Health Program of the Medical Society of New Jersey or similar program and the persons involved in the intervention process. Records shall be kept separate from the practitioner's credentials file. Concomitant files may be kept by the Physician Health Program of the Medical Society of New Jersey or similar program. Assistance with all cases of impairment or potential impairment may be provided by the Physician Health Program, similar program or other healthcare provider. The Medical Executive Committee and the governing body shall receive periodic reports on the number, but not the identity of the practitioner, which the committee has under its care at any given time.

10.19 Diabetes Management

The purpose of the Diabetes Management Committee is to optimize diabetes management for patients in the Hospital, the Hunterdon Behavioral Health Day Hospital, and the Emergency Department.

The Committee members shall consist of endocrinology physicians, one (1) who shall be appointed as Chair of the Committee by the President of the Medical Staff. Other Committee members shall include a Hospitalist, Family Medicine (Primary Care), Pulmonary/Critical Care physician, and a Pediatrician. Other Committee attendees shall include the following: a nurse-educator from the Center for Diabetes/Nutrition Management (CDNM), a clinical inpatient nurse, a pharmacist, a representative from Quality/Utilization, a representative from the Intensive Care Unit (ICU), a representative from the Emergency Department, and a representative from Behavioral Health.

The Committee shall report to the Medical Staff Performance Improvement Committee, and shall meet at least quarterly.

10.20 Intensive Care Unit (ICU)

The purpose of the ICU Committee is to ensure quality and efficient evidence based care in the ICU.

The Committee members shall consist of Pulmonary/Critical Care physicians, one (1) who shall be appointed as Chair of the Committee by the President of the Medical Staff. Other Committee members shall include a General Surgery physician, Family Medicine (Primary Care) physician, and a Cardiology physician. Other committee attendees shall include the following: the ICU Nurse Manager, a pharmacist, a social worker, a dietitian, a representative from the step-down unit, a representative from the Emergency Department, and a representative from the ICU Quality Committee, which is a subcommittee of the ICU Committee.

The Committee shall report to the Medical Staff Performance Improvement Committee, and shall meet at least quarterly.

10.21 Medical Staff Charitable Donations

10.21(a) Purpose

The purpose of this committee is to review and discuss the requests for charitable donations on behalf of the Medical Staff.

10.21(b) Composition

The Committee shall consist of the Medical Staff Officers (President, Vice President, Secretary and Treasurer) and the Residency Program Director.

10.21(c) Responsibilities

This Committee will review the mission statement of the organization making the request; in addition, request what percentage of charitable donations reach the intended recipients versus what percentage is used for administrative costs.

Recommendations by the committee will be presented to the Medical Staff at quarterly Medical Staff meetings. Requests over $1,500.00 will require a vote of the Medical Staff.

10.21(d) Meetings
The Committee shall meet at least annually.

10.21(e) Minutes
Minutes shall be maintained in the Medical Staff Office.

ARTICLE XI
HISTORIES AND PHYSICALS

A history and physical examination shall be performed by the attending physician, oral maxillofacial surgeon, or podiatrist within thirty (30) days prior to admission or within twenty-four (24) hours after admission. This may be delegated to an Advanced Practice Professional holding appropriate Scope of Practice. Changes will be documented at the time of admission. History and Physicals shall include, at a minimum, history of present illness; relevant past family social history; pertinent physical examination to the complaint; clinical assessment; and plan of care. If a patient is being admitted for a procedure/surgery, an updated note must be in or attached to the history and physical immediately prior to the procedure/surgery. For a hospital inpatient, a progress note or consult note relevant to and prior to the procedure/surgery shall meet this requirement. For patients admitted to the inpatient Psychiatry Unit, a medical exam done by the Emergency Physician or Advanced Practice Professional, with psychiatric diagnostic evaluation performed by a Psychiatrist or designated Advanced Practice Professional will be sufficient.

ARTICLE XII
RULES AND REGULATIONS

Rules and regulations for the governance of the Medical Staff shall be developed and adopted by the Medical Executive Committee and shall receive the approval of a majority of the Medical Staff pursuant to Article 9.3(b) and Article 9.3(h). They shall be subject to approval by the Board of Trustees. These Rules and Regulations shall be reviewed annually. A copy is attached.

ARTICLE XIII
CONFIDENTIALITY, IMMUNITY AND RELEASE

13.1 Authorization and Conditions

By applying for staff membership and clinical privileges, a practitioner agrees to three implied actions:

13.1(a) the practitioner authorizes Medical Center representatives to request from others (or provide to others) and to act upon information bearing on his or her professional ability and qualifications;

13.1(b) the practitioner agrees to be bound by this Article 12 and to waive all legal acts in accordance with this Article 12; and

13.1(c) the practitioner acknowledges that this Article 12 is an express condition to his or her application for and acceptance of staff membership and to his or her exercise of clinical privileges at the Medical Center.

13.2 Confidentiality of Information

Information (whether provided by the Medical Center or a third party) concerning any practitioner shall, to the fullest extent permitted by law, be deemed confidential and shall not be disseminated to anyone other than representative of this or any other health care facility or organization, medical staff, educational institution or licensing board, nor be used in any way except as provided in this Article 12 or except as otherwise permitted or required by law. This rule of confidentiality shall be extended to information, which is submitted, collected or prepared for any of the following:

13.2(a) evaluating and improving the quality and efficiency of patient care;

13.2(b) reducing morbidity and mortality;

13.2(c) contributing to teaching or clinical research;

13.2(d) determining that health care services are professional, indicated and performed in compliance with the applicable standard of care;

13.2(e) establishing and enforcing guidelines to keep health care costs within reasonable bounds;

13.2(f) establishing the practitioner's qualifications for appointment to, reappointment to, promotions within the Medical Staff or corrective action pursuant to Article 6.

13.3 Privilege and Immunity from Liability

13.3(a) There shall be to the fullest extent permitted by law, a privilege extended to any information with respect to any practitioner given or made in good faith and without malice and at the request of a representative of this or any other health care facility or organization, medical staff, educational institution or licensing board, for the purposes set forth in Article 12.2.

13.3(b) There shall be to the fullest extent permitted by law, absolute immunity from civil liability arising from the disclosure of any such information as described in Article 12.3(a), even where the information involved would not otherwise be deemed privileged.

13.3(c) No representative of this or any other health care facility or organization, medical staff, educational institution or licensing board shall be liable to a practitioner for damages or any other relief (if in either case such representative or third party acts in good faith and without malice) because of:

(1) providing information to the Medical Center, any other health care facility or organization, medical staff, educational institution or licensing board; or

(2) any decision, opinion, action, statement or recommendation made within the scope of his duties as a representative.

13.4 Definitions

13.4(a) The term "information" as used in this Article 12 shall include all written or oral disclosures and communications of any nature whatsoever, performed or made in connection with the activities of this or any other health care facility or organization, medical staff, educational institution or licensing board concerning, but not limited to:

(1) applications for appointment and clinical privileges;
(2) periodic reappraisals for reappointment and clinical privileges;
(3) corrective or disciplinary action, including summary suspension and resignation;
(4) hearings and appellate reviews;
(5) quality improvement program activities and medical care evaluations;
(6) utilization reviews;
(7) claims reviews;
(8) profiles and profile analysis;
(9) malpractice loss prevention; and
(10) all other hospital and medical staff activities related to monitoring, maintaining and improving quality and efficient patient care and appropriate professional conduct.

13.4(b) The term "representative" as used in this Article 12 shall include the board of trustees of a hospital and any member or committee thereof; a chief executive officer of a hospital or his designee; a nurse or other employee of the hospital; a medical staff organization and any member, officer, clinical unit or committee thereof, and any duly-authorized individual by any of the foregoing.

13.5 Releases

Each practitioner shall, upon request of the Medical Center, execute general and specific releases in accordance with this Article 12, but execution of such releases is not a prerequisite to the effectiveness of this Article 12.

13.6 Superseding Law

This Article 12 is in addition to any other and further protection provided by law and not in limitation thereof.

ARTICLE XIV
REVIEW OF BYLAWS

14.1 These Bylaws will be reviewed annually and revised as necessary under the direction of the Medical Executive Committee.

APPENDIX A
STATEMENT OF PROFESSIONAL RESPONSIBILITY

The practitioner agrees:

(a) to be bound by and adhere to the Hospital's Bylaws, the Bylaws and Rules and Regulations of the Medical Staff, and the Bylaws, Rules and Regulations of my department; and

(b) to fulfill the following professional obligations of the Hospital:

(i) teaching, as determined by the Department Chairperson and the Chief Medical Officer/Vice President Medical Affairs;

(ii) in-hospital physician coverage (including evening, night, weekend and holiday coverage), indigent care, committee membership, and involvement in community programs, as determined by the Department Chairperson.

(c) to promptly report to the Vice President Medical Affairs/Chief Medical Officer or President of the Medical Staff any of the following:

(i) Revocation, expiration, suspension, voluntary surrender or the placement of conditions or restrictions on the practitioner's license.

(ii) Revocation, expiration, suspension, voluntary surrender or the placement of conditions or restrictions on the practitioner's DEA or state controlled substance license.

(iii) Termination or lapse of the practitioner's professional liability insurance coverage, or other action causing the coverage to fall below the minimum required by the Medical Center.

(iv) Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.

(v) Indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving controlled dangerous substances; illegal drugs; Medicare, Medicaid, or insurance health care fraud or abuse; or violence.

(vi) Voluntary or involuntary limitation, reduction, suspension or relinquishment of medical staff appointment and/or clinical privileges by any health care facility (hospital, clinic, surgery center, etc.) or managed care organization (HMO/PPO)

(vii) Denial of application for medical staff appointment and/or clinical privilege by any health care facility (hospital, clinic, surgery center, etc.) or managed care organization (HMO/PPO)

APPENDIX B
ACCEPTANCE

I accept appointment to the Medical Staff of Hunterdon Medical Center and I agree:

(a) to be bound by and to adhere to the Hospital's Bylaws, the Bylaws and Rules and Regulations of the Medical Staff, and the Bylaws, Rules and Regulations of my department; and

(b) to fulfill the following professional obligations of the Hospital:

(i) teaching, as determined by the Department Chairperson and the Chief Medical Officer/Vice President Medical Affairs;

(ii) in-hospital physician coverage (including evening, night, weekend and holiday coverage), indigent care, committee membership, and involvement in community programs, as determined by the Department Chairperson.

APPROVAL SIGNATURES

HUNTERDON MEDICAL CENTER
BYLAWS OF THE MEDICAL STAFF

ADOPTED & APPROVED:

By: ______________________________ March 28, 2019
Andrew Rudnick, MD Date
President of the Medical Staff

By: ______________________________ March 28, 2019
Patrick J. Gavin Date
President and Chief Executive Officer

By: ______________________________ March 28, 2019
Robert Cody, MD Date
Chairperson, Board of Trustees

Approved by the Medical Staff: May 1993
Approved by the Board of Trustees: June 24, 1993
Amended: February 1994
Amended: January 1996
Amended: February 1997
Amended: December 1998
Amended: March 2000
Amended: December 2001
Amended: May 2002
Amended: December 2002
Amended: April 2003
Amended: June 2004
Amended: April 2005
Amended: June 2005
Amended: April 2007
Amended: October 2008
Amended: February 2009
Amended: April 2009
Amended: January 2010
Amended: February 2011
Amended: October 2011
Amended: January 2013
Amended: January 2014
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Amended: October 2018
Amended: March 2019
Amended: March 2020

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