



# **Bylaws of the Medical Staff**

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

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## PREAMBLE

Since the basic objectives of the Medical Staff of Hunterdon Medical Center are to provide high quality medical care for patients, promote the education of doctors, nurses and paramedical personnel, contribute to the development of medical knowledge and to ensure 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 the Board of Trustees of the Hunterdon Medical Center in conformity with the Bylaws hereinafter set forth. These Bylaws, Rules & Regulations and Manuals of the Medical Staff 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.

## 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.

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

**Department Chairperson**: means the elected head of a clinical department listed in Article 8.1.

**Division Director**: means the elected head of a specialty group within a department.

**Hospital**: means Hunterdon Medical Center.

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

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

**Medical Staff**: means the following licensed practitioners (Doctors of Medicine, Doctors of Osteopathy, Doctors of Dental Surgery, Doctors of Medical Dentistry, Doctors of Podiatric Medicine) holding appointments on the Medical Staff of Hunterdon Medical Center approved by the Board of Trustees of Hunterdon Medical Center.

**Primary Care Physician**: means any physician member of the Medical Staff who is board certified or board eligible in Primary Care Medicine, General Internal Medicine, Family Medicine or Pediatrics.

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

**Specialty Physician**: means any physician member of the Medical Staff who is not a Primary care Physician.

## ARTICLE III PURPOSE

The purpose of this Medical Staff organization shall be:

- 3.1 To ensure that all patients treated at the Hospital receive care according to recognized high quality standards.
- 3.2 To provide high-quality education and research within the framework of the Hospital.
- 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 professional association of the individual provider, as appropriate, shall guide the professional conduct of the Medical Staff.

Upon appointment and reappointment to the Medical Staff, each member, non-member physician, and Advanced Practice Professional 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 Dental Surgery, 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 Article VII 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 Qualifications for Appointment

Only Licensed Practitioners licensed to practice in the State of New Jersey, who can document their background, experience, training, and demonstrate competence, their physical and/or mental health status, evidence of professional liability insurance coverage as required herein, their adherence to the ethics of their profession, their good reputation, and their ability to work with others, with sufficient adequacy to assure the Medical Staff and the Board of Trustees that any patient treated by them in the Hospital will be given high quality medical care in an economically efficient manner, taking into account patient needs, the available Hospital facilities and resources, and utilization standards in effect at the Hospital, shall be qualified for membership on the Medical Staff. No Physician or Dentist shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that they are duly licensed to practice medicine, dentistry, or podiatric medicine in this or in any other state, or that they are a member of any professional organization, or that they had in the past, or presently have such privileges at another Hospital.

### 5.3 Procedure for Appointment

- (a) The applicant must submit a completed application as defined in the Credentials Manual.
- (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).
- (c) The application must be submitted to the President of the Hospital 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. 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 the Hospital (see Article 7.2(a)). Exception to this limitation is set forth in Article 7.1(a).

- (d) No application for appointment to the Active, Community Active, Courtesy or Consulting Staff of the Hospital 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 the Hospital). The Needs Process excludes the following: the Hospitalist Group and the groups who are contracted with the Hospital for services (pathology, radiology, anesthesiology, and emergency medicine).
- (e) Prior to these further determinations regarding an application, the applicant shall indicate in writing acceptance of Article 13 of these Bylaws (Confidentiality, Immunity and Releases).
- (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 the Hospital has no need for such a position, those who had petitioned the Needs Committee for said Need shall be notified, in writing, by the Chair of the Needs Committee or designee with a copy to the appropriate Department Chairperson.
- (g) Applicants for positions approved by the Medical Staff Needs Committee and others not requiring such approval pursuant to Article 5.2(d) 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 Hospital Quality Committee for review and subsequent recommendation to the Board of Trustees or designee. Final decision of the Board of Trustees shall be communicated in writing by the Secretary of the Board or their designee to the applicant.
- (h) 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.

#### 5.4 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 Hospital 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 Hospital 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. Privileges shall be determined utilizing references from training institutions and/or current affiliations, experience, quality assessment evaluation, the Credentials Manual and other documentation. 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 Committee, the Medical Executive Committee, the Hospital Quality Committee, and the Board of Trustees. Requests for privileges new to the Hospital 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 and set forth in departmental policies.

In an emergency, any Medical Staff member and non-member Advanced Practice Professional 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 regardless of the Medical Staff member's and non-member Advanced Practice Professional's defined privileges.

#### 5.5 Reappointment

Recommendations for biennial reappointments shall be made to the Board of Trustees by the Selection and Credentials and Medical Executive Committees of the Medical Staff after consultation with the appropriate Department Chairperson and further review by the Hospital Quality Committee. 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 in accordance with Departmental policies and the Credentials Manual, 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 two year period. 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 may be required for practitioners with such low volume as to make quality assessment difficult. 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 **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.

## 5.7 **Temporary Privileges**

The Hospital President, or designee, acting on behalf of the Board and based on the recommendation of the Medical Staff President may grant temporary privileges. Temporary privileges may be granted only in two (2) circumstances: 1) to fulfill an important patient care, treatment, or service need, or 2) when an applicant with a complete application that raises no concerns is awaiting review and action by the MEC and the Board.

- 5.7.1 **Important Patient Care, Treatment, or Service Need:** Temporary privileges may be granted on a case-by-case basis when an important patient care, treatment, or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days. When granting such privileges, the organized Medical Staff Office verifies NPDB, current licensure and current competence.
- 5.7.2 **Clean Application Awaiting Approval:** The application must meet the criteria for expedited credentialing consideration as noted in the Credentialing Manual. Temporary privileges may be granted for up to one hundred and twenty (120) calendar days when the new applicant for Medical Staff Membership and/or privileges is waiting for review and recommendation by the MEC and approval by the Board. Criteria for granting temporary privileges in these circumstances include 1) complete application 2) fully verified application, 3) positive recommendation from the Department Chair, and 4) positive recommendation from the Selections and Credentials Committee.
- 5.7.3 **Special requirements of consultation and reporting** may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the bylaws, rules, and regulations and policies of the Medical Staff and hospital in all matters relating to their temporary privileges. Whether or not such written agreement is obtained, these bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.
- 5.7.4 **Termination of temporary privileges:** The Hospital President, acting on behalf of the Board and after consultation with the Medical Staff President, may terminate any or all of the practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's privileges. When a patient's life or wellbeing is endangered, any person entitled to impose a summary suspension under the Medical Staff Bylaws may effect the termination. In the event of any such termination, the practitioner's patients then will be assigned to another practitioner by the Staff President or their designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

- 5.7.5 Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded in Article VI of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) because their request for temporary privileges is refused or because all or any part of their temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.

## 5.8 **Leave of Absence**

A practitioner wishing a leave of absence greater than one month 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 month may be approved by the Department Chairperson and the Chief Medical Officer. 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. In an emergency situation, leave may be granted by the President of the Medical Staff upon notice of the member subject to later review and recommendation by the Medical Executive Committee and final approval by 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 Medical 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 was for a medical reason, a note of medical clearance should accompany the request for reinstatement. 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.

## 5.9 **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 Medical Staff member who is more than six (6) months in arrears in the payment of dues shall have their Medical Staff membership suspended at the recommendation of the Medical Executive Committee.

Any Medical Staff member 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**

- (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 Hospital 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.
- (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.
- (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/his 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.
- (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.
- (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).
- (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 their 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**

- (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.

- (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**

- (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.
- (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).
- (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**

- (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.
- (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).

- (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

- (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.
- (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.
- (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.
- (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.
- (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:

- (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.
- (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.
- (c) The proceedings shall be transcribed by a stenographer with expense to be paid by the hospital.
- (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.
- (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.
- (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 their own behalf, they 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.

- (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.
- (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.
- (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 their 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:

- (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.
- (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

#### (a) Definition

The Active Staff shall consist of members of several departments of the Hospital. All members of the Active Medical Staff shall have the right to vote. The President of the Hospital and the Chief Medical Officer 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 Hospital or Hospital affiliated employed practitioners shall not be affected by resignation from or termination of the employed position unless termination of the Medical Staff appointment is required by their 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. Members of the Active Staff shall not hold an appointment on the Active Staff of any other hospital or such medical staff unit as corresponds to the Active Staff of the Hospital. 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 the number of cases, to have the practitioners of that specialty concentrate their in-hospital activities at the Hospital, 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.
- (2) Applicant must have a bona fide office outside of Hunterdon County in the service area defined by the Board of Trustees.
- (3) Applicant must practice in a specialty that requires the ability to provide services to existing patients of Hunterdon Health System affiliated practices when they are admitted to another hospital in the Hospital's service area through the other hospital's Emergency Department. As used here, "requires" means it is not feasible to conduct a practice in this specialty in the geographic area of the Hospital 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) Applicants must agree that they will only exercise privileges at the other hospital as necessary to admit patients to such 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 the Medical Executive Committee in consultation with the President of the Hospital may rescind the waiver granted to the Applicant for any or no reason.

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.

(b) Minimum Activity Required

Appointees to the Active Staff are expected to participate in patient care activities at the Hospital. No appointee to the Active Staff shall be eligible for reappointment unless they have had at least ten (10) documented patient encounters at the Hospital or at a Hospital-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 Chairperson upon a finding that continued appointment of the practitioner is in the best interest of the Hospital.

7.2 **Community Active Staff**

(a) Definition

The Community Active Staff shall consist of those practitioners, primarily community based, who desire to be associated with the Hospital 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 medical staff unit as corresponds to the Active Staff of the Hospital.

(b) Privileges

Community Active Staff members do not hold clinical privileges at the Hospital. They may request "Refer and Follow", which will give them access to the patient's medical 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.

- (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 **Consulting Staff**

(a) Definition

The Consulting Staff shall consist of practitioners from outside the area normally served by the Hospital who fill a vacancy not otherwise filled and benefit the hospital by their appointment.

(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 Hospital or designee and the Executive Committee after consultation with the appropriate Department Chairperson.

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

7.4 **Courtesy Staff**

(a) Definition

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



(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 Hospital or designee and the Medical Executive Committee after consultation with the appropriate Department Chairperson. A written statement as to the applicant's privileges shall include the maximal privileges, if any, allowed.

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

(d) Minimum Activity Requirement

Appointees to the Courtesy Staff are expected to participate in patient care activities at the Hospital. No appointee to the Courtesy Staff shall be eligible for reappointment unless they have had at least ten (10) documented patient encounters at the Hospital or at a Hospital 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 Chairperson upon a finding that continued appointment of the practitioner is in the best interest of the Hospital.

**7.5 Telemedicine Privileges**(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).

(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.

(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.

**7.6 Honorary Recognition**

Honorary Recognition may be granted to practitioners who have served on the Active or Community Active Staffs for at least ten (10) years and who no longer wish to maintain an Active or Community Active Staff position on the Medical Staff. Honorary Recognition may also be granted to 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 Hospital or have retired from the practice of medicine.

Members with Honorary Recognition shall have no clinical privileges, or shall not be eligible to vote or hold office, shall not be required to pay dues, and shall have no assigned duties.

## ARTICLE VIII CLINICAL DEPARTMENTS

**8.1 Composition**

The Medical Staff shall consist of the following departments:

- Adult Hospitalists
- 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 Dentistry, 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 majority of the Department members who vote within 30 days for a two-year term. 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 Department Chairperson is felt to fail in their role, they may be replaced by majority of the department members, who vote within 30 days, subject to review and approval by the Medical Executive Committee.

The Department Chairperson shall be responsible to the President of the Hospital Medical Staff.

Each department shall also have a Vice Chairperson (nominated by the department and an electronic ballot will be provided to each member of the department with a specified return deadline of thirty (30) days following the issuance of the ballots) who can take over the chairmanship of the department if the current chairperson resigns or is unable to fulfill their duties.

Division Directors shall be elected by the members of their respective divisions for a two-year term. In the event of a tie, 8.2(a) II be deferred to the Department Chairperson.

The Division Directors will be responsible to consult with and provide recommendation to the applicable Department Chairperson on all matters regarding credentialing and privileging of medical and advanced practice professional staff members within their respective divisions. They will also be responsible to provide an on-call schedule for their Division.

## 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, the Rules and Regulations of the Medical Staff and department policies. The responsibility shall include, but not be limited:

- (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 examining any matter that arises about an individual practitioner during quality review (10.6), and by selecting cases for discussion at the departmental meetings;
- (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;
- (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;
- (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;
- (e) to recommend to the Medical Staff Needs Committee as to the need for new appointments;
- (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;
- (g) to confer with other Department Chairpersons under the direction of the President of the Medical Staff through the Chief Medical Officer and subject to the ultimate authority of the Board of Trustees; to provide professional guidance and supervision of all medical programs in the Hospital, for the recognition of the primary responsibility and dedication to the goals of the Hospital;
- (h) to make recommendations concerning space and resources needed by the department;
- (i) 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

- (j) to assess and recommend off-site sources for needed patient care services not provided by the department or organization.
- (k) The coordination and integration of interdepartmental and intradepartmental services.

#### 8.4 Department Meetings

- (a) Regular meetings of the department will be held in accordance with these Bylaws and the Rules and Regulations of the Medical Staff, in any event not less than four times per year.
- (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.
- (c) Each department may adopt Departmental policies consistent with these Bylaws, the Rules and Regulations and the Hospital Bylaws after review and approval by the Medical Executive Committee.

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

#### 9.1 Meetings

##### (a) Annual Meeting

Annual meeting shall be held at least once per calendar year. It shall be called by the President of the Medical Staff for the purpose of reviewing the Medical 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.

##### (b) Regular Meetings

Regular meetings shall be held at least four (4) times a year. These shall be business meetings at which reports from the Medical Executive Committee shall be heard. Any actions taken by the Medical 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.

##### (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 (electronically or hard copy), 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 electronically mailed to all members of the Active and Community Active Staffs at least seven (7) days before the date of the meeting.

##### (d) Requirements for Action at Medical Staff Meetings

Action will be based on a majority vote of the Active and/or Community Active Staff present at any meeting.

##### (e) Board of Trustees Attendance

Two (2) members of the Board of Trustees of the Hospital 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.

#### 9.2 Governance

##### (a) Officers

The Officers of the Medical Staff shall consist of the President, Vice President, and Treasurer. They shall be selected from Active and/or Community Active Staff members who are in good standing. Medical Staff officers may not hold leadership positions at a competing healthcare organization. The office of President shall alternate between a Medical Staff member who is board certified in Family Medicine and a member who is board certified in another specialty.

(b) 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. In the vacancy of the Department Chairperson, the Vice Chairperson shall serve the balance of the term.
- (2) For vacancies in other offices and committee positions, the procedure specified in 9.3(c) shall apply.
- (3) All such partial terms shall not apply to the term or qualifications for re-election.

(c) 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 Medical Executive Committee. The President is a member of all Medical Staff committees, ex-officio without vote. The President shall attend one meeting per year of the Board of Trustees of Hunterdon Medical Center to present a report of the Medical Staff before the governing board 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) 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.

(4) Records

The Manager of the Medical Staff Office shall keep accurate and complete minutes of all the meetings, call meeting to order of the President, attend to all correspondence, perform such other duties as required by the officers of the Medical Staff.

(d) Recall of Officers

Officers shall be subject to recall by a majority vote of those who vote within 30 days of the Medical Staff upon regular motion at any regular Medical 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, 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 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 examination, the Medical Executive Committee may, by two-thirds vote, recommend to the entire Active Staff that the officer be removed from office.

The Medical 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 their behalf. Minutes of the meeting will be recorded and filed.

Removal from office will require an affirmative vote of a majority of the Active and Community Active Staffs who cast ballots within thirty (30) days. Voting will be conducted electronically. 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**

- (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.

- (b) Voting shall take place by electronic 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 Medical Staff pursuant to Article 9.1.

- (c) Elections

Candidates to fill vacancies in the positions of President, Vice President, 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. An electronic ballot will then be provided to each member of the Medical Staff with a specified return deadline of thirty (30) days following the issuance of the ballots.

- (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.

- (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 Medical 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.

- (f) Reporting of Results of Elections

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

- (g) Term; Term Limits

The following terms and term limits apply to Officers and Medical Staff Members on Hospital Boards and Committees:

- (1) The President, and Vice President of the Medical Staff will serve a two (2) year term
- (2) The Treasurer of the Medical Staff will serve a two (2) year term and may be reelected for subsequent terms without limits
- (3) Terms for representatives of the Selection and Credentials Committee are defined in 10.4(a)
- (4) The Medical Staff representatives on the Hospital Needs Committee and the Quality Committee will serve a two (2) year term and can serve two (2) consecutive terms
- (5) The Medical Staff Trustees will each serve a three (3) year term and, upon reelection, can serve up to an additional two (2) consecutive terms for a maximum of three (3) year terms.

(h) Removal from Office

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

(i) Adoption, Repeal, Amendment of the Medical Staff Bylaws

Bylaws 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 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 thirty (30) days for it to be a valid election. Two-thirds of those voting must vote in assent to make a change to the Bylaws. 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 the Hospital.

## ARTICLE X COMMITTEES

### 10.1 **Standing Committees**

These shall be the Medical Executive, the Selection and Credentials, and the Medical Staff Performance Improvement Committees.

### 10.2 **Committee Appointments**

All appointments will be made by the Medical Executive Committee with the exception of the Hospital Needs Committee, the Selection and Credentials Committee, the Hospital Quality Committee, and physicians who serve on the Board of Trustees.

Non-physician members of these Medical Staff committees shall be selected by the President of the Hospital. 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 chairperson of the Medical Executive Committee.

### 10.3 **Medical Executive Committee**

(a) The Medical Executive Committee shall consist of the elected Chairperson of each department. Members may send a designee when unable to attend. The President, Treasurer, 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 the Hospital and/or Chief Operating Officer, the Chief Medical Officer, the Vice President of Patient Care Services, the Chairperson of the Medical Staff Performance Improvement, the Director of the Family Medicine Residency Program, and the Medical Staff Trustees. Other resource persons may be present by invitation of the Chairperson of the Committee. The Committee shall meet eleven (11) times per year.

#### (b) Functions

(1) To formulate and recommend to the Board of Trustees rules and regulations pertaining to medical care within the Hospital. Such rules and regulations, or changes thereof, may be proposed by voting members of the Medical Staff. When the Medical Executive Committee adopts a rule and regulation, 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 rule 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 rule and regulation or 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 structure and professional credentials.
- (3) To supervise the continuous assessment and improvement of the quality of the medical care provided in the Hospital.
- (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 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 Article 10.3(b)(1).

#### 10.4 Selection and Credentials Committee

##### (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 Chief Medical Officer 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.

##### (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.

##### (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 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.

## **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 will be in accordance with these Bylaws and the Bylaws of the Hospital. The shall be subject to approval by the Board of Trustees. These Rules and Regulations shall be reviewed as required by regulatory. 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:

- (a) the practitioner authorizes Hospital representatives to request from others (or provide to others) and to act upon information bearing on their professional ability and qualifications;
- (b) the practitioner agrees to be bound by this Article 13 and to waive all legal acts in accordance with this Article 13; and
- (c) the practitioner acknowledges that this Article 13 is an express condition to their application for and acceptance of staff membership and to their exercise of clinical privileges at the Medical Center.

### **13.2 Confidentiality of Information**

Information (whether provided by the Hospital 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 13 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:

- (a) evaluating and improving the quality and efficiency of patient care;
- (b) reducing morbidity and mortality;
- (c) contributing to teaching or clinical research;
- (d) determining that health care services are professional, indicated and performed in compliance with the applicable standard of care;

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

- (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 13.2.
- (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 13.3(a), even where the information involved would not otherwise be deemed privileged.
- (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 Hospital, 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 their duties as a representative.

### 13.4 **Definitions**

- (a) The term "information" as used in this Article 13 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.
- (b) The term "representative" as used in this Article 13 shall include the board of trustees of a Hospital and any member or committee thereof; a chief executive officer of a Hospital or their 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 Hospital, execute general and specific releases in accordance with this Article 13, but execution of such releases is not a prerequisite to the effectiveness of this Article 13.

### 13.6 **Superseding Law**

This Article 13 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 as required by regulatory statutes 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), as determined by the Department Chairperson, charity care, committee membership, and involvement in community programs.
- (c) to promptly report to the 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 Hospital.
  - (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 (the "Hospital") and I agree:



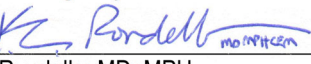
- (a) to be bound by and to adhere to the Hospital's Bylaws, the Bylaws and Rules and Regulations of the Medical Staff, and the Bylaws, Rules and Regulations of my department; and
- (b) to fulfill the following professional obligations of the Hospital:
  - (i) teaching, as determined by the Department Chairperson and the Chief Medical Officer;
  - (ii) in-Hospital physician coverage (including evening, night, weekend and holiday coverage) in accordance with the practitioner's privileges;
  - (iii) indigent care;
  - (iv) Committee membership, and
  - (v) involvement in community programs.



# APPROVAL SIGNATURES

## HUNTERDON MEDICAL CENTER BYLAWS OF THE MEDICAL STAFF

ADOPTED & APPROVED:

By:	<div>DocuSigned by:</div>  <div>E8E13485-C602-408D-BBD5-E0559C02F2F3...</div> Lisa Plunkett, MD President of the Medical Staff	6/27/2024 <hr/> Date
By:	<div>DocuSigned by:</div>  <div>E8E13485-C602-408D-BBD5-E0559C02F2F3...</div> Patrick J. Gavin President and Chief Executive Officer	6/27/2024 <hr/> Date
By:	<div>DocuSigned by:</div>  <div>E8E13485-C602-408D-BBD5-E0559C02F2F3...</div> K.C. Rondelle, MD, MPH Chairperson, Board of Trustees	6/27/2024 <hr/> Date

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  
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 Amended: January 2014  
 Amended: March 2015  
 Amended: November 2015  
 Amended: March 2016  
 Amended: May 2016  
 Amended: March 2018  
 Amended: October 2018  
 Amended: March 2019  
 Amended: March 2020  
 Amended: February 2022  
 Amended: July 2022  
 Amended: June 2024