Medical Staff BYLAWS

Last Updated: May 2011

The University Hospital Medical Staff Bylaws

PREAMBLE

WHEREAS, University Hospital is a health care entity of the University of Medicine and Dentistry of New Jersey (UMDNJ), licensed by the State of New Jersey to provide health care services, organized under the laws of the State of New Jersey "Medical and Dental Education Act of 1970" and in conformance with the requirements of The Joint Commission (TJC) ; and

WHEREAS, its purpose is to serve as an acute care Hospital providing patient care, medical education programs, and research as the primary teaching Hospital of the UMDNJ-New Jersey Medical School; and the UMDNJ-New Jersey Dental School; and

WHEREAS, it is recognized that one of the aims and goals of the Medical Staff (*henceforth referred to hereafter as Medical Staff and/or Adjunct Staff*) is to strive for optimal patient care in the Hospital, and that the Medical Staff must cooperate with and is subject to the ultimate authority of the Board of Trustees through the President of UMDNJ, the Dean of New Jersey Medical School, and the Chief Executive Officer of University Hospital, and that the cooperative efforts of the Medical Staff, Hospital Administration, and the Board of Trustees are necessary to fulfill the Hospital's aims and goals in providing optimal patient care to patients in the Hospital; and the Medical Staff endorses and supports the Mission Statement adopted by University Hospital; and

WHEREAS, it is the intent and purpose of these Bylaws that the initiation and conduct of professional review actions hereunder comply in all material respects with the provisions of S 412 of the HCQI Act of 1986,

THEREFORE, the physicians and dentists, and other practitioners providing health care services in the University Hospital hereby organize themselves into a Medical Staff in conformity with the following Bylaws and Rules and Regulations approved by the Medical Staff and by the Board of Trustees to facilitate the aims, goals and purposes listed above.

UNIVERSITY HOSPITAL ORGANIZED MEDICAL STAFF MISSION STATEMENT

To promote quality medical care and the spirit of cooperation amongst our peers in striving to achieve medical and academic excellence.

The Medical Staff of University Hospital shall provide educational guidance to members of the Medical Staff, serve community and the hospital through participation and sharing medical expertise with our colleagues.

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ARTICLE I-NAME

The name of this organization shall be The Medical Staff of University Hospital, University of Medicine and Dentistry of New Jersey.

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ARTICLE II- PURPOSE

2.1 Purposes of the Medical Staff

The Medical Staff is self-governing and provides the oversight of care, treatment and services provided by practitioners with privileges; provides for a uniform quality of patient care, treatment and services; submits its proposals and reports to and is accountable to the Board of Trustees.

The purpose of the Medical Staff is:

2.1-1 To ensure that the Medical Staff provides to all patients admitted to or treated in any of the facilities, departments or services of the University Hospital, a uniform standard of quality patient care, treatment, and services;

2.1-2 To ensure that designated members of the organized Medical Staff who are Licensed Independent Practitioners (LIP) with privileges, provide the oversight of care, treatment, and services;

2.1-3 To ensure accountability of the Medical Staff to the Board of Trustees for the quality of the medical care and service provided to patients. The Chief of Service or designee shall ensure an optimal level of professional performance of all practitioners authorized to practice in the University Hospital through the approved clinical delineation of privileges, focused professional practice evaluation (FPPE), ongoing professional practice evaluation (OPPE), which is an objective review and evaluation of each practitioner's performance. At the ninth month, the Chief of Services shall be required to submit a written explanation of the lack of FPPE. If by the twelfth month it has not been completed, the practitioner’s appointment will expire;

2.1-4 To report to The Board of Trustees the results of focused professional practice evaluations, ongoing professional practice evaluations, and performance improvement (PI) activities *that are* in accordance with the University Hospital's

PI Plan;

2.1-5 To provide an appropriate educational setting that will assist in maintaining patient care standards, and that will lead to continuous advancement in professional knowledge and skill for the Medical Staff, and all health care professional students and trainees;

2.1-6 To initiate, develop, amend and approve Medical Staff Bylaws and Rules and Regulations;

2.1-7 To provide a mechanism whereby issues concerning the Medical Staff and Hospital may be discussed by the Medical Staff with the Board of Trustees and the Chief Executive Officer (CEO).

2.2 Responsibilities/Performance

The Medical Staff is accountable to the Board of Trustees for the quality of medical care and services provided to patients.

The Medical Staff is organized, enforces, and complies with the Medical Staff Bylaws and Rules and Regulations in a manner approved by the Board of Trustees

The Medical Staff Bylaws and Rules and Regulations, and Policies do not conflict with the Bylaws of the Board of Trustees.

Neither the Medical Staff nor the Board of Trustees may unilaterally amend the Medical Staff Bylaws and Rules and Regulations.

The responsibilities of the Medical Staff which may be through the Medical Executive Committee (MEC) are:

2.2-1 To account for the quality and appropriateness of patient care rendered by all licensed independent practitioners who are privileged by The University Hospital to provide patient care services in the hospital by establishing and maintaining criteria and standards for:

- Medical Staff membership;
- oversight responsibilities for practitioners with independent privileges; and
- patient care standards, credentialing, and delineation of clinical privileges.

2.2-2 To develop a mechanism for:

- selecting and removing officers of the Medical Staff;
- establishing a Continuing Medical Education Program that addresses

the needs identified through the PI program**;**

- **i**mplementing corrective actions with respect to practitioners and other Medical Staff members, as warranted;
- identifying community health needs, institutional goals, and programs that will meet those needs.

2.2-3 In the event that conflict occurs between the Medical Staff and the MEC concerning proposed changes to rules, regulations, and policies, the Medical Staff may propose such changes directly to the governing body. In this event, a committee comprised of elected members of the Medical Staff will be convened to discuss and resolve conflict or make proposals directly to the governing body.

2.3 Ethical Behavior

All members of the organized Medical Staff shall conduct their professional activities in accordance with the ethical code of their respective organized professional associations in accordance with the laws and regulations covering physician practice.

All members of the Medical Staff are obligated to abide by the requirements of the UMDNJ University Hospital Compliance Program.

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ARTICLE III-STAFF APPOINTMENTS AND REAPPOINTMENTS

The Board of Trustees shall make appointments, reappointments or revoke appointments and grant, revoke or restrict clinical privileges of the Medical Staff. The Board of Trustees shall act only after there has been a recommendation from the Medical Executive Committee as provided in these Bylaws.

3.1 Nature of Appointment

Appointment to the Medical Staff is a privilege extended by the Board of Trustees and is not a right of any practitioner. Appointment to the Medical Staff or the exercise of temporary privileges shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws and in the Rules and Regulations.

3.2 Credentialing and Privileging Process

The Medical Staff Office will conduct primary source verification to assure evidence of

current licensure, relevant training or experience, current competence and the ability to perform the privileges requested. This will include the six areas of "General Competencies" which include: Patient Care, Medical/Clinical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communication Skills, Professionalism and Systems- based Practice. At a minimum , the following items will be verified: licensure, challenges to licensure, relevant education for both medical school and graduate medical education training, board status, malpractice claims history, affiliation(s) at other health care institutions[i.e.. regarding the voluntary or involuntary relinquishment of Medical Staff membership or limitation, reduction, suspension of or loss of clinical privileges], clinical competence and the ability to perform the privileges requested will be determined by professional reference questionnaires and a confidential evaluation sent to an individual in the same specialty in an authoritative position. The Medical Staff Office will also query the NPDB (National Practitioner Data Bank), the OIG (Office of Inspector General), EPLS (Excluded Parties List System) and NJ Debarment and other sources, including the NJDHHS. To ensure the practitioner requesting privileges is the same practitioner identified in the credentialing documents, each practitioner will be required to submit a notarized copy or original governmental photo ID. Individuals who are listed on either the OIG or EPLS list of excluded providers cannot be granted clinical privileges as a member of the Medical Staff of University Hospital.

The Hospital Administration, in conjunction with the Chief of Service, Credentials Committee, MEC and Chief Medical Officer shall make a thorough and independent evaluation of each application to include verification of all credentials and documents. No practitioner shall be automatically entitled to appointment or reappointment to the Medical Staff or to exercise clinical privileges because of membership in any professional organization, board certification, or past or existing staff appointment at the University Hospital or at another health care facility. Further information regarding the applicant's performance at any other health care facility will be checked with the Department of Health and Human Services.

3.3 Nondiscrimination

Appointment to the Medical Staff or any aspect of clinical privileges shall not be denied to any individual for reason of sex, race, national origin, creed, color, age, marital status, sexual orientation, or disability except where that disability renders the person incapable, despite reasonable accommodation, of performing the essential functions of the Medical Staff appointment.

3.4 Appointment

Only fully licensed independent practitioners; MD's, DO's DPM's, DMD's and DDS's who are currently licensed to practice in the State of New Jersey and who abide by the provisions described below shall be qualified for appointment to the Medical Staff.

These practitioners shall:

- Be currently board certified in their specialty area or must be within five years of becoming exam admissible to take certification boards in their specialty. In extraordinary instances, and after providing sufficient justification to the Credentials Committee, a Department Chairperson or Chief of Service may recommend to the MEC the appointment of a candidate who does not have active board certification in his or her specialty and has been exam eligible for more than 5 years;

- The applicant shall document at a minimum, current competence, his/her qualifications and/or certification in his/her specialty(ies), training, education and the ability to perform the privileges requested;

- The applicant shall demonstrate to the Hospital and the Board of Directors that any patient treated by the applicant will receive care at the generally recognized professional level established by the Hospital;

- The applicant shall establish to the Hospital, on the basis of documented professional references that they have satisfactorily demonstrated the adherence to the six areas of "General Competencies" developed by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS). Included are: patient care, medical/clinical knowledge, practice based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice;

- The applicant shall provide to the Medical Staff Office, department Chairperson, and Credentials Committee information including, but not limited to: challenges to any licensure or registration, voluntary and involuntary relinquishment of any license or registration, voluntary and involuntary termination of Medical Staff membership, voluntary and involuntary limitation, reduction, denial of or loss of clinical privileges, any professional liability actions, documentation of health status or sanctions by a government or third party payer against the applicant;

- The applicant shall hold or initiate the process for a faculty appointment at the New Jersey Medical School or New Jersey Dental School, unless exempt, as provided for elsewhere in these Bylaws.

3.5 Basic Responsibilities of Staff Appointees

Each new appointee to the Medical Staff shall:

- Achieve board certification within five years of becoming exam admissible and maintain active certification within his or her specialty unless a specific exemption has been made by the Medical Executive Committee;

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- Provide patients with care at the generally recognized level of quality within the appointee's delineated clinical privileges;

- Be informed of and abide by the current Medical Staff Rules and Regulations, Bylaws, and current policies of the Hospital;

- Maintain and respect the confidentiality of patient health information (PHI) as required by state and federal law and as required by the Hospital policies and procedures, including, but not limited to the Health Insurance Portability and Accountability Act (HIPAA);

- Perform such Medical Staff service, committee, and hospital functions for which he or she is responsible by appointment, election or otherwise in the University Hospital;

- Prepare and complete, in timely fashion, according to the requirements of the Department of Health and Senior Services (DOHSS) and existing Hospital policy, the medical and other required records for all patients of UH for whom patient care has been provided by the Medical Staff member or in any way provides care to in the Hospital;

- Pay the required annual Medical Staff dues.

3.6 Initial Appointment

3.6-1 Burden of Proof

The applicant shall:

- Produce adequate information on a signed application form to enable evaluation of education, training, experience, clinical competency, and the ability to perform privileges requested;

- Provide documentation of all challenges to licensure, including the reporting of past, present or pending liability actions and documentation of clinical competence;

- If requested, appear for interview(s);

- Sign a statement that the applicant has agreed to abide by the current Bylaws, Policies, and Rules and Regulations of the Medical Staff;

- Authorize representatives of the Hospital to review records and documents about the applicant's license, training, clinical competence, and health status;

- Provide two current professional references, in the same discipline, who can attest to the applicant's mastery of the six competencies established by the ACGME and ABMS;

- Provide the contact information of someone in a supervisory role and in the same discipline who can complete a Confidential Evaluation as it relates to the applicant's request for privileges and the six general competencies;

- Provide documentation of continuing relevant medical training, education and experience which qualify the applicant for the privileges requested;

- Provide information regarding any challenges to any licensure or registration, including but not limited to the voluntary or involuntary relinquishment of licensure or registration; provide information regarding Medical Staff membership including, but not limited to, whether the applicant's appointment status and/or clinical privileges at another health care institution have ever been revoked, suspended, reduced, not renewed, or voluntarily relinquished for any reason, whether there has been termination of Medical Staff membership, limitation of, reduction of, loss of, denial of, or adverse actions against any clinical privileges at any hospital or healthcare facility; and provide information regarding any involvement in a professional liability action or any sanction by a government or other third party payor;

- Provide information about current and professional liability insurance coverage;

- Release from liability all representatives of the hospital and of its Medical Staff for any actions performed (in good faith and without malice) in evaluating the application. This may include a review of privileged or confidential information;

- Authorize the hospital to consult with members of the Medical Staff of other heath care institutions with which the applicant has been associated and with others that may have information bearing on the competence, character and ethical qualifications of the applicant. The applicant shall consent to the Hospital's review of all records and documents that may be material to an evaluation of the professional qualifications and competence of the applicant's professional qualifications;

3.6-2 Application Form

Each application for appointment and reappointment shall be in writing or electronically submitted on a prescribed form or in the prescribed format to the Medical Staff Office. The application covers the applicant's basic qualifications. It shall also include, but is not limited to the following:

- A statement that the applicant has agreed to abide by the current Bylaws, Policies, and Rules and Regulations.

- A statement that the applicant is willing to appear for an interview about the application, during which the applicant may need to provide information about the applicant's education, experience, physical and/or mental health;

- A consent form signed by the applicant so that representatives of the Hospital can inspect records and documents about the applicant's license, training, clinical competence, and health status;

- A description by the applicant indicating which staff category, service, and specific clinical privileges the applicant is applying for;

- Two or more peer references who can attest to applicant's training, clinical competence, ability to work with others, and ethical standards;

- Documentation of continuing training, education and experience which qualifies the Medical/Adjunct Staff appointee for the privileges requested;

- Information about whether the applicant's appointment, status and/or clinical privileges at another health care institution have ever been revoked, suspended, reduced, not renewed, or voluntarily relinquished for any reason;

- Information about the applicant's involvement in any professional liability action, whether filed, pending or resolved, including details about malpractice insurance claims, suits, and settlements;

- Information about any prior, existing or pending challenges to licensure or registration(s); voluntary relinquishment or reduction of applicant's professional licensure or registration; or any past action on professional license or registration;

- Information about applicant's current professional liability insurance coverage;

- Information about whether the applicant has a prior, current or pending sanction(s) by a government or third party payor which limits the practitioner’s ability to provide medical care to patients;

- Specific information about the applicant’s professional ethics, qualifications, and ability that may bear on his/her ability to provide good patient care in the Hospital; and including a review of performance improvement data;

- Information about compliance with medical records activity;

- Information about any adverse actions relating to credentialing or privileges due to peer review activities;

- Specific information about criminal charges pending, convictions, and misdemeanors, other than minor traffic violations;

- A statement that the applicant shall hold harmless and indemnify the University and University Hospital, its representatives and employees and, also, the third party facility and its employees with respect to reports, recommendations or disclosures about the applicant with respect to information requests which are made to third parties by University Hospital and, thereafter, provided by the third party to UH.

3.7 Processing the Application

There will be a process for the Medical/Adjunct Staff applicant to present an official governmental issued photo identification to the Medical Staff Office to ensure that the applicant is the one named on the documents.

3.7-1 Action by Chief of Service

Once the Medical Staff Office has completed the primary source verification and investigation, the designated Chief of Service shall review the application and supporting documentation. The Chief of Service may conduct a personal interview with the applicant. In the case of a dual appointment, the Chief of Service for the secondary department may also require a personal interview with the applicant. The Chief of Service shall forward to the Credentials Committee a written recommendation with supporting documentation of the category, service, clinical privileges and the Focused Professional Practice Evaluation Plan for the applicant. A Chief of Service may recommend deferring action on the application.

3.7-2 Credentials Committee Action

The members of the Credentials Committee shall review the recommendation of the Chief of Service, the application for appointment with the supporting documentation and any other information that may be relevant to the applicant's qualifications. The Credentials Committee shall make their final recommendation to the MEC. The Credentials Committee may defer action on the application and privilege pending additional information. The Credentials Committee can recommend the application for appointment or can recommend denial of the application to the MEC.

3.7-3 Medical Executive Committee Action

After receipt of the Credentials Committee recommendation, the Medical Executive Committee shall consider the recommendation and all other supporting documentation

that may be relevant to the applicant's qualifications for the staff category, service and clinical privileges requested.

Options by the Medical Executive Committee:

Recommendation - If the MEC has recommended the appointment, the Chairperson of the MEC shall forward it to the Board of Directors for their recommendation. The Board of Directors will then forward to the Board of Trustees for final approval of clinical privileges.

Deferral – If the action by the MEC is to defer the application for further consideration, a recommendation to either grant a provisional appointment or deny the appointment must be made at the next scheduled meeting of the MEC.

Adverse Recommendation – If there is an adverse recommendation of the MEC, the Chairperson of the MEC shall inform the CEO who shall immediately so inform the applicant by written notice, and he or she shall be entitled to the procedural rights as provided in Article 6.

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3.7-4 Board of Directors Action

Recommendation - On favorable MEC recommendation, the Board of Directors or the Committee or Body designated to act on its behalf shall, in whole or part, accept or reject a favorable recommendation of the MEC, or refer the recommendation back to the MEC for further consideration stating the reasons for such referral and setting a time limit within which the MEC must review the case. If the recommendation is favorable, it will be forwarded to the Board of Trustees for approval.

Adverse Recommendation - If the action of the Board of Directors or the Committee or Body designated to act on its behalf is adverse to the applicant, the CEO of the Hospital shall so inform the applicant by special notice and he or she shall be entitled to the procedural rights as provided in Article 6.

3.7-5 Board of Trustees Action

All final decisions regarding clinical privileges of the Medical/Adjunct staff are subject to the approval of the Board of Trustees of UMDNJ.

Recommendation - On favorable BOD recommendation, the Board of Trustees shall accept or reject a favorable recommendation of the BOD, or refer the recommendation back to the BOD for further consideration stating the reasons for such referral and setting a time limit within which the BOD must review the case. If the recommendation is favorable, the CEO or designee will notify the

applicant.

Adverse Recommendation - If the Board of Trustees action is adverse to the applicant, the CEO of the Hospital shall so inform the applicant by special notice and he or she shall be entitled to the procedural rights as provided in Article 6.

3.7-6 Time Periods for Processing

The Chief of Service or designee will be responsible for providing the applicant with the pre application, application, and the Delineation of Privileges. Once the forms have been completed, the applicant should provide them, with the supporting documentation and the initial application fee, to the Medical Staff Office. The University Hospital Administration in conjunction with the Chief of Service and the Chairperson of the Credentials Committee are responsible for reviewing all statements, evaluations, primary source verifications and any documentation submitted with the application. The primary source verification process shall include but is not limited to the querying of the National Practitioner Data Bank. This is done for all new applicants and at a minimum every two years for Medical/Adjunct staff members who apply for reappointment.

Primary source verifications shall commence following receipt of the pre-application. The completed application shall be forwarded to the Chief of Service who shall review and forward a recommendation to the Credentials Committee. This is done within 30 days following receipt by the Chief of Service. The Credentials Committee shall review the application, supporting documentation, primary source verification, Delineation of Privileges and the Focused Professional Practice Evaluation Plan, and forward its recommendation at the next scheduled MEC meeting unless the application is deferred pending further information. The recommendation of the MEC shall be forwarded to the next meeting of the UH Board of Directors. The Board of Directors will make the recommendation to the Board of Trustees

3.8 Reappointment Process

Reappointments to the Medical/Adjunct Staff shall be for a period not to exceed 24 months.

3.8-1 Reappointment Application

Approximately 6 months prior to the expiration of the appointment, the Medical Staff Office, shall provide each Medical/Adjunct staff member with a reappointment application and requested delineation of privileges. The Medical/Adjunct staff member requesting reappointment shall complete the application and requested delineation of privileges and submit required documentation within 30 days. Failure to return the completed application after this date will incur a late fee and may result in a voluntary resignation of privileges and the expiration of the appointment to the Medical/Adjunct

staff.

Once the reappointment application is complete and reviewed by the Director of the Medical Staff Office, the application shall be forwarded to the Chief of Service who shall review and provide a recommendation regarding the reappointment to the Credentials Committee The Credentials Committee shall review the application, supporting documentation, primary source verification, delineation of privileges and the Ongoing Professional Practice Evaluation data from the Chief of Service.

3.8-2

The reappointment application form shall be a prescribed form, and shall comply with all the statutory and regulatory requirements. This information shall include, but is not limited to:

- Current licensure, professional performance, judgment, clinical and/or technical skills;
- Adherence to membership requirements as stated in the Bylaws; (Refer to Bylaws Section 3.5 and the Rules and Regulations);
- The ability to perform privileges requested;
- The name and address of any other health care organization or practice setting where the Medical/Adjunct Staff member has been affiliated within the past five years;
- Sanctions of any kind imposed by a government or other third party payor, any other health care institution, professional health care organization, or licensing authority including: those related to any UMDNJ entities;
- previously successful or currently pending challenges to any licensure or registration (State, or DEA);
- the voluntary or involuntary relinquishment of licensure or registration; voluntary or involuntary termination of Medical/Adjunct Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another health care facility;
- Details of past, pending or anticipated malpractice claims, suits, and settlements;
- Such other specific information about the staff member's professional ethics, and qualifications, that may bear on the Medical/Adjunct Staff member’s ability to provide good patient care in University Hospital, including a review of

Ongoing Professional Practice Evaluation and performance improvement data;

- Specific information about criminal charges pending, convictions, and misdemeanors, other than minor traffic violations;

- A statement that the re-applicant shall hold harmless and indemnify the University and University Hospital, its representatives and employees and, also, the third party facility and its employees with respect to reports, recommendations or disclosures about the re-applicant with respect to information requests which are made to third parties by University Hospital and, thereafter, provided by the third party to UH.;

- Proof of training, education, experience, and competency which qualifies the Medical/Adjunct Staff member for the privileges sought on reappointment;

- Proof of Continuing Medical Education (CME) and any other requirements as required by the New Jersey State Board of Medical Examiners as a condition for biennial registration; and

3.8.3 Verification of Information

The University Hospital Administration, in conjunction with the Medical Staff Office, Chief of Service of the applicant's department and the Chairperson of the Credentials Committee shall verify any additional information made available on each reappointment application form and collect any other materials or information deemed pertinent, including but not limited to information regarding the staff member's professional activities and the six general competencies as described in Article 3.2. When collection and verification is complete and reviewed the Medical Staff Office shall forward the application and supporting documentation to the Chief of Service.

3.8-4 Action by Chief of Service

Once the Medical Staff Office has completed the primary source verification and investigation, the Chief of Service shall review the re-application and supporting documentation. The Chief of Service shall forward to the Credentials Committee a written evaluation with supporting documentation of the category, service, clinical privileges and the Ongoing Professional Practice Evaluation for the re-applicant.

3.8-5 Credentials Committee Action

The Credentials Committee shall review each reapplication and all other pertinent information available on each member being considered for reappointment, including the recommendation of each Chief of Service under which the staff member has

requested privileges, and shall transmit to the MEC, its report and recommendation that appointment be either renewed, renewed with modified staff category and/or clinical privileges, or terminated.

3.8-6 MEC Action

The MEC shall review the Credentials Committee recommendation and all other relevant information and shall forward to the Board of Directors its report and recommendation that appointment be either renewed, renewed with modified staff category and/or clinical privileges, or terminated. If the decision is adverse the specific reasons to support the decision must be submitted for review by the Board of Directors. Any minority views shall also be submitted in writing and transmitted with the majority report, if so requested. The MEC may also defer action.

3.8-7 Board of Directors Action

The Hospital Board of Directors shall make recommendations to the UMDNJ Board of Trustees regarding Medical Staff, appointments and reappointments, the categories of staff privileges authorized and clinical [privileges granted, after review and consideration of the recommendations of the MEC.

If the UH Board of Directors requests additional information regarding the MEC recommendations, the MEC may either appoint a Special Committee or refer the matter back to the Credentials Committee for further investigation. The appointed committee will refer its findings to the MEC for consideration and recommendation to the Board of Directors.

3.8-8 Board of Trustees Action

The UMDNJ Board of Trustees shall either vote on the requests regarding Medical Staff appointments and reappointments, the categories of staff privileges authorized, and clinical privileges granted, after review and communicate the results of this vote to the Board of Directors, or request additional information of the Board of Directors.

3.8-9 Time Periods for Processing

An application shall be given to a Medical Staff member and shall be returned in a timely fashion (Article III, Section 3.8-1).

All parties required by these Bylaws to act on the application shall complete and shall transmit the application, with their recommendation, to the MEC and to the UH BOD for action before the expiration date of the staff member's appointment. Completion shall be in a timely manner except for good cause shown.

3.8-10 Requests for Modification of Appointment

A Medical Staff member, either in connection with reappointment or at any other time, may request modification of staff category, service assignment or clinical privileges by submitting a written request. Such application shall be processed in the same manner as provided for reappointment.

3.8-11 Notification of Change in Privileges at Another Healthcare Facility

In the event of any voluntary or involuntary restriction, limitation, suspension or loss of clinical privileges at another healthcare facility, the Medical Staff member must notify their Chief of Services at University Hospital in writing within 2 working days following notice of such change.

3.8-12 Non-Faculty "Open Staff" Status

A new appointment to the University Hospital Medical/Dental staff requires a simultaneous application for a NJMS or NJDS faculty appointment or a current NJMS or NJDS faculty (Podiatric Services excluded). In the event of a non faculty status application, the department Chief of Service shall submit a written request with a detailed justification to the Chief Medical Officer for approval. The CMO's recommendation will be forwarded to the Credentials Committee and to the Medical Executive Committee for approval of the waiver.

3.9 Leave of Absence

a. Voluntary

A Medical Staff member may obtain a voluntary leave of absence from the Medical Staff by submitting written request to the Chief of Service. The request should include the exact dates the leave commences and anticipated return. The request may not exceed one year with the exception of a military leave. The Chief of Service shall then convey this information to the Medical Staff Office. It will be placed on the next Credentials Committee.

b. Compliance with Health Care Quality Improvement Act of 1986

The above leave of absence is non-reportable under the state or federal reporting systems providing such actions are/were not taken because the applicant was under investigation.

3.10 Termination of Leave

Any time during the period of Leave of Absence a Medical Staff appointee may seek reinstatement by submitting a written request to the Medical Staff Office, which will be forwarded to the Credentials Committee for processing in the usual manner. The staff appointee shall submit a written summary of his or her relevant activities during the leave. Failure to request reinstatement within one year shall be deemed a voluntary

resignation from the Staff and shall result in automatic termination of Staff membership.

A request for staff membership subsequently received from a staff member so voluntarily resigned shall be submitted and processed in the manner specified for applications for initial appointments.

3.11 Resignation from Medical Staff

3.11-1 Non-Reappointment

Any Medical Staff member who fails to reapply shall be terminated. Termination is considered a voluntary resignation and not reportable.

3.11-2 Resignation

A Medical Staff member may request in writing, resignation from the Staff, stating the effective date of such resignation. Such notification shall be submitted to the appropriate Chief of Service and transmitted in the same manner as in Section 3.11-1.

3.11-3 Loss of Faculty Appointment

A staff member who loses his/her faculty appointment to the New Jersey Medical School or New Jersey Dental School loses membership on the Medical Staff as of the date of notification of the Medical Staff Office by the respective school unless exempted as provided for elsewhere in these Bylaws.

A staff member who does not receive his faculty appointment to the New Jersey Medical School or the New Jersey Dental School within a year of appointment to the Hospital loses membership on the Medical Staff as of the date of notification of the Medical Staff Office by the respective school unless exempted as provided for elsewhere in these Bylaws.

3.11-4 Compliance with Health Care Quality Improvement Act of 1986

The above non-reappointments or resignations are non reportable under the state or federal reporting systems providing such actions are/were not taken because the applicant was under investigation, had a payor or other regulatory sanction or loss of license.

IV-1

ARTICLE IV-CATEGORIES OF THE MEDICAL/ADJUNCT STAFF

Categories

The Medical Staff shall include Attending Physician, Courtesy Physician, Affiliate Physician, Emeritus, Adjunct Staff, and Administrative Physician - Non-Clinical.

4.1 Initial Appointment

All initial appointments to the Medical Staff shall be subject to FPPE not to exceed one year. Each initial appointee shall be assigned to a department and shall be observed by the Chief of Service or proctor to determine his or her suitability for continued appointment to the Medical Staff. At the end of the provisional year, the Chief of Service shall recommend appointment to full status or to terminate.

4.2-2 Qualifications

The Staff shall consist of practitioners serving in a proctored status as specified above, each of whom shall meet the basic qualifications set forth in Article III, Section 4.

4.2-3 Prerogatives

The prerogatives of a Staff appointee shall be to:

a.) Admit patients to the Hospital as permitted by the Chief of Service.
b.) Exercise such clinical privileges as are granted to him or her pursuant to Article V.
c.) Vote on all matters presented at meetings of the Department and committees to which he or she is appointed.

4.2-4 Limitations

Initial Staff appointees shall not be eligible to vote or to hold a Medical Staff office for one year.

4.3 Attending Physician

4.3-1 Qualifications

The Attending Staff shall consist of practitioners, each of whom:

Shall be either a member of the faculty of the New Jersey Medical School or the New Jersey Dental School, with the exception of Podiatry. Upon recommendation of the respective Dean, under extraordinary circumstances, when needed for patient care, exemptions to this requirement may be granted by the MEC, and may include, but are not limited to Physician Specialists.

Meets the basic qualifications set forth in Article III; and

Complies with Chief of Service assignments.

4.3-2 Prerogatives

The Attending Staff shall:

Exercise such clinical privileges in accordance with the Staff Bylaws, Rules and Regulations, and Hospital policies as are granted to him or her pursuant to Article V;

Actively participate in the quality assessment activities required of the staff, in proctoring appointees where appropriate, in emergency services coverage, and in discharging such other Medical Staff functions as may be required; and

Satisfy the requirements set forth in Article X for attendance at meetings of the Medical Staff and of the department and committees to which he or she is appointed; and

Be eligible for election to office of the Medical Staff; and remain a member in good standing pursuant to Article XI.

4.4 Courtesy Physician

4.4-1 Qualifications

The Courtesy Staff shall consist of voluntary practitioners, each of whom meets the basic qualifications set forth in Article III, Section 4, but, who do not routinely admit patients to the Hospital or are not routinely involved in the care of Hospital patients.

Each member of the Courtesy Staff shall be a member of the faculty of the New Jersey Medical School or the New Jersey Dental School or any other clinical service established by the MEC and approved by the Dean and the UMDNJ Board of Trustees or the committee or body designated to act on their behalf.

4.4-2 Prerogatives

The prerogatives of Courtesy Staff appointees shall be to:

Admit patients to the Hospital within the limitations provided in Section 4.3-2 (a) for Attending Staff appointees.

Exercise such clinical privileges as are granted to him or her pursuant to Article V.

Attend meetings of the Medical Staff and the Service of which he or she is an appointee and any Medical Staff or Hospital education programs.

4.4-3 Limitations

Courtesy Staff appointees shall not be eligible to vote or to hold office.

4.4-4 Responsibilities

Each appointee of the Courtesy Staff shall be required to discharge the basic responsibilities specified in Article III, Section 4.

4.5 Administrative Physician - Non Clinical

4.5-1 Qualifications

Administrative Staff shall consist of a special category of practitioners who do not have clinical privileges but wish to maintain Medical Staff membership.

Must present documented evidence of his or her qualifications, each of whom meets the basic qualifications set forth in Article III, Section 4, but, who do not admit patients and are not involved in the care of patients.

4.5-2 Prerogatives

The Administrative Staff (Ancillary) will maintain Medical Staff membership with “citizenship” privileges:

a. Vote on all matters presented at meeting of the Department and committees to which he or she is appointed.
b. May Chair a department.
c. Shall be a full time member of the faculty of the New Jersey Medical School of the
New Jersey Dental School, with the exception of Podiatry.
e. Take on duties of Medical Staff administration.

4.5-3 Limitations

Administrative Staff (Ancillary) appointee shall not admit patients, shall not have clinical privileges, and shall not be entitled to hold a Medical Staff office.
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4.6 Affiliate Physician

The Affiliate Staff shall consist of practitioners who do not wish to have admitting or clinical privileges, or to manage the care of their patients in the University Hospital.

Applicants for Affiliate Staff membership shall meet regulatory requirements for credentialing as it pertains to primary source verification. They shall be appointed to a specific department and be responsible to the appropriate Chief of Service. They shall have no admitting, operating, or consulting privileges and have no patient care duties in the UH.

Since they have no direct patient care responsibilities at UH, Affiliate Physician Staff members may be appointed and reappointed pursuant to an abbreviated application process and shall not be entitled to a Fair Hearing and Appeal Process as set forth in these Bylaws, Article VI.

Affiliate Staff are not eligible to vote, hold office, or hold standing committee appointments.

4.7 Emeritus Physician

4.7-1 Qualifications

Honorary Staff shall consist of practitioners recognized for their outstanding reputation, their noteworthy contribution to the health and medical sciences, or their previous longstanding service to the Hospital. These may be physicians, dentists, or podiatrists who have retired from active practice and, qualify for an Emeritus position.

Honorary Staff are not eligible to participate in patient care, vote, hold office, or hold standing committee appointments. They may, however, participate in the Hospital's teaching programs only insofar as such participation does not involve the practice of medicine or dentistry, if they maintain a faculty appointment..

4.8 Adjunct Staff

4.8-1 Qualifications

The members of the Adjunct Staff are Allied Health Professionals as defined by the scope of the individual’s specific license or certification. The Adjunct Staff shall consist of licensed practitioners permitted by law and by the Hospital to provide specific patient care services within their scope of practice and training as defined by the Medical Executive Committee of the Hospital. They include, but are not limited to Physician Assistants, Advanced Nurse Practitioners, Certified Registered Nurse Anesthetists and Psychologists. They shall not have the privilege to admit patients, and may attend patients only in collaboration with a physician member of the Medical Staff, within the scope of practice of the collaborating physician as defined by the Medical Executive

Committee of the Hospital, to the extent permitted by New Jersey statutes, rules and regulations.

4.8-2 Applicants for Appointment to Adjunct Staff shall:

a) Hold a NJ license, certificate or other legal credentials in a category of Adjunct Staff;
b) Document their experience, training, competency and all other criteria required of members of the Medical Staff where applicable.

The Adjunct Staff shall be subject to ongoing Professional Practice Evaluation and to reappointment of clinical privileges every other year. They will have their performance evaluated and privileges renewed in accordance with the Hospital's policies and procedures and will be employees of the Hospital and/or Medical or Dental School.

A member of the Adjunct Staff who is required to have a collaborating and/or sponsoring physician may not exercise any clinical privileges if there no longer is a sponsoring physician. In the event that a member of this staff who is required to have a collaborating and/or sponsoring physician no longer is sponsored by that physician, the member immediately shall notify the Chief Medical Officer and provide the name and written agreement of a new sponsoring physician within 30 days.

4.8-3 Appointments

The qualification and credentials of the Adjunct Staff will be reviewed and approved by the appropriate Departmental Chairperson or his/her designee and, in the case of an APN, by the Nursing Executive.

4.8-4 Prerogatives

Adjunct Staff may provide only such patient care services as are specifically designated by the Board of Trustees. Such services must be provided under the supervision of a member of the Medical Staff and must be consistent with limitations stated in these Bylaws and all applicable statutes and regulations.

The Adjunct Staff shall be subject to disciplinary action, when indicated, according to the Hospital's Policies and Procedures and Rules and Regulations. The hearing and appeals process set forth in Section VI if these Bylaws shall apply.

4.8-5 Limitations

Members of the Adjunct Staff shall not be entitled to vote or hold office.

V-1

ARTICLE V-DELINEATION OF CLINICAL PRIVILEGES

Exercise of Privileges

Every practitioner providing clinical services at this Hospital shall be entitled to exercise only those clinical privileges or services specifically granted to him or her by the Board of Trustees.

5.2 Delineation of Privileges in General

5.2-1 Request

Each application for appointment and reappointment to the Medical/Adjunct Staff must contain a request for the specific clinical privileges desired by the applicant. A request for a modification of privileges including but not limited to the use of approved new technologies or new techniques must be supported by documentation of training and experience supportive of the request.

5.2-2 Basis for Delineation of Privileges

The decision about granting or modifying clinical privileges is based on the credentialing and privileging process (see Article 3.2) as required by these Bylaws.

5.3 Special Conditions for Privileges for Oral and Maxillofacial Surgeons (OMFS) and Dentists

Applications for clinical privileges for dentists and oral and maxillofacial surgeons shall be processed and granted in the manner specified in Article III. All patient care by dentists and OMFS shall be under the supervision of the Chief of Service of Dental Medicine of OMFS or his/her designee and this medical care shall be consistent with the standard of care provided to all University Hospital patients. Dentists other than OMFS are not privileged to admit patients or perform history and physical examinations; however, they can be privileged for consultation purposes and for the provision of patient care. OMF surgeons can be privileged to admit patients, perform history and physicals, provide consultation services, and provide in-patient care.

5.4 Special Conditions for Privileges for Podiatrists

Applications for clinical privileges for podiatrists shall be processed and granted in the manner specified in Article III. All patient care by podiatrists shall be under the supervision of the Chief of Service and Chair of the Department of Podiatry or his/her designee and this medical care shall be consistent with the standard of care provided to

all University Hospital patients. A podiatrist who is a member of the medical staff is responsible to ensure that a physician who has an MD or DO degree and is appointed to the Medical Staff shall be responsible for the admission and pre-operative history and physical examination of podiatric patients and for the medical co-management of all podiatric patients during their hospitalization. The Chief of Service and Chair of Podiatry shall report administratively to the University Hospital Chief Medical Officer.

5.5 Temporary Privileges

5.5-1 Temporary Privileges for a New Applicant

The CEO of the University Hospital, or designee, upon written request of the Chief of Service involved, shall have the authority to grant temporary privileges to a new applicant for a period not to exceed 120 days in duration provided there is verification by the Medical Staff Office including the following:

- Documentation of current licensure, education, relevant training or experience;
- Documentation of current competence;
- Proof of ability to perform the privileges requested;
- Proof of identification and other criteria as set forth in Article III.

Temporary privileges granted under this Article shall continue, unless terminated, as provided in Article VI, until action on the application is taken by the Board of Trustees, but in no event shall exceed 120 days. Provisional status will commence at the time of temporary appointment.

Rights of the Practitioner

A practitioner shall be entitled to the procedural rights afforded by Article VI.

5.5-2 Emergency Privileges (Temporary)

Upon request of the Chief of Service or his/her designee and the recommendation from the Chief Medical Officer (or designee), the CEO (or designee) shall have the authority to grant temporary privileges to a practitioner providing there is an urgent patient care need that requires immediate authorization to practice for a limited period of time. Examples include, but are not limited to:

- A practitioner who has necessary skills to provide care to a specific patient(s) that a currently privileged practitioner does not possess;

- For the proctoring of a medical staff member, when proctoring by a current medical staff member cannot be done;

- Court ordered evaluation of a UH patient;

- A requested second-opinion

- Serving as a locum tenens for a current member of the Medical Staff. In some instances with an urgent patient care need, and at the request of the Chairperson, a locum tenens may have a temporary appointment renewed once for an additional 120 days. The verification and recommendation process is identical to the initial appointment.

5.5-3 Disaster Privileges (Temporary)

Disaster privileges may be granted by the CEO or designee when The Disaster Plan is activated and the University Hospital Medical Staff is unable to provide for immediate patient needs. This can be a major local or regional occurrence, which may result in the presentation of more patients than can be safely accommodated with the normal resources available at the University Hospital. Temporary privileges may be granted to a Licensed Independent Practitioner (LIP) who presents any of the following:

- A current picture hospital ID card from a New Jersey Institution;
- Proof of a current medical license and a valid state, federal or regulatory agency picture ID;
- Identification indicating membership in a Disaster Medical Assistance Team (DMAT);
- Identification from a federal, state, or municipal entity indicating the individual has been granted authority to render patient care in emergency circumstances;
- Presentation by current hospital medical staff members with personal knowledge regarding the practitioner's identity.

The LIP granted disaster privileges shall work under the supervision of the Chief Medical Officer or his/her designee. Primary source verification of the credentials and privileges are to begin once the disaster situation is deemed under control or within 72 hours of when the LIP presents to the Hospital. If primary source verification cannot be completed in the required time frame, The Hospital must document reason why.

VI-1

ARTICLE VI-DISCIPLINARY ACTIONS

6.1 Summary Suspension

6.1-1 Criteria and Initiation

Whenever an immediate action needs to be taken to protect the health and safety of any patient(s) or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other person present in the Hospital, then, on the recommendation of their Chief of Service or the Chief Medical Officer, the President of the Medical Staff, the CEO, and the Chairperson of the MEC or their respective designees, by majority agreement, shall have the authority to summarily suspend the staff appointment status or all or any portion of the clinical privileges of such practitioner. Such summary suspension shall become effective immediately when imposed, and subsequently the CEO shall give notice of the suspension to the practitioner. The notice of a practitioner's summary suspension shall be in writing, by certified mail, return receipt requested or by personal delivery, and regular mail. If certified mail, return receipt requested or personal delivery is not practicable, the chair shall notify the practitioner by any other means reasonably calculated to give notice to the practitioner (email).

The terms of the summary suspension shall remain in effect pending a meeting of the MEC as described in Section 6.1-2. If it is determined that the individual appears on the Office of the Inspector General (OIG) or the Government Services Agency (GSA) listing of excluded parties, the CEO, in consultation with the President of the Medical Staff and the Chairperson of the Medical Executive Committee will, after verifying the individual is an excluded party, automatically **suspend** this practitioner. He/she is not entitled to a fair hearing. The Office of Corporate Compliance must be notified immediately.

Immediately upon the imposition of a summary suspension, the responsible Chief of Service shall make provisions for alternative medical care for those Hospital patients of the suspended practitioner.

6.1-2 Medical Executive Committee Action

As soon as possible after such summary suspension, but not to exceed three (3) business days, a meeting of a subcommittee of the MEC, composed of three (3) to five (5) members approved by the Chairperson of the MEC, as recommended by the Chief Medical Officer and the President of the Medical Staff, shall be convened to review and consider the action taken. The subcommittee may recommend to the CEO termination of the terms of the summary suspension or conversion to an adverse professional action as referenced in Section 6.4. The suspended practitioner has the right to present a written statement of explanation or to meet with the subcommittee prior to the subcommittee's meeting. The suspended practitioner shall not be present when the subcommittee meets.

6.2 Automatic Suspension

Practitioners must report any of the circumstances described below to the CEO, through the Chief of Service or the Chief Medical Officer, within 24 hours of their occurrence. As soon as possible, but not to exceed 30 days after automatic suspension, the MEC, or

sub-committee thereof, shall convene to review and consider the facts under which the adverse action was taken. The MEC may then recommend termination of the suspension or further corrective action including the recommendation that Adverse Action, as articulated in Section 6.4, be taken.

6.2-1 License

A staff appointee whose license, certificate or other legal credential authorizing him or her to practice in this state is, or will be revoked, suspended or modified, may immediately and automatically be suspended from practicing in the Hospital by the CEO or designee.

6.2-2 Drug Enforcement Administration (DEA) and Controlled Dangerous Substance (CDS) Numbers

A practitioner whose DEA and/or CDS number is revoked or suspended shall immediately and automatically be divested by the CEO, or designee, of his or her right to prescribe medications covered by such number.

6.2-3 Conviction of a Felony

A practitioner convicted of a felony, whether it is related to the practice of medicine or not, is subject to suspension from the Staff by the CEO.

6.2-4 Medical Record Delinquency

An automatic suspension or other appropriate penalties of a practitioner's admitting privileges may, after written warning of delinquency, be imposed by the CEO, or designee, for failure to complete medical records in a timely fashion as delineated by current Hospital policy and State Health Department requirements. Such suspension and associated penalties shall continue until such records are completed, unless the practitioner satisfies the CEO that he or she has a justifiable excuse for such omissions. Three continuous months of suspension or three suspensions in any twelve-month period may constitute grounds for termination of all privileges and attending status. Failure to complete charts as required may constitute grounds for deeming the physician “not in good standing by reason of failure to complete medical records”, for purposes of responding to inquiries as to the physician’s privileges.

6.2-5 Loss of Privileges in Another Facility

Practitioners whose privileges have been suspended or revoked in another health care facility for conduct that may require that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other person present in the Hospital are subject to automatic suspension.

6.2.6 Appearance on Regulatory Reports

Any practitioner who is adversely listed in any health care regulatory reporting system, including, but not limited to the the Office of the Inspector General (OIG) or the Government Services Agency (GSA) listing of excluded parties is subject to automatic suspension.

6.3 Initiating Corrective Action in Non-Emergent Situations

6.3-1 Criteria for Initiation

Whenever the activities or professional conduct of any practitioner with clinical privileges are detrimental to patient safety, or to the delivery of quality patient care, or are disruptive to the Hospital's operations, corrective action against such practitioner may be requested by the responsible Chief of Service, the Chief Medical Officer, the MEC, the CEO, the Board of Directors, or any officer of the Medical Staff, or their designees.

6.3-2 Requests and Notices

All requests for corrective action shall be in writing, submitted to the MEC, and supported by reference to the specific activities or conduct which constitute the grounds for the request. The Chairperson of the MEC shall promptly notify the CEO, in writing, of all requests for corrective action received by the Committee and shall continue to keep the CEO fully informed of all action taken in conjunction therewith.

6.4 Adverse Professional Review Actions

The following recommendations or actions shall, if deemed adverse to the practitioner, entitle the practitioner to a hearing:

Denial of initial staff appointment
Denial of reappointment
Suspension of staff membership
Revocation of staff membership
Denial of requested advancement in staff category
Reduction in staff category
Limitation of the right to admit patients
Denial of requested service/section affiliation
Denial of requested clinical privileges
Reduction in clinical privileges
Suspension of clinical privileges
Revocation of clinical privileges
Individual requirement of consultation/supervision
Summary suspension that has not been terminated

6.4-1 Exceptions

Neither the issuance of warning, or a summary suspension that has not been terminated or requests to appear before a Committee, or a letter of admonition, or a letter of reprimand, nor the denial, termination or reduction of temporary privileges, nor any other actions except those specified in 6.4-1 above shall give rise to any right to a hearing.

Withdrawal of a practitioner's privileges for grounds unrelated to professional clinical capability and exercise of clinical privileges must comply with the usual personnel policies of the Hospital or the terms of such practitioner's employment agreement, if any. To the extent that the grounds for removal include matters relating to competence in performing professional clinical tasks or in exercising clinical privileges, resolution of the practitioner's medical staff privileges shall be in accordance with Article V.

6.5 Special Notice of Adverse Professional Review Action of the Practitioner

A practitioner who receives an adverse recommendation or action described in Section 6.4 of this article shall, within 10 business days, be given special notice of such action by the CEO. Such notice shall:

- Briefly state the grounds upon which the adverse action is based and include, where appropriate, a list of specific or representative patient records in question or the other reasons or subject matter forming the basis for the adverse professional review recommendation.

- Advise the practitioner of the right to a hearing pursuant to Article VI and the procedures described therein. The practitioner shall be advised that an advisor or legal representative may accompany him or her to the hearing.

- Specify that within 30 calendar days following the date of the notice of adverse action the practitioner must request a hearing, in writing, to the CEO of University Hospital.

- State that failure to request a hearing within the specified time shall constitute a waiver of rights to a hearing and to an appellate review in a matter.

- State that upon receipt of his or her request for a hearing, the practitioner will be notified of the date, time, and place of the hearing.

6.6 Hearing Procedures

6.6-1 Notice of Time and Place for Hearing

Upon receipt of a timely request for hearing from the practitioner, the CEO shall deliver such request to the Chairperson of the MEC. The hearing date shall be between 30 calendar days and , 60 calendar days, from the date of receipt of the practitioner's request for a fair hearing. A practitioner under suspension is entitled to a fair hearing no later than 14 business days after receipt by the CEO of his or her request for a hearing. At least 7 business days days prior to the hearing, the CEO shall send the practitioner, by certified mail, return receipt requested, special notice of the time, place and date of the hearing. The hearing notice shall also contain a preliminary list of expected witnesses, if any, to testify at the hearing on behalf of the MEC or the Board of Directors, depending on whose action prompted the request for hearing.

Statement Issues and Events

The notice of hearing shall contain a concise statement of the basis for the adverse action against the practitioner, including any alleged acts or omissions and a list, by number, where applicable, of the patients records in question and/or the other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing.

6.6.2 Appointment of Hearing Committee

The hearing shall be conducted by a Hearing Committee consisting of the six-at-large members and one officer of the MEC. The President of the Medical Staff may not sit on the hearing body,

All members of the Hearing Committee have an affirmative duty to reveal the basis for any conflict of interest, including, but not limited to personal or familial relationships with either the practitioner, a complainant, a patient or a witness. Such conflicts may be grounds for disqualification from the Hearing Committee.

Hearing committee members shall not include those who occupy the rank of Dean or Chairperson/Chief of Service or are in direct economic competition with the physician involved.

Any individual who has participated in initiating or investigating underlying matters at issue may be disqualified from serving on a Hearing Committee.

Any vacancies that occur, for any reason, after the Hearing Committee has been appointed, shall have replacements selected by the President of the Medical Staff.

The practitioner shall have the right to challenge one or more members of the hearing committee for cause by written application to the presiding officer, whose decision on the matter shall be final. Failure to make such application within ten

(10) business days of notice to challenge the membership of the hearing committee shall constitute waiver of the right to challenge.

6.6-3 Presiding Officer

The Presiding Officer shall be one of the following Officers of the Medical Staff: President-Elect, Secretary/Treasurer, or Immediate Past President, and shall be selected by the President of the Medical Staff. The Presiding Officer of the Hearing Committee shall act to maintain decorum and to ensure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The Presiding Officer shall determine the order of procedure during the hearing and shall make all rulings on matters of procedure, and the admissibility of evidence. The Presiding Officer may be assisted in the performance of these duties by a representative from the Attorney General's Office or legal counsel.

6.6-4 Representation

The personal presence of the practitioner who requested the hearing is required. A practitioner who fails, without good cause, to appear and proceed at such hearing, shall be deemed to have waived his or her rights to the hearing and to have accepted the adverse action at issue.

The Practitioner who requested the hearing shall be entitled to be represented by an advisor or legal representative admitted to practice in New Jersey. The advisor may be a member of the Medical Staff in good standing, a member of a local professional society or other person chosen by the practitioner. The practitioner must inform the Hearing Committee within ten (10) calendar days of receiving notice if an advisor or attorney is to be present at the hearing. In the event The Practitioner chooses not to use his or her advisor or legal representative to represent him or her at the hearing, the Practitioner may elect to have his or her counsel or advisor present as an observer at the Hearing.

6.6-5 Rights of Parties

During a hearing, each of the parties shall have the right to:

- Call and examine witnesses who voluntarily agree to appear on behalf of the participants. Notice is hereby given to the participants that neither the Medical Staff nor the Hospital has the legal power of subpoena.

- Introduce exhibits and documents relevant to the issues. The Practitioner shall bear the reproduction costs for any documents requested from the Hospital, the New Jersey Medical School or any part of the University.

- Cross-examine any witness on any matter relevant to the issues.

- Rebut any evidence.

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

6.6-6 Procedure and Evidence

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely shall be admitted, regardless of the admissibility of such evidence in a court of law. All parties shall, prior to or during the hearing, be entitled to submit memoranda concerning an issue of law or fact and such memoranda shall become part of the hearing record. The Presiding Officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation by a person designated by the Presiding Officer and entitled to notarize documents in the state where the hearing is held.

6.6-7 Official Notice

In reaching a decision, the Hearing Committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the State of New Jersey. Parties present at the hearing shall be informed of matters to be noticed and those matters shall be included in the hearing record. Any party shall be given opportunity on timely request, to request that a matter be officially noticed and to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the Hearing Committee. The Committee shall also be entitled to consider all other information that can be considered pursuant to the Medical Staff Bylaws, in connection with applications for appointment or reappointment to the Medical Staff and for clinical privileges.

6.6-8 Record of Hearing

A permanent record of the hearing shall be kept. The Hearing Committee may select the method to be used for making the record, such as court reporter or electronic recording unit if the material recorded is to be reduced to writing promptly after the Hearing. The practitioner shall bear the cost of recording and transcription fees and copies of the record for use by the practitioner. The Hospital may obtain a copy of the record upon payment of any reasonable charges or fees.

6.6-9 Postponements

Postponement of the hearing shall be granted by the Hearing Committee only upon a showing of good cause and only if the request is made as soon as is reasonably

practical.

6.6-10 Presence of Hearing Committee Members and Vote

A majority of the Hearing Committee must be present throughout the hearing and deliberations. All voting will be determined by a simple majority.

6.6-11 Recess and Adjournment

The Hearing Committee may recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of its deliberation, the Presiding Officer shall declare the hearing finally adjourned.

6.6-12 Hearing Committee Report and Further Action

Within 10 business days after final adjournment of the hearing, the Hearing Committee shall make a written report of its findings and recommendations in the matter and shall forward the same, together with the hearing record and all other documentation considered by it, to the CEO, President of Medical Staff the CMO and the MEC whose adverse professional review recommendation or action occasioned the hearing. All findings and recommendations by the Hearing Committee shall be supported by reference to the hearing record and the other documentation by it. The Hearing Committee report shall specifically affirm, reverse or modify the adverse professional review recommendation or action, which was reviewed. If the adverse professional review recommendation or action is affirmed, the Hearing Committee report shall include a statement that it is the reasonable belief of the Hearing Committee that the action taken or recommended is warranted by the facts, as presented at the hearing.

6.6-13 Action on Hearing Committee Report

Within 10 business days after receipt of the report of the Hearing Committee, the MEC shall consider same and affirm, modify or reverse the Committee's determination in this matter. The Chairperson of the MEC shall transmit the result, together with the hearing record, the report of the Hearing Committee and all other documentation considered, to the Board of Directors, with a copy to the CEO, President of Medical Staff and the CMO.

6.6-14 Notice and Effect of Result

The CEO shall promptly send a copy of the decision of the MEC to the practitioner by certified mail, return receipt requested, and to the Chief of Service of the department in which the individual practices.

If the result of the MEC is adverse to the practitioner in any of the respects listed in Section 6.4 the CEO, by certified mail, return receipt requested, shall inform the practitioner of the right to request an appellate review by the Board of

Directors as provided in Section 6.7 below.

The practitioner is entitled to a copy of the record of the Hearing Committee at the practitioner's request and expense.

6.7 Appellate Review

6.7-1 Request for Appellate Review

A practitioner shall have 14 calendar days following his receipt of adverse action to file a written request for an appellate review. Such request shall be delivered to the CEO either in person or by certified or registered mail and may include a request for a copy of the report and record of the Hearing Committee and all other material, favorable or unfavorable, if not previously forwarded, that was considered in making the adverse action or result.

A practitioner who fails to request an appellate review within the time and in the manner specified above waives any right to such review.

6.7-2 Notice of Time and Place for Appellate Review

Upon receipt of a timely request for appellate review, the CEO shall deliver such request to the Board of Directors. As soon as practicable, the Board or subcommittee thereof (described below), shall schedule and arrange for an appellate review which shall be between 14 and 21 business days from the date of receipt of the appellate review request,

Any Board member who has participated in initiation or investigation of the matters at issue shall be disqualified from considering the appeal. At least 7 business days prior to the appellate review, the CEO shall inform the practitioner by certified mail, return receipt requested, of the time, place and date of the appellate review. The time for the appellate review may be extended by the appellate review body for good cause and if such request is made as soon as is reasonably practical.

6.7-3 Appellate Review Body

The Board of Directors or sub-committee thereof shall determine whether the appellate review shall be conducted by the Board, as a whole, or by an appellate review committee of 5 members of the Board appointed by the Chairperson of the Board or the Chairperson's designee. If a committee is appointed, one of its members shall be designated as The Presiding Officer by the Chairperson of the Board of Directors.

6.7-4 Appellate Proceedings

The proceedings by the appellate body shall be based upon the record of the hearing

before the Hearing Committee, that Committee's report, the decision of the MEC and all subsequent results and actions thereon. The appellate review body shall also consider any written statements and such other material as may be presented and accepted, as described below.

a. Written Statements by the Parties

The practitioner seeking the appellate review may submit a written statement detailing the findings of fact, conclusions, and procedural matters with which the practitioner disagrees, and reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. At least 5 copies of the statement shall be submitted to the appellate review body, with additional copies to the MEC, The President of the Medical Staff, The CEO & the CMO. The written statement must be provided at least five (5) calendar days prior to the scheduled date of the appellate review, except if such time limit is waived by the appellate body. A written statement in reply may be submitted by the MEC, through its representative. If submitted, the CEO shall provide a copy thereof to the practitioner at least 3 calendar days prior to the scheduled date of the appellate review.

b. Presiding Officer

The Presiding Officer of the appellate review body shall determine the order of procedure during the review, make all required rulings and maintain decorum.

c. Oral Statement

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

d. Consideration of New or Additional Matters

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review, only in exceptional circumstances, at the discretion of the appellate review body following an explanation as to why it was not presented earlier.

e. Presence of Members and Vote

A majority of the appellate review body must be present throughout the review and deliberations. If a member of the review body is absent from any part of the proceedings, that member shall not be permitted to participate in the deliberations or the decision.

f. Recesses and Adjournment

The appellate review body may recess the review proceedings and reconvene the same without additional notice for good cause. Upon the conclusion of oral statements, if allowed, the appellate review body shall conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be ended.

g. Action Taken

The appellate review body may recommend that the Board of Directors as a whole, affirm, modify or reverse results or action taken by the MEC, or at its discretion, may remand the matter back to the MEC for further review and recommendation. The MEC shall provide its recommendation to the Appellate Review Body within 14 business days as in accordance with its instructions. Within 7 business days after receipt of such recommendations from the MEC, the appellate review body shall make its recommendation to the entire Board.

6.7-5 Final Decision of the Board of Directors

Within 14 business days after the receipt of the recommendation of the appellate review body, the Board shall render a final decision and the matter shall be finally closed. If the appellate review body consists of the entire Board, then its action shall (after any referral) be the final action of the Board. Special notice of final action, which shall include a statement of the basis of the decision, shall promptly be given to the practitioner and the MEC, CEO, President of the Medical Staff and the CMO. The CEO shall report as required by state and/or federal law, any final adverse professional review action.

6.8 General Provisions

Practitioner's Right to Limit Number of Hearings and Reviews

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

6.9 Release

By requesting a hearing or appellate review, a practitioner agrees to be bound by the provisions of the Medical Staff Bylaws relating to immunity of the University and its representatives from liability in all matters relating thereto.

6.10 Waiver

If, within 30 calendar days after receipt of special notice of an adverse recommendation, action, or result, a practitioner fails to make a required request or appearance or

otherwise fails to proceed with the matter, he/she shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights to which he/she might otherwise have been entitled under the Medical Staff Bylaws then in effect.

6.11 Misconduct Reporting

In accordance with University policy implementing the requirements of Title IV of Public Law 99-660 (the Health Care Quality Improvement Act of 1986) and the Professional Medical Conduct Reform Act of 1989 of the State of New Jersey, all reportable disciplinary actions will be transmitted to the National Practitioner Data Bank (NPDB) and/or the Review Panel of the Board of Medical Examiners of New Jersey by the CEO or his designee in full compliance with the specific requirements and time frames set forth for each. Disciplinary actions not related to professional competence or professional conduct as required by the foregoing laws will not be reported to the NPBD or to the State. The staff member will be notified that such notification has taken place.

VII-1

ARTICLE VII-CLINICAL SERVICES

7.1 Organization of Clinical Services

Each service shall be organized as a separate part of the staff and shall be administered by a Chief of Service (Chairperson). Each Department of the New Jersey Medical School and the New Jersey Dental School that provides clinical services shall be a Service of the Hospital. The Chief of each Service thus created may be the Chairperson of the respective Department of the NJMS or NJDS, pursuant to the Bylaws of the University of Medicine and Dentistry of New Jersey, as cited in Article IX, Section 2-1 of these Bylaws. In addition, Services may be established by the MEC, as provided for in Article VII, Section 2-2. In such cases, the Chief of Service shall be appointed by the MEC, as provided for in Article IX, Section 2-1, subject to approval by the Board of Trustees. Each Chief of Service shall be a member of the MEC and shall have the authority, duties, and responsibilities as specified in Article VII, Section 4.

Each section or division shall be organized as a subspecialty within a service and shall be directly responsible to the service within which it functions. A Section or Division Chief shall be appointed who has the authority, duties, and responsibilities as specified in Article VII, Section 5.

7.2 Designations

7.2-1 Current Hospital Services

A. Anesthesiology
B. Emergency Medicine
C. Family Medicine
D. Dental Medicine
E. Pathology and Laboratory Medicine
F. Medicine
G. Neurosciences
H. Neurosurgery
I. Obstetrics & Gynecology Women's Health
J. Ophthalmology
K. Orthopaedics
L. Otolaryngology – Head and Neck Surgery
M. Pediatrics
N. Podiatry
O. Psychiatry
P. Radiology
Q. Radiation Oncology
R. Physical Medicine & Rehabilitation
S. Surgery

7.2-2 Service Changes

The Chief of Service may request the creation of, elimination of, or subdivision of a service or section subject to the recommendation of the Bylaws Committee, to the MEC, and the recommendation of the MEC to the BOD and Subsequently, to the Board of Trustees for approval.

7.3 Assignment to a Service or Section

Each appointee of the Medical/Adjunct Staff shall be assigned to at least one department, and if applicable, may be granted privileges in one or more of the other departments (dual appointment). The exercise of clinical privileges within any service shall be subject to the Rules and Regulations of that service and the authority of the Chief of Service.

7.4 Function of Services

Responsibilities of services are to:

- Require a planned and systematic process for monitoring and evaluating the quality and appropriateness of the care by the service and the clinical performance of each individual with clinical privileges, including peer review.
- Establish guidelines for the granting of clinical privileges and appointment within the service and submit the recommendations required under Articles V and VII

regarding the specific privileges each staff member or applicant may exercise.

- Arrange continuing education programs to meet the needs of the members of the staff as determined by their evaluations and review of medical advances in the field.
- Monitor, on a continuing and concurrent basis, adherence to:
- Staff and Hospital policies and procedures;
- Requirements for adequate coverage and for consultations;
- Fire and other regulations designed to promote patient safety.
- Coordinate the patient care provided by the service members with nursing and other non-physician patient care services and with administrative support services.
- Foster an atmosphere of professional decorum.
- Meet at least monthly for the purposes indicated in (h) and receive, review, and consider reports on other service and staff functions.
- Submit written reports or minutes of service meetings to the MEC and the Quality Assurance and Performance Improvement Committee on a regular basis concerning:
    a) Findings, conclusions, recommendations, actions and evaluations of continuous performance improvement activities as defined in the hospital-wide PI Plan.
    b) Recommendations for maintaining and improving the service and the Hospital; and
    c) Such other matters as may be requested from time to time by the MEC or Quality Assurance and Performance Improvement Committee.

- Establish committees within the services, as necessary.

- Formulate rules and regulations consistent with the rules and regulations of the Hospital, Bylaws of the Board of Directors and the Bylaws of Medical Staff.

7.4-1 Function of Chief of Service (Chairperson)

Qualifications

- Certification by an appropriate specialty board or affirmatively established comparable competence through the credentialing process

Roles and Responsibilities

- Clinically related activities of the department
- Administratively related activities of the department, unless otherwise provided by the hospital
- Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges
- Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department
- Recommending clinical privileges for each member of the department

- Assessing and recommending to the relevant hospital authority offsite sources for needed patient care, treatment, and services not provided by the department of the organization.
- The integration of the department or service into the primary functions of the organization
- The coordination and integration of interdepartmental and intradepartmental services
- The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.
- The recommendations for a sufficient number of qualified and competent persons to provide care, treatment , and service
- The determination of the qualification and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.
- The continuous assessment and improvement of the quality of care, treatment, and services
- The maintenance of quality control programs as appropriate
- The orientation and continuing education of all persons in the department or service.
- Recommendations for space and other resources needed by the department or service.

7.5 Function of Sections/Divisions

Each section/division shall perform the functions assigned to it by the Chief of Service. Such functions may include, but are not necessarily limited to, the continuous monitoring of patient care practices, credentials or privilege delineation review, continuing education programs and quality assurance activities.

VIII-I

ARTICLE VIII-STANDING COMMITTEES

8.1 General Description

a. The MEC and other standing committees and special committees established and supervised by the MEC shall perform the functions of the Medical Staff, as required by these Bylaws, the Hospital's Performance Improvement plan and such other staff functions as the MEC or the Board of Trustees shall reasonably require.

b. Except as otherwise specified below, all committee appointments are subject to the approval of the Executive Committee. In addition, except as otherwise

specified below, the Chairpersons of the Committees shall be nominated by the Chairperson of the Executive Committee, after consultation with the President and President-elect of the Medical Staff. The members of committees shall be nominated by the Chairperson of the Executive Committee, after consultation with the President and President-elect of the Medical Staff and with the Chairperson of the respective committee.

c. Voting membership is limited to members. Except where noted, three or more committee members shall constitute a quorum for the transaction of all business properly presented to such meetings.

d. The committees, through their Chairpersons, have the prerogative of inviting guests as may seem indicated and/or appropriate.

e. Except where provided, appointment and reappointments to such committees shall be for a period of one year, commencing January 1 of any given year.

f. A permanent and concise record shall be kept of all proceedings of all meetings of all committees of the Medical Staff, whether standing or special, including, but not limited to, the date, time of starting, those in attendance, those absent, matters discussed, together with the signature of the Chairperson or one member appointed by the committee to act as secretary.

g. All minutes shall be forwarded to the Chairperson of the MEC for inclusion on the agenda on the next regularly scheduled meeting of the MEC.

h. Committee members must attend 50% of scheduled meetings in a twelve-month period or be removed from the membership. Attendance will be reported to the MEC at least annually.

8.2 Standing Committees

8.2-1 Medical Executive Committee (MEC)

a. Membership

The MEC shall consist of members who are approved by the Board of Trustees. The Dean of NJMS shall be its Chairperson and shall preside at meetings. The President, the President-elect, the Immediate Past-President and the Secretary Treasurer shall be members of the MEC. The Dean of UMDNJ-NJDS or designee shall be a member. The CEO, the Chief Nursing Officer and the Chief Medical Officer shall be ex-officio members without vote. The MEC includes physicians and may include other licensed independent practitioners. The remaining members of the committee shall be as follows: Chairpersons and Chiefs of the services as specified in Article VII and six additional members elected at large from

different services to adequately represent the population of the Staff. The President of the Medical Staff shall preside at meetings in the absence of the Dean.

b. Functions

The duties include:

1. Receive and act upon reports and recommendations from the services, standing committees, special committees and officers of the Staff concerning performance improvement and quality assessment activities and the discharge of the delegated medical administrative responsibilities of the services, committees and officers.

2. Report results and recommendations concerning staff functions to the Staff and Board of Trustees.

3. Coordinate the activities of and policies adopted by service and staff committees. Make recommendations to Board of Directors on Medical Staff structure.

4. Recommend to the Board of Trustees all matters relating to appointments, reappointments, staff categories, service assignments, clinical privileges, specified services and corrective action and/or termination.

5. Account to the Board of Trustees and to the Staff of the overall quality and efficiency of medical care rendered to the patients in the Hospital.

6. Initiate and pursue corrective action, when warranted, in accordance with Article VI.

7. Make recommendations on medico-administrative and Hospital management matters.

8. Inform the Staff of the accreditation program and the accreditation status of the Hospital.

9. Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs.

10. Represent and act on behalf of the Staff, subject to such limitations as may be imposed by these Bylaws.

11. Determine membership of committees and determine how often committees must meet.

12. MEC is empowered to act for the Medical Staff between meetings of the Medical Staff.

c. Meetings

Meetings shall be held at least ten times a year and at the call of the Chairperson for special meetings. Fifty percent of the voting members of the MEC shall constitute a quorum at any meeting of the MEC.

8.2-2 Ambulatory Care Committee

a. Membership

The Ambulatory Care Committee shall consist of representatives from each clinical service providing out-patient services, Administration, Nursing, Medical Records, Radiology, and any other ancillary services that are deemed to be important by the Committee.

b. Functions

The duties include:

1. Providing medical direction and supervision of the medical aspects of the Out Patient Services.

2. Monitoring and evaluating the quality, safety, and appropriateness of Out Patient Services.

3. Assuring that appropriate action is taken based on findings from PI activities and any other monitoring activities and identified problems.

4. Developing, reviewing and recommending to the MEC and Administration, as appropriate, policies and procedures for the safe, prompt and efficient functioning of the Out-Patient Services.

5. Documenting all findings and conclusions and submitting all reports of committee meetings to the Performance Improvement Committee.

c. Meetings

Meetings shall be held at least ten times a year and at the call of the Chairperson for special meetings.

8.2-3 Blood Utilization Review Committee

a. Membership

The Blood Utilization Review Committee shall consist of representatives from Pathology, Medicine, Surgery, OB/GYN, Pediatrics, Nursing,

Administration, and the Director of the Blood Bank.

b. Functions

The duties include:

1. Oversight of policies, procedures and/or criteria issues related to the ordering, distribution, handling, dispensing, administration and monitoring of blood and blood products.

2. Ongoing monitoring focusing on the distribution, handling, dispensing and administration of blood and blood components including reviewing the number of blood transfusions, the number of units of whole blood used, the number of single unit transfusions and identifying and reviewing cases of suspected and confirmed transfusion reactions and adverse occurrences.

3. Reviewing medical records of patients who did not meet the Staff's approved transfusion criteria.

4. Action to resolve problems and follow-up action to assure the resolution of problems identified.

5. Documentation of the performance of these functions shall be reflected in the appropriate committee minutes.

6. Reports findings, conclusions, recommendations, actions and evaluations of actions taken to the QA and PI Committee and the MEC, as identified in the hospital-wide PI Plan.

c. Meetings

This Committee is subject to the call of the Chairperson, but not less than quarterly.

8.2-4 Bylaws Committee

a. Membership

The Bylaws Committee shall consist of one member from the Executive Committee and no less than six (6) members of the Medical Staff.

b. Functions

The duties include:

1. When necessary, and, at least once a year, the Medical Staff Bylaws and Rules and Regulations are reviewed and/or revised to reflect the hospital’s current practices with respect to Medical Staff Organization and functions. Approved revisions in the Bylaws will be referred to the MEC and the Medical Staff for action.

2. Submitting recommendations for revisions, through the MEC, to the Medical Staff.

3. Acting upon all matters as may be referred by the MEC, members of the Medical Staff, Board of Trustees, the President of the Staff, the CEO or other committees of the Staff.

c. Meetings

The Committee shall meet at least annually or at the call of the Chairperson.

8.2-5 Clinical Practice Committee

a. Membership

The Clinical Practice Committee shall consist of representatives from clinical services and representatives from Nursing, Nutrition and Food, Social Work, Medical Records, Infection Control, Utilization Management, QA/PI, Medical Informatics, and Administration.

b. Functions

The duties include:

1. Recommending guidelines and procedures to clarify functions and responsibilities of clinical care.

2. Reviewing clinical care issues charged by the Executive Committee and making recommendations regarding same.

3. Monitoring the various components of patient care at University Hospital and recommending appropriate corrective actions.

c. Meetings

Meetings shall be held quarterly and as called by the Chairperson.

8.2-6 Combined Critical Care/Resuscitation Committee

a. Membership

The Combined Critical Care/Resuscitation Committee shall consist of selected representation from critical care patient units, Infection Control, Quality Assurance/Performance Improvement, Nursing, Emergency Department, Respiratory Therapy, Pharmacy, and Administration.

b. Functions

The duties include:

1. Monitoring and evaluating the quality of care rendered in the critical care and progressive care units.

2. Monitoring and evaluating care rendered in those units and elsewhere by respiratory therapy.

3. Reviewing the delivery of resuscitation activity within the institution.

4. Establishing policies and procedures common to all units related to the delivery of critical health care services.

5. Standardizing the plan of care and use of equipment in critical care areas wherever possible.

6. Establishing policies and procedures common to all units related to the delivery of critical health care services.

7. Monitoring and evaluating the delivery of care by support services to critically ill patients.

8. Addressing future plans for the critical care**,** progressive care, and respiratory therapy units and establishing how positive change can be effected.

9. Reporting proceedings of committee meetings to the MEC.

c. Meetings

Meetings are to be held at least ten times a year, five of which shall include a full report from the respiratory therapy.

8.2-7 Credentials Committee

a. Membership

The Credentials Committee shall consist of physician representatives from clinical services, the Chief Medical Officer, Adjunct Staff and Hospital Administration.

b. Functions

The duties include:

1. Review and evaluation of the qualifications of each applicant for initial appointment, reappointment or modification of appointment and clinical privileges, respectively, and make appropriate recommendations to the MEC.

2. Submit a report, in accordance with Article III, to the MEC on the qualifications of each applicant for staff appointment or particular clinical privileges. Such report shall include recommendations with respect to appointment, staff category, staff service, clinical

privileges or specified services and special conditions attached thereto. If the Credentials Committee is unable to determine adequacy of qualifications of an applicant for particular clinical privileges, the Credentials Committee will refer this to the MEC for resolution.

3. Document information on matters, including the clinical or ethical conduct of any practitioner assigned or referred to it by: 1) the President of the Staff; 2) the Trustees; or 3) those responsible, respectively, for functions described in Article VII.

4. Documentation of the performance of these functions shall be reflected in the appropriate committee minutes or on an as needed basis.

5. In consultation with the clinical services, review and develop policies relating to credentialing and privileging for physicians and other LIPs**.**

c. Meetings

Meetings shall be held at least ten times a year and at the call of the Chairperson for special meetings

8.2-8 Committee on Impairment

a. Membership

The Officers of the Medical Staff, in consultation with the Chairperson of the MEC (Dean, NJMS) shall select three (3) representatives from the Medical Staff to serve on the Committee on Impairment, one of whom shall be designated as Chairperson. No two representatives may be from the same clinical department. In addition, the Chairperson/Director of the University-wide Impairment Committee shall be an ex-officio member of the committee. Each selected member shall serve for a four (4) year term and may be re-appointed. Each committee member shall, where appropriate, receive training to fulfill his/her duty as determined by the committee.

b. Functions

The duties include:

The Chairperson will be responsible for performing or assigning to members of the committee the following non-therapeutic functions:

1. Assessment of allegation of impairment.

2. Discussion of Committee findings with involved individual.

3. Referral to appropriate state agency, as indicated.

4. Monitoring of identified impaired individuals until final disposition in concert with appropriate agencies.

5. Maintain a resource list to include consultative/technical advisors with expertise in problems related to impairment.

6. Establish a system to maintain confidentiality as delineated by the University Hospital Procedure Manual.

7. Report annual statistics to the MEC through the Credentials Committee and the University-wide Impairment Committee.

c. Meetings

This committee is subject to the call of the Chairperson.

d. Committee Reports

Committee reports will be considered as confidential and will be presented only to the CEO; to the Dean, NJMS; and to others as may be required by law or regulation to receive them.

8.2-9 Ethics Committee

a. Membership

The Ethics Committee shall consist of, at minimum, the following representatives: UH Medical Staff (not to exceed two persons from any one department), Nursing, Administration, Social Services, Legal Counsel, the Institutional Review Board of NJMS, the Community, and a Bioethicist.

b. Functions

The duties include:

1. Creating a forum for discussion of ethical issues including end-of-life issues and their impact on University Hospital.

2. Documenting conclusions of the Committee's deliberations and recommendations to the MEC.

3. Planning for and implementing educational programs for physicians and Hospital staff regarding ethical matters.

c. Meetings

Meetings shall be held at least ten times a year and at the call of the Chairperson for special meetings

8.2-11 Infection Control Committee

a. Membership

The Infection Control Committee shall be a multidisciplinary committee. It shall consist of the Hospital Epidemiologist and representatives from each of the clinical services, Administration, Nursing, Housekeeping, Respiratory Therapy, Pharmacy, Dietary, Employee Health, Quality Assurance/Performance Improvement, Operating Room and the Surveillance Officers.

b. Functions

The duties include:

1. Maintaining surveillance of hospital infection potential

2. Identifying and analyzing the incidence and cause of all nosocomial infections.

3. Developing and implementing a preventive and corrective program designed to minimize infection hazards.

4. Supervising infection control in all phases of the hospital's activities.

5. Acting upon recommendations related to infection control received from the MEC, other Staff and Hospital committees and the Department of Health of New Jersey.

6. Maintaining a permanent record of all activities relating to infection control and submitting periodic reports thereon to the MEC and the Quality Assurance Committee.

7. Maintaining a permanent record of all activities relating to infection control and submitting periodic reports or findings, conclusions, recommendations, actions and evaluations of actions taken thereon to the Clinical Practice Committee and the MEC.

c. Meetings

Meetings shall be held at least ten times a year and at the call of the Chairperson for special meetings.

8.2-12 Institutional Review Board of New Jersey Medical School

The Institutional Review Board (IRB) is not a Medical Staff Committee, but works closely with the Medical Staff Leadership and Hospital Administration to ensure appropriate and safe research studies the Hospital. The Institutional Review Board

(IRB) is responsible for the approval of all research protocols involving human subjects that are proposed by (submitted by) the faculty and staff of University Hospital. The charge for this board, its membership, and its operating procedures must conform to Federal and State regulations governing IRBs.

Specific requirements for the IRB: This IRB shall serve jointly as the New Jersey Medical School and University Hospital IRB. Members are appointed by the UMDNJ Senior Vice President for Academic Affairs after consultation with the Dean of NJMS, the Chairperson of the IRB and the Associate Dean for Research and Sponsored Programs. There is no limitation in the number of years an IRB member may serve on the committee. The IRB must include Medical Staff, faculty, non-faculty Hospital and University employees, and community members not otherwise affiliated with this institution. The IRB shall be heterogeneous in its make-up in order to insure (1) a broad base of knowledge and expertise among its membership and (2) equal consideration of the interests of researchers, patients, and the community in the Board's decision-making process.

8.2-13 Invasive and Other Procedure Review Committee

a. Membership

The Invasive Procedure Review Committee shall consist of representatives from the surgical specialties, Nursing, Administration, Quality Improvement and Pathology.

b. Functions

The duties include:

1. Review of cases involving discrepancies between pre-operative and post-operative diagnosis, discrepancy in pathologic diagnosis, unexpected neoplasm, and unexpected, inadequate or too extensive tissue removal, and in which a specimen was removed as well as those cases in which no specimen was removed.

2. Measurement of the selection of appropriate surgical, other invasive, and non-invasive procedures, the preparation of the patient for the procedure, the performance of the procedure and monitoring of the patient, the provision of post-procedure care; and post-procedure education.

3. Review of cases involving significant surgical or anesthesia related complications or adverse occurrences.

4. Oversight of policy, procedure and criteria issues related to the scope of assessment, preparation, monitoring, discharge or other aspects of the care of surgical, invasive or other procedure patients.

5. Documentation of the performance of these functions shall be reflected in the appropriate committee minutes and report of findings, conclusions, recommendations, actions and evaluations of actions taken to the Quality Assurance Committee and the MEC.

c. Meetings

Meetings shall be held quarterly and at the call of the Chairperson for special meetings.

8.2-14 Medical Informatics Committee

a. Membership

The Medical Informatics Committee shall consist of no less than six (6) members of the Medical Staff and representatives from Hospital Medical Information Systems (HMIS), Administration, Compliance Office, Radiology Information Systems, and Nursing.

b. Functions

The duties include:

1. Defines rules and regulations governing electronic medical records. Functions as a liaison between the Medical Staff and UH Corporate Compliance regarding issues of exchanges of medical information involving the Medical Staff, as well as compliance issues and HIPPA violations governing the electronic medical record.

2. Assists the Hospital Administration in developing automated information systems, such as an electronic medical record, which meets the needs of the Medical Staff .

c. Meetings

Meetings shall be held at least six times a year and at the call of the Chairperson for special meetings.

8.2-15 Medical Records Committee

a. Membership

The Medical Records Committee shall consist of no less than six (6) members of the Medical Staff, Director of Medical Records, who shall serve as secretary, and representatives from Nursing, Administration, and QA/PI.

b. Functions

The duties include:

1. Review and evaluation of the format of medical records to determine that they: a) permit description of the condition and progress of the patient, the therapy provided, the results thereof, and the identification of responsibility for all actions taken; b) meet the standards of patient care usefulness and of historical validity required by the Staff and by acknowledged authorities, including TJC on Accreditation of Healthcare Organizations; and c) are adequate in form and content to permit patient care evaluation and quality improvement activities to be performed.

2. Review of Staff and Hospital policies, rules and regulations relating to medical records including medical records completion, confidentiality, forms and formats, filing, indices, storage and availability, and recommend methods of enforcement thereof and changes therein.

3. Acting upon recommendations from committees responsible for patient care evaluation and quality improvement activities.

4. Providing liaison with Hospital Administration and the medical records professionals in the employ of the Hospital on matters relating to medical records practice.

5. Documentation of the performance of these functions shall be reflected in the appropriate committee minutes on at least a quarterly basis.

c. Meetings

The Medical Records Committee shall meet on a monthly basis.

8.2-16 Nominating Committee

a. Membership

The Nominating Committee shall consist of the President, the President-elect of the Medical Staff, and the at-large members of the Executive Committee.

b. Functions

The duties include:

1. Consulting with members of the Medical Staff on their willingness to serve in an elected capacity.

2. Submitting, at the appropriate times, as provided in these Bylaws, one or more nominations of qualified candidates for each elective

office of the Staff to be filled.

c. Meetings

Meetings are subject to the call of the Chairperson, who shall be the President of the Medical Staff.

8.2-17 Oncology Committee

a. Membership

The Oncology Committee shall consist of representatives from all medical specialties involved in the care of cancer patients. Required physician members represent surgery, medical oncology, radiation oncology, diagnostic radiology, pathology, and the cancer liaison physician; required nonphysician members represent administration, social service, quality assurance/performance improvement, Oncology Nursing, and a Certified Tumor Registrar (CTR). Additional nonphysician members are required for specific categories; these include, but are not limited to: Pain Control/Palliative Care Physician or specialist, and a Clinical research data manager or nurse. The committee shall consist of at least one physician representative from the five major cancer sites seen at University Hospital, and other representatives as needed.

b. Functions

The duties include:

1. Develop and evaluate annual goals and objectives for the clinical, community outreach, quality improvement, and programmatic activities related to cancer;

2. Establishes the tumor conference frequency and format on an annual basis;

3. Establishes the multidisciplinary attendance requirements for tumor conferences on an annual basis;

4. Ensures that the required number of cases are discussed at the tumor conferences on an annual basis and that at least 75 percent of the cases are discussed at the tumor conference on an annual basis and that at least 75 percent of the cases discussed are presented prospectively;

5. Monitors and evaluates the tumor conference frequency, multidisciplinary attendance, total case presentation, and prospective case presentation on an annual basis;

6. Establishes and implements a plan to evaluate the quality of

cancer registry data and activity on an annual basis. The plan includes procedures to monitor casefinding, accuracy of data collection, abstracting timeliness, follow-up and data reporting;

7. Each year, the Oncology Committee analyzes patient outcomes and disseminates the results of the analysis;

8. Each year the Oncology Committee completes and documents the required studies that measure quality and outcomes.

9. Recommend to the MEC those policies and processes that will provide optimal diagnostic and therapeutic services as well as preventive care.

10. Evaluate overall care for cancer patients;

11. Document the proceedings of committee meetings and report them to the MEC

c. Meetings

Meetings shall be held at least quarterly**.**

8.2-18 Operating Room Committee

a. Membership

The Operating Room Committee shall consist of representatives from the surgical specialties, Radiology, Pathology, Administration, Quality Improvement, Nursing and the Director of the Operating Room.

b. Functions

The duties include:

1. Developing, recommending and reviewing policies and procedures for the prompt and efficient functioning of the Operating Room suite.

2. Making recommendations to the MEC and the CEO regarding unmet needs necessary for the operating suite.

3. Reporting findings, conclusions, recommendations, actions and evaluations of actions taken and the proceedings of this committee to the Clinical Practice Committee and the MEC.

c. Meetings

Meetings shall be held at least ten times a year and at the call of the Chairperson for special meetings.

8.2-19 Pharmacy and Therapeutics Committee

a. Membership

The Pharmacy and Therapeutics Committee shall consist of representatives from the clinical services, Administration, Quality Improvement, Nursing and the Director of Pharmacy, Director of Food Services, Chief Therapeutic Dietitian.

b. Functions

The duties include:

1. Developing and maintaining surveillance over drug utilization policies and practices throughout the Hospital, including the use of antibiotics, including measurement of the appropriate prescription of medications, preparation and dispensing of medications, administration of medications, and monitoring of medication effects.

2. Making recommendations concerning drugs to be stocked by patient care units and by other services.

3. Developing and reviewing, periodically, a formulary or drug list for use in the Hospital.

4. Reviewing in detail (to include defining, reviewing, trending and assessing) all reported adverse drug reactions and medication errors and recommending corrective action.

5. Reviewing all data relative to drug effectiveness, side effects and new drugs or uses, and disseminating such information as needed.

6. Preparing a quarterly report consisting of statistical data involving drug reactions and drug errors, their probable causes and actions taken to resolve problems and follow up action to assure the resolution of problems.

Nutrition Services

a. Functions

The duties include:

1. Review and revise, as necessary, the diet manual of the Hospital.
2. Develop and supervise a hospital-wide system for rapid initial assessment of nutritional status of patients, recommendations for adequate support, and periodic follow-up and discussion of these with staff caring for patient when clinically indicated.
3. Assure that food and nutrients offered to each patient meet the nutritional requirements of that patient.
4. Evaluate the adequacy of methods used to ensure an adequate food intake, regardless of the mode of feeding, i.e., oral, tube or parenteral.

5. Performing such other duties as assigned by the Executive Committee of the Medical/Dental Staff.
6. Report findings, conclusions, recommendations, actions and evaluation of actions taken to the Quality Assurance Committee and the MEC, as identified in the hospital-wide PI Plan.

Meetings

Meetings shall be held no less than quarterly.

8.2-20 Quality Assurance and Performance Improvement Committee

a. Membership

The Quality Assurance (QA) and Performance Improvement (PI) Committee (QA/PI) shall consist of select representative(s) of the Joint Conference/Planning Committee of the Board of Trustees, each clinical service, Administration, Nursing, Medical Records, Risk Management, Quality Improvement and the President-elect of the Medical Staff who shall serve as Chairperson.

b. Functions

The duties involved in performing quality review and evaluation in accordance with the Hospital's Performance Improvement Plan include:

1. Reviewing all reports submitted by the clinical and hospital services concerning the quality of patient care and peer review activities.

2. Recommending to appropriate individuals or committees those additional activities and modifications of existing activities in order to improve care.

3. Requesting submission of reports not routinely submitted to coordinate and evaluate them, and to recommend quality improvement activities and programs to enhance patient care.

4. Reviewing all reports of the Ambulatory Care, Blood Utilization Review, Operative and Invasive and P&T Committees; Risk and Claims data and Ancillary Service Department's PI Reports to identify issues related to the quality of care and instituting recommendations for corrective action where necessary.

5. Establishing priority for investigations of problems and to propose resolution of patient care problems, including the assignment of responsibility for resolution of identified problems.

6. Implementing solutions to patient care problems, which may include educational training programs, new or revised policies or

procedures, staffing changes, or equipment changes.

7. Re-evaluating all unsolved problems for further corrective action.

8. Monitoring corrective action effectiveness of identified problems.

9. Report findings, conclusions, recommendations, actions, and evaluations of actions taken to the MEC, as identified in the hospital-wide PI Plan.

c. Meetings

Meetings shall be held at least ten times a year and at the call of the Chairperson for special meetings.

8.2-21 Radiation Safety Committee

a. Membership

The Radiation Safety Committee shall consist of, at a minimum, a representative from Radiology, Medicine, Pathology, and each service that is a user of radioactive materials, as well as Administration and the Radiation Safety Officer.

b. Functions

The duties include:

1. Reviewing and recommending procedures and policies concerning the safe and effective administration of devices which produce radioactive substances and radiation throughout the Hospital.
2. Reviewing and recommending the proper handling, disposal, and storage of radioactive materials to comply with the New Jersey state codes and directives of the Federal Nuclear Regulatory Commission.

3. Reporting findings, conclusions, recommendations, actions, and evaluations of actions taken to the Clinical Practice Committee and the MEC as identified in the hospital-wide PI Plan.

c. Meetings

Meetings are subject to the call of the Chairperson.

8.2-22 Utilization Management Committee

a. Membership

The Utilization Management (UM) Committee shall consist of selected representatives from the clinical services, Social Services, Admitting, and the Utilization Management Department.

b. Functions

The primary function of the Utilization Management Committee shall be to ensure that all of the inpatient care given by the Hospital is necessary and could not be provided as effectively in some alternative setting. Specifically, the duties include:

1. Undertaking studies designed to evaluate the appropriateness of admission to the Hospital, delays in use of, or overuse of ancillary services, delays in consultations and referrals, lengths of stay and discharge planning.

2. Fostering methods for the more effective utilization of Hospital services by studying patterns of care by obtaining data about the average or normal lengths of stay by specific disease category; undertaking studies and evaluating systems of utilization management employing such data in order to contribute to the development of optimum utilization management.

3. Conducting its activities in compliance with applicable federal and state regulations and TJC requirements.

c. Meetings

Meetings shall be held at least bi-monthly.

8.3 Representation on Interdisciplinary Hospital Committees

Staff functions and responsibilities relating to liaison with the Hospital may be discharged by the appointment of one or more Medical Staff members to the appropriate Hospital committees. These appointments shall be made by the MEC as and when appropriate.

8.4 Special Committees

a. Composition and Appointment

If a special committee is established by the MEC to perform one or more of the Staff functions required by these Bylaws, it shall be composed of appointees of the Attending or Associate Attending Staffs and may include, where appropriate, representation from Hospital Administration, Nursing, Medical Records, Pharmaceutical Services, Social Services and such other Hospital services as are appropriate to the function(s) to be discharged. Unless otherwise specifically provided, the Staff appointees and the Chairperson shall be appointed by the MEC.

b. Term and Prior Removal

Unless otherwise specifically provided, a special committee appointee shall continue as such until the specific task of the committee is completed

or until his or her successor is elected or appointed. Staff special committee appointee, other than one serving ex-officio, may be removed by a majority vote of the MEC. n administrative staff committee appointee may be removed by action of the CEO.

c. Vacancies

Unless otherwise specifically provided, vacancies on any Staff committee shall be filled in the same manner in which original appointment to such committee is made.

d. Meetings

A special committee established to perform one or more of the Staff functions required by these Bylaws shall meet as often as is necessary to discharge its assigned duties. Reports of these meetings will be submitted to the MEC, which shall also receive a final report when the Committee's work is completed.

e. Minutes

All standing committees shall document the proceedings of meetings in regularly kept minutes, which are to be forwarded to the MEC and the QA/PI Committee.

IX-I

ARTICLE IX-OFFICERS

9.1 Officers of the Staff

9.1-1 Identification

The officers of the Staff shall be:

a. President
b. President-elect
c. Secretary-Treasurer
d. Immediate Past-President

9.1-2 Qualifications of Officers

Officers must be members in good standing of the Attending Staff at the time of nomination and election and must remain so during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. The President and President-elect must be practitioners with demonstrated qualifications on the basis of experience and ability.

9.1-3 Nominations

a. By Nominating Committee

The Nominating Committee shall consist of the President and the President-elect the Medical Staff, and the six at-large members of the Executive Committee as described in Section 8.2-16 and shall convene not less than 90 days prior to the annual meeting; and shall submit to the Secretary/Treasurer of the Medical Staff one or more qualified nominees for each office. The names of such nominees shall be reported to the Medical Staff at least 60 days prior to the annual meeting.

b. By Petition

Nominations may also be made by petition signed by at least 10% of the members in good standing, of the Medical Staff, with a signed statement of willingness to serve by the nominee, and filed with the Secretary of the Staff at least 45 days prior to the annual meeting.

As soon thereafter as reasonably possible, the names of these additional nominees shall be reported to the Staff.

c. By Other Means

If, before the election, any of the individuals nominated for an office pursuant to Section 9.1-3 (a) and (b) shall refuse, be disqualified from or otherwise be unable to accept nomination, then the Nominating Committee shall submit one or more substitute nominees at the annual meeting, and nominations shall be accepted from the floor.

9.1-4 Election

Officers shall be elected at the annual meeting of the Staff in each alternate year. Only Staff members accorded the prerogative to vote for Medical Staff Officers under Article IV shall be eligible to vote. Voting shall be by secret written ballot, and voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of the valid votes cast.

If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes. Each member of the Staff eligible to vote will receive a ballot sent out by the Secretary of the Staff and it will be the Secretary's duty to assure that each member of the Staff receives a ballot at least 30 days prior to the date of the election. Every member of the Staff who receives a ballot has the opportunity to vote. If a tie results from a runoff election, the deciding votes will be cast by the six at-large members of the MEC and the three incumbent officers of the Medical Staff.

As an alternative, a mail ballot may be held with ballots to be distributed at least 30 days prior to the annual meeting, to be returned no later than midnight 15 days prior to the

annual meeting. In the event of a mail ballot tie, a runoff election will be held at the annual meeting. If a tie then occurs, the deciding votes will be cast in the same manner as for an annual meeting election.

9.1-5 Exceptions

Sections 9.1-3 and 9.1-4 shall not apply to the office of President-elect. The President-elect shall, upon completion of his or her term of office in that position, immediately succeed to the office of President.

9.1-6 Term of Elected Office

Each officer shall serve a two-year term, commencing on the first day of January of the year following his or her election. Each officer shall serve until the end of his or her term and until a successor is elected, unless he or she shall sooner resign or be removed from office.

9.1-7 Vacancies in Elected Office

Vacancies in offices, other than President and President-elect shall be filled by the MEC. If there is a vacancy in the office of President, the President-elect shall serve out the remaining term. A vacancy in the office of President-elect shall be filled by a special election conducted as reasonably soon after the vacancy occurs as possible, following the general mechanism outlined in Sections 9.1-3 and 9.1-4.

9.1-8 Removal from Office

Removal of an elected officer of the Medical Staff may only be for just cause. Failure to fulfill the prescribed duties of office, loss of membership in good standing, suspension or withdrawal of clinical privileges or other incurred serious disciplinary actions are grounds for removal.

Removal from office requires a two-thirds majority of the voting membership of the Medical Staff. Voting may be conducted by mail ballot.

9.1-9 Duties of Elected Officers

a. **President**

The President shall serve as the principal elected official of the Staff. As such, he or she shall:

1. Aid in coordinating the activities and concerns of the Hospital Administration, the Medical and Dental Schools, Nursing, and non-physician patient care services with those of the Staff.

2. Be responsible to the Board of Trustees, in conjunction with the MEC, for the quality and efficiency of clinical services and professional performance within the Hospital and for the effectiveness of patient care evaluations and the quality maintenance functions delegated to the Staff.

3. Develop and implement, in cooperation with the Chiefs of Services, methods for credentials review and for delineation of privileges, continuing education programs, utilization review, continual monitoring functions and patient care evaluation studies.

4. Participate in the selection of Staff representatives to Staff and Hospital management committees including Safety and Quality Assessment.

5. Communicate and represent the opinions, policies, concerns, needs and grievances of the Staff to the Board of Trustees via the Joint Conference/Planning Committee, the MEC, the CEO and other officials of the Staff.

6. Call, preside at, and be responsible for the agenda of all general meetings of the Staff.

7. Serve as Chairperson of the MEC in the absence of the Dean, as an ex-officio appointee of the Joint Conference and Planning Committee and as ex-officio member without vote of other Staff Committees and functions, as necessary.

b. **President-elect**

The President-elect shall be a member of the MEC and serve as Chairperson of the Quality Assurance Committee, in the temporary absence of the President, he or she shall assume all the duties and have the authority of the President of the Staff. He or she shall perform such additional duties as may be assigned to him or her by the President, the MEC or the Board of Trustees.

c. **Secretary-Treasurer**

The Secretary-Treasurer shall be a member of the MEC. His or her duties shall be to:

1. Give proper notice of all Staff meetings on order of the appropriate authority.
2. Prepare accurate and complete minutes for all staff meetings.
3. Supervise the collection and accounting of any Staff funds.
4. Perform such other duties as ordinarily pertain to his or her office.

d. **Immediate Past-President**

The Immediate Past-President shall be a member of the MEC. He or she shall serve as an advisor to the President of the Staff, and perform whatever additional duties are mutually agreed upon, consistent with these Bylaws.

e. **At-Large Representatives**

The six At-Large Representatives shall be members of the MEC. Whenever necessary, they shall serve as liaisons between at-large members of the Medical Staff and the President of the Staff, and perform whatever additional duties are mutually agreed upon, consistent with these Bylaws.

9.2 Other Officials of the Staff

Chief of Service

Unless otherwise specified by the Board of Trustees, the Chairperson of a Clinical Department in the NJMS and the NJDS will serve as Chief of Service for that Department at University Hospital. In the case of Services, which are not departments of the NJMS or NJDS, the Chief of Service will be nominated by the Chairman of the MEC and the President of the Medical Staff and recommended to the MEC for approval.

The Department Chairperson, or Chief of Service in the situation where the service does not have a department in the NJMS or NJDS, shall participate in the evaluation of practitioners practicing within the department. These roles and responsibilities include, but are not limited to:

- Oversee clinically related activities of the department;
- Oversee administratively related activities of the department, unless otherwise provided by the hospital
- Continue surveillance of the professional performance of all individuals in the department who have delineated clinical privileges
- Recommend to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department
- Recommend clinical privileges for each member of the department
- Assess and recommend to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by department or the organization
- Integrate the department or service into the primary functions of the organization
- coordinate and integrate interdepartmental and intradepartmental services
- Develop and implement policies and procedures that guide and support the provision of care, treatment and services
- Make recommendations for a sufficient number of qualified and competent persons to provide care, treatment and service

- Determine the qualifications and competence of department or service Adjunct Staff who provide patient care, treatment and services
- Continuously assess and improve the quality of care, treatment and services
- Maintain quality control programs, as appropriate
- Oversee the orientation and continuing education of all persons in the department or service
- Make recommendations for space and other resources needed by the department or service

9.3 Administrative Officers

The Board of Trustees may appoint additional practitioners to administrative positions within the Hospital, e.g., Chief Medical Officer, to perform such duties as prescribed by the Trustees, or as defined by amendment to these Bylaws. To the extent that any such officer performs any patient care function, he or she must become and remain an appointee of the Staff. In this event, he or she must be subject to these Bylaws and to the other policies of the Hospital.

X-1

ARTICLE X-MEETINGS

10.1 Annual Meeting

10.1-1 Meeting Time

The annual Staff meeting shall be held within the last sixty (60) days of the Staff year.

10.1-2 Order of Business and Agenda

The order of business at an annual meeting shall be determined by the President of the Staff. The agenda shall include at least:

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

Reports from the CEO, the President of the Staff, Chiefs of Service, and certain committee Chairperson, as deemed appropriate.

The election of officers and at-large representatives of the Staff as required by these Bylaws.

Recommendations for maintenance and/or improvement of patient care. Other

old and new business, as appropriate.

10.2 Special Meeting

Special meetings of the Staff may be called at any time by the Board of Trustees, the President of the Staff, by action of the MEC or not less than 20% of the members of the Medical Staff, and shall be held at the time and place designated in the meeting notice. In the event that it is necessary for the Staff to act on a question without being able to meet, the voting Staff may be presented with the question by mail and their votes returned to the President of the Staff by mail within a specified time period. Such a vote shall be binding so long as the question is voted on by a majority of the Staff eligible to vote. No business shall be transacted at any special meeting except that stated in the meeting notice.

10.3 Notice of Meetings

The President of the Staff shall determine the meeting hour and place. A written notice stating the date, time and place of such meeting shall be delivered to each member not less than seven days before the meeting date. If mailed, the notice of the meeting shall be deemed delivered forty-eight hours after deposit, postage prepaid, in the United States mail, addressed to each person entitled to such notice at his or her address as it appears on the records of the Hospital. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

10.4 Quorum

10.4-1 General Staff Meetings

The presence of 30 voting members of the Attending Staff at any regular or special meeting shall constitute a quorum.

10.4-2 Service and Committee Meetings

Except where otherwise provided in these Bylaws, those present of the voting members of a service or committee, but not less than three members, shall constitute a quorum at any meeting of such service or committee.

10.5 Manner of Action

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. The presence (may include electronic) of 30 voting members of the Attending Staff at any regular or special meeting shall constitute a quorum. Action may be taken without a formal meeting by a service or committee if there is agreement by two-thirds of the members, provided that the names of those who concur shall be recorded with the report of the action agreed upon.

10.6 Minutes

Minutes of all meetings shall be prepared by the Secretary or designate of the meeting and shall include a record of attendance and the Vote taken on each matter. Copies of such minutes shall be signed by the presiding officer and forwarded to the MEC and made available to the Staff. A permanent file of the minutes of each meeting shall be maintained. Where appropriate, copies of committee minutes must also be forwarded to the Quality Assurance Committee. Minutes of the MEC shall be forwarded to the Board of Trustees, through the Joint Conference and Planning Committee.

10.7 Attendance Requirements

10.7-1 Regular Attendance

Each member of the active Staff is requested to attend meetings outlined in Article IV including the Annual Staff Meeting.

10.7-3 Special Appearance

A practitioner whose patient's clinical course of treatment is scheduled for discussion at a regular service or committee meeting shall be so notified. The Chairperson of the meeting shall give the practitioner at least 7 days advance written notice of the time and place of the meeting. Whenever apparent or suspected deviation from standard clinical practice is involved, special notice shall be given and shall include a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to which he or she was given such special notice shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or a portion of the practitioner's clinical privileges. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Trustees.

XI-1
ARTICLE XI-DUES

11.1

The determination of the need for bi-annual dues for Staff membership is the responsibility of the MEC. Payment of annual dues shall be for the period July 1 through June 30 of the following year. (Refer to Section 3.5e). A basic responsibility of each staff appointee and re-appointee is the payment of appropriate Medical Staff dues.

XII-1

ARTICLE XII-ADOPTION AND AMENDMENT OF BYLAWS

12.1 Adoption

The Staff, through the MEC, shall have the initial responsibility to formulate and recommend to the Board of Trustees Bylaws, which shall be effective when approved by the Board of Trustees. Medical Staff Bylaws and rules and regulations are adopted by the Medical Staff and approved by the governing body before becoming effective. Neither body may unilaterally amend the Medical Staff Bylaws or rules and regulations.

12.2 Amendments

Proposed amendments to the Bylaws may emanate from a variety of sources, e.g., Board of Trustees, MEC, Hospital Administration, staff committees or individual members. Each proposal must be reviewed by the Bylaws Committee, which shall forward its recommendation to the MEC for approval. Ordinarily, proposed amendments to the Bylaws are presented at the annual meeting of the Medical Staff, along with the recommendation of the MEC and the Bylaws Committee. Under urgent circumstances declared by the MEC, proposed amendments may be presented at other regular or special meetings of the Medical Staff or proposed electronically to the Medical Staff for consideration. Proposed amendments are then submitted to the Medical Staff for a mail ballot, which can be electronic or paper, to be returned to the President of the Staff within a specified time period. A two-thirds majority of the votes cast by members of the Staff in good standing is required for approval.

12.3 Review

When necessary, and, at least annually the Medical Staff Bylaws and Rules and Regulations are reviewed and/or revised to reflect the hospital's current practices with respect to Medical Staff Organization and functions. Approved revisions in the Bylaws will be referred to the MEC and the Medical Staff for action.

XIII-1

ARTICLE XIII-PARLIAMENTARY PROCEDURE

13.1 Parliamentary Procedure

The conduct of meetings will be governed by Sturgis Standard Code of Parliamentary Procedure, current edition, as most recently revised. In case of a conflict between Sturgis Standard Code of Parliamentary Procedure and these Bylaws, these Bylaws will govern.

Approved by Medical Staff e-Ballot on March 18, 2011. Accepted by the Medical Executive Committee on March 22, 2011.

Michael A. Sirkin, MD
President of the UH Medical Staff

Justin Sambol, MD
Secretary/Treasurer of the Medical Staff

Robert T. Johnson, MD
Chairperson, Medical Executive Committee

Thomas M. Jackson, President
Approved by UH Board of Directors