

The
University
Hospital
Medical
Staff

BYLAWS

Revised: June 2001

PREAMBLE

WHEREAS, University Hospital is a health care entity of the University of Medicine and Dentistry of New Jersey, 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 JCAHO; 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 is to strive for optimal achievable quality 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, the Dean of UMDNJ-New Jersey Medical School, and the Chief Executive Officer of University Hospital, and that the cooperative efforts of the Medical Staff, Management and the Board of Trustees are necessary to fulfill the Hospital's aims and goals in providing optimal achievable patient care to patients in the Hospital; and goals in providing optimal achievable patient care to patients in the Hospital; and the Medical Staff endorses and supports the vision & Mission Statements 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.

Date of Revision: June 2001

UNIVERSITY HOSPITAL 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 will 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.

II-1

ARTICLE II-PURPOSES AND RESPONSIBILITIES

2.1 Purposes of the Medical Staff

The purposes of the Medical Staff are:

2.1-1 To ensure that all patients admitted to or treated in any of the facilities, departments, or services of the Hospital shall receive optimal achievable quality patient care commensurate with available resources; and that all patients being treated for the same health problem or with the same methods/procedures receive the same level of quality care.

2.1-2 To serve as primary means for accountability to the Board of Trustees to ensure an optimal level of professional performance of all practitioners authorized to practice in the Hospital through the appropriate delineation of clinical privileges and through an ongoing objective review and evaluation of each practitioner's performance in the Hospital following a peer review process;

2.1-3 To report the results to the Board of Trustees of patient care evaluations, continued monitoring and other performance improvement (PI) activities in accordance with the Hospital's PI Plan;

2.1-4 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 members, and all health care professional students;

2.1-5 To initiate and maintain rules and regulations for the proper functioning of the Medical Staff; and

2.1-6 To provide a means 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

The responsibilities of the Medical Staff, through the Medical Executive Committee (MEC) are:

2.2-1 To account for the quality and appropriateness of patient care rendered by all licensed individuals permitted by law and by the Hospital to provide patient care services in the Hospital. The methods of such accounting include:

- a. A credentials procedure, including mechanisms for appointment and reappointment and the delineation of clinical privileges consistent with the verified credentials, training and demonstrated experience of the applicant or member.
- b. Recommendations to the JCPC and/or Board of Trustees about appointments, reappointments and staff category, including clinical privileges.
- c. A Utilization Management program based on the requirements of the Hospital's Utilization Management Plan.
- d. A continuing medical education program that includes the needs identified through the PI program.
- e. A continual evaluation and monitoring of the quality and appropriateness of patient care as described in the functions enumerated in these Bylaws.
- f. Implementation of corrective actions with respect to practitioners and other Medical Staff members, as warranted.
- g. A means to develop, administer and monitor compliance with these Bylaws, the Rules and Regulations of the Staff, and other medical care related to current Hospital policies.
- h. Ways to assist in identifying community health needs and in meeting appropriate institutional goals and implementing programs to meet those needs.
- i. The exercise of the authority granted by these Bylaws as necessary to adequately fulfill the foregoing responsibilities.

ARTICLE III-STAFF APPOINTMENTS AND REAPPOINTMENTS

3.1 Nature of Appointment

Staff appointment is a privilege extended by the Board of Trustees and is not a right of any practitioner. Appointment to the 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.

3.2 Applicant Evaluation

The Hospital Administration, through its Medical Staff Office, and in conjunction with the Chief of Service and Credentials Committee, 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 Staff or to the exercise of particular clinical privileges merely because he/she is a member of any professional organization, or because he/she is certified by any clinical board, or because he/she had, or presently has, staff appointment at this Hospital or at another health care facility or in another practice setting. Further information regarding the applicant's performance at any other health care facility will be checked with the Department of Health and Human Services. Prior to extending clinical privileges as a member of the Medical Staff of University Hospital, the Medical Staff Office must verify that the individual does not appear on the Office of the Inspector General (OIG) or the Government Services Agency (GSA) listing of excluded parties.

If the above indicates that the individual is on either the OIG or GSA list of excluded individuals, this individual cannot be granted clinical privileges as a member of the Medical Staff of University Hospital.

3.3 Nondiscrimination

No aspect of staff appointment or particular clinical privileges shall be denied on the basis of sex, race, creed, color, or national origin or on the basis of any other criterion unrelated to the delivery of quality patient care in the Hospital.

3.4 Basic Qualifications for Appointment

Only practitioners who are legally licensed to practice in the State of New Jersey and who abide by the provisions described below shall be qualified for appointment to the Staff. These practitioners must

- a. Document their experience, qualifications and/or certification in their specialties, background, training, physical and mental health status and current competency,

with sufficient adequacy to demonstrate to the Hospital, and the Board of Trustees, that any patient treated by them will receive care of the generally recognized professional level established by the Hospital and that they are qualified to provide needed services within the Hospital; and

- b. Establish, on the basis of documented references, that they have adhered strictly to the ethics of their respective professions, worked cooperatively with others and participated appropriately in the discharge of staff responsibilities.
- c. Provide information to the Chief of Service and Credentials Committee regarding: any previously successful or currently pending challenges to any licensure or registration (state, district or DEA) or the voluntary relinquishment of such licensure or registration; any voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital; any involvement in a professional liability action under circumstances specified in Medical Staff Bylaws, Rules and Regulations and Policies and any sanction by a government or other third party payor.
- d. Hold or, for new appointments, initiate process for a faculty appointment at the New Jersey Medical School or New Jersey Dental School, unless exempted, as provided for elsewhere in these Bylaws.

3.5 Basic Responsibilities of Staff Appointees

Each appointee of the Staff shall:

- a. Provide his or her patients with continuous care at the generally recognized professional level of quality patient care within the appointee's delineated clinical privileges;
- b. Abide by and keep informed of the current Staff Rules and Regulations, Bylaws, and current policies of the Hospital; appointee shall keep informed of Rules, Bylaws and Policies through attendance at staff meetings, through newsletters, electronic mail and through distribution of Bylaws.
- c. Discharge such Staff, Service, Committee, and Hospital functions for which he or she is responsible by appointment, election or otherwise in the hospital or UH outpatient facilities;
- d. Prepare and complete, in timely fashion, according to the requirements of the State Health Department, and existing Hospital policy, the medical and other required records for all patients he or she admits or in any way provides care to in the Hospital.
- e. Pay appropriate annual medical staff dues.

3.6 Initial Appointment

All initial appointments to the Staff are provisional and shall be for a period of one year. Provisional appointments may be renewed for a period not to exceed 6 months. At the termination of provisional status the individual will then be considered for permanent status.

3.6-1 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 also includes the following:

- a. A statement that the applicant has agreed to abide by the current Bylaws, Policies, and Rules and Regulations of the Staff.
- b. A statement that the applicant is willing to appear for interviews about the application, during which the applicant may need to provide information about the applicant's education, experience, physical and/or mental health.
- c. 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.
- d. Description by the applicant indicating which staff category, service, and specific clinical privileges the applicant desires.
- e. Questions about references who can attest to applicant's training, clinical competence, ability to work with others, and ethical standards.
- f. Questions about whether the applicant's appointment, status and/or clinical privileges at another health care institution have ever been revoked, suspended, reduced or not renewed.
- g. Questions about the applicant's involvement in any professional liability action, whether filed, pending or resolved.
- h. Questions about any challenges or changes to the applicant's licensure or registration.
- i. Questions about applicant's current professional liability insurance coverage.
- j. Questions about whether the applicant has a prior, current or impending sanction by a government or third party payor which limits the practitioner's ability to provide medical care to patients.

- k. A statement that the applicant shall hold and keep harmless and indemnify the Hospital, its representatives and third parties, representatives of governmental agencies, partnerships, associations, and corporations from any and all claims and liability arising from communications, reports, recommendations, or disclosures about the applicant/appointee when they are requested by the Hospital as part of the following:
 - 1. Applications for appointment or clinical privileges, including temporary privileges.
 - 2. Reviews undertaken for reappointment or change in clinical privileges.
 - 3. Any disciplinary actions.
 - 4. Patient care evaluations.
 - 5. Utilization reviews
- l. A statement that the applicant has applied for or has a faculty appointment at NJMS or NJDS and verification of this by the department Chair or Chief of Service, unless exempted as provided elsewhere.

3.7 Processing the Application

3.7-1 Action by Chief of Service

The designated Chief of Service shall review the application and supporting documentation. The Chief of Service shall, at his or her discretion, conduct a personal interview with the applicant. The Chief of Service for other areas in which the applicant seeks privileges may, at his or her discretion, also require a personal interview with the applicant. They shall then transmit to the Credentials Committee, on the prescribed form, a written report and recommendation as to staff appointment and, if appointment is recommended, as to staff category and service, clinical privileges to be granted, and any special conditions to be attached to the appointment. A Chief of Service may also recommend deferring action on the application. The reason for each recommendation shall be stated and supported by reference to the completed application and all other documentation considered by the Chief of Service, all of which shall be transmitted with the report.

3.7-2 Credentials Committee Action

The members of the Credentials Committee shall review the material contained within the application, the supporting documentation, the report and recommendations of the Chief of Service, and such other information available to it that may be relevant to consideration of the applicant's qualifications for the staff category and clinical privileges requested. The Credentials Committee shall transmit to the MEC, on the prescribed form, a written report and recommendations as to staff appointment and, if appointment is recommended, as to staff category and service, clinical privileges to be granted, and any special conditions to be attached to the appointment. The Credentials Committee may also recommend that the MEC defer action on the application. The reason for each recommendation shall be stated and supported by references to the completed

application and other documentation considered by the Committee.

3.7-3 Medical Executive Committee Action

At its next regular meeting, after receipt of the Credentials Committee recommendations, the MEC shall consider the report and such other information available to it that may be relevant to the applicant's qualifications for the staff category, service and clinical privileges requested.

a. MEC Options:

1. **Deferral** - Action by the MEC to defer the application for further consideration must be followed up at their next regularly scheduled meeting with a recommendation for either provisional appointment with specified clinical privileges, or for rejection for staff appointment.
2. **Favorable Recommendation** - When the recommendation of the MEC is favorable, the MEC, through the Dean and Joint Conference and Planning Committee, shall promptly forward it together with all supporting documentation, to the Board of Trustees. Any minority views shall be made in writing, supported by reasons and references, and transmitted with the majority report, if so requested.
3. **Adverse Recommendation** - When the recommendation of the MEC is adverse to the applicant, the CEO shall immediately so inform the practitioner by special notice, and he or she shall be entitled to the procedural rights as provided in Article VI. The applicant shall exercise his or her procedural rights prior to submission of the adverse recommendation to the Trustees.

3.7-4 Board of Trustees Action

1. **Favorable Recommendation** - On favorable MEC recommendation, the Board of Trustees 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 the CEO will notify the applicant.
2. **Adverse Recommendation** - If the Board of Trustees or the Committee or Body designated to act on its behalf's action is adverse to the applicant, the CEO of the Hospital shall promptly so inform the applicant by special notice and he or she shall be entitled to the procedural rights as provided in Article VI.

3.7-5 Reapplication after Adverse Appointment Decision

An applicant who has received an adverse decision regarding appointment shall ordinarily not be reconsidered for application to the Staff for a period of one year after notice of such decision is sent. Any such reapplication shall be processed as an initial application and the applicant shall submit such additional information as the Staff, The Board of Trustees, or the Committee or Body designated to act on its behalf may require to show that the basis for the earlier adverse action no longer exists.

3.7-6 Time Periods for Processing

The Medical Staff Office shall be responsible for providing application forms to and receiving completed forms from all applicants. The Hospital Administration in conjunction with the Chief of Service and the Chairman of the Credentials Committee are responsible for verification of all statements and documents contained in the application. The verification process shall include but is not limited to querying the National Practitioner Data Bank for all new applicants and every two years for Medical Staff members who apply for reappointment. Verification shall ordinarily be completed within 90 days following receipt of the application. Once verified and complete, the application shall be transmitted to the appropriate Chief of Service who shall transmit it to the Credentials Committee, with recommendation(s) within 30 days following receipt. The Credentials Committee shall review the application and transmit its recommendation(s) within 30 days following receipt to the MEC, which will act on it at its next regularly scheduled meeting. The recommendation of the MEC shall be forwarded to the Board of Trustees or the Committee or Body designated to act on its behalf through the Dean and the Joint Conference and Planning Committee to be acted on, respectively, at their next regularly scheduled meeting.

3.8 Reappointment Process

Reappointments to the Staff shall be for a period of two (2) years. Effective at the time of the adoption of these Bylaws, the Staff shall be divided into the following two (2) groups:

Group One

Department of Anesthesiology
Department of Medicine
Department of Neurological Surgery
Department of Orthopaedics
Department of Pathology
Department of Physical Medicine & Rehab
Service of Podiatry
Department of Radiology/Nuclear
Medicine/Radiation Oncology
Department of Surgery
The Stone Center of New Jersey

Group Two

Department of Dental Medicine:
▪ General Dentistry
▪ Oral/Maxillofacial Surgery
▪ Pediatric Dentistry
Department of Family Medicine
Department of Neurosciences
Department of Obstetrics/Gynecology
Department of Ophthalmology
Department of Pediatrics
Department of Psychiatry

The application for reappointment for Group One will be processed during the first even year following the adoption of these Bylaws. The applications for reappointment for Group Two will be processed during the first odd year following the adoption of these Bylaws. In all subsequent years, the application for reappointment for Group One will be processed every two (2) years during even years. The applications for reappointment for Group Two will be processed every two (2) years during odd years.

3.8-1 Reappointment Application

The Medical Staff Office, at least 150 days prior to the expiration of the present staff appointment, shall provide each staff member with a reappointment application. Staff members desiring reappointment shall complete the application and send it, within 30 days of receipt, to the Medical Staff Office, which will forward it to the Chief of Service for review.

Failure to return the completed application, after written warning of imminent expiration from the Medical Staff Office, shall result in expiration of membership at the end of the current term.

3.8-2 The reappointment application form shall be a prescribed form and shall contain information necessary to maintain as current the medical file on the staff member's health care activities. This information shall include, without limitation, information about :

- a. Current licensure, professional performance, judgement clinical and/or technical skills;
- b. Adherence to membership requirements as stated in the Bylaws;
- c. Current physical and mental health status;
- d. The name and address of any other health care organization or practice setting where the staff member provided clinical services during the proceeding period;
- e. Membership, awards, or other honors conferred or granted by any professional health care societies, institutions or organizations;
- f. Sanctions of any kind imposed by a government or other third party payor or any other health care institutions, professional health care organization, or licensing authority including: those related to NJMS (eg. Faculty practice plan or professional corporation), previously successful or currently pending challenges to any licensure or registration (state, district, or DEA) or the voluntary relinquishment of such licensure or registration; voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital.
- g. Details about malpractice insurance, claims, suits, and settlements;
- h. Such other specific information about the staff member's professional ethics, qualifications, and ability that may bear on his ability to provide good patient care in the Hospital; and including a review of performance improvement data.
- i. A statement that the applicant shall hold and keep harmless and indemnify the Hospital, its representatives and third parties, reports recommendations, or

disclosures about the applicant/appointee when they are requested by the Hospital.

- j. Continuing training, education and experience which qualifies the Medical Staff appointee for the privileges sought on reappointment; and proof of attendance at continuing education programs or courses.
- k. Up-to-date medical records activity.
- l. Peer review activities, to ensure appropriate reappointment according to the JCAHO and as defined by departmental policy.

3.8.3 Verification of Information

The Hospital Administration, in conjunction with the Chief of Service and the Chairman of the Credentials Committee shall, in timely fashion, seek to clarify and verify the additional information made available on each reappointment application form and to collect any other materials or information deemed pertinent, including information regarding the staff member's professional activities, performance and conduct. When collection and verification is accomplished, the Medical Staff Office shall transmit the information form and supporting materials to the Chief of each service in which the staff member requests privileges.

3.8-4 Action by Chief of Service

The Chief of Service shall review the reapplication and the staff member's file and shall transmit to the Credentials Committee, on the prescribed form, his 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. A Chief of Service may also recommend deferral of action, giving specific reasons for such.

3.8-5 Credentials Committee Action

The Credentials Committee shall review each reapplication form and all other pertinent information available on each member being considered for reappointment, including the recommendation of each Service in which the staff member has requested privileges, and shall transmit to the MEC, in a timely fashion, 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. Any minority views shall also be reduced to writing and transmitted with the majority report, if so requested.

3.8-6 MEC Action

The MEC shall review the Credentials Committee recommendation and all other relevant information available to it and shall forward to the Dean and the Board of Trustees or the Committee or Body designated to act on their behalf, 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. The Committee may also defer action. Any minority views shall also be reduced to writing and transmitted with the majority report, if so requested.

3.8-7 Final Processing and Board Action

Thereafter, the procedure provided in Article III, Section 3.7-4 shall be followed. For purposes of reappointment, the terms "applicant" and "appointment" as used in those sections shall be read, respectively, as "staff member" and "reappointment".

3.8-8 Time Periods for Processing

Transmittal of the reappointment application form to a staff member and his return of it shall be carried out in a timely fashion, in accordance with Article III, Section 3.8-1. Except for good cause, each person, service and committee required by these Bylaws to act thereon shall complete such action in timely fashion such that all reports and recommendations concerning the reappointment of a staff member shall have been transmitted to the MEC for its consideration and action and to the Board of Trustees or the Committee or Body designated to act on its behalf all prior to the expiration date of the staff membership of the member being considered for reappointment.

3.8-9 Requests for Modification of Appointment

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

3.8-10 Notification of Change in Privileges at Another Hospital

In the event of a change in privileges at another hospital, the Staff member must notify the Medical Staff Office at University Hospital in writing within seven (7) working days following notice of such change.

3.8-11 Non-Faculty "Open Staff" Status

New appointment to the Medical Staff requires simultaneous application for or appointment to the faculty. In the event of a non-faculty status, the department Chair or Chief of Service shall provide the MEC with a written request for waiver of faculty appointment, with reasons for such. Such a waiver of faculty appointment requires the approval of MEC.

3.9 Leave of Absence

a. Voluntary

A staff appointee may obtain a voluntary leave of absence from the Staff by submitting written notice to the Chief of Service stating the exact period of time of leave, which may not exceed one year. The Chief of Service shall then convey this information to the Medical Staff Office and the CEO. During the period of a leave, the staff appointee's privileges and prerogatives shall be inactive.

b. Involuntary

When an active staff appointee has not provided services to any patients in the Hospital for 12 months, he or she may be given special notice by the CEO that in 30 days he or she shall automatically be deemed to be in a leave-of-absence status. The appointee may request re-activation for six months, during which time services must be provided within the Hospital. Alternatively, the practitioner may request a change in category to Courtesy Staff.

c. Compliance with Health Care Quality Improvement Act of 1986

The above leaves of absence are 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

At least 120 days prior to the termination of the leave, or at any earlier time, the staff appointee may request reinstatement of his or her privileges and prerogatives by submitting a written request to that effect to the Chief of Service for transmittal to the Chairman of the MEC. The staff appointee shall submit a written summary of his or her relevant activities during the leave. The MEC shall process the request in the usual manner for appointments and reappointments to make recommendations to *the* Dean and the Board of Trustees or the committee or body designated to act on their behalf, through the Joint Conference and Planning Committee concerning reinstatement of the members' privileges and prerogatives. Failure, without good cause, to request reinstatement or to provide a requested summary of activities as required above shall be deemed a voluntary resignation from the Staff and shall result in automatic termination of Staff membership, privileges, and prerogatives. A practitioner whose membership is so terminated shall be entitled to the procedural rights provided in Article VI for the sole purpose of determining the issue of good cause. A request for staff membership subsequently received from a staff member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

3.11 Resignation from Medical Staff

3.11-1 Non-Reappointment

A staff member who wishes to terminate his staff membership at the end of a period of appointment may do so by failure to reapply. Notification of desire to terminate is desirable, and should be submitted to the appropriate Chief of Service who shall so inform the Medical Staff Office and the CEO.

3.11-2 Resignation

A staff member who for any reason can no longer comply with the applicable qualifications for and responsibilities of membership on the Staff, and who does not desire a voluntary leave of absence, must submit, in writing, a request for modification of Staff status as per Article III, Section 3.8-9 or must submit, in writing, a 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 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 STAFF

4.1 Categories

The staff shall include Provisional, Attending, Associate Attending, Courtesy, Consulting, Adjunct, and Honorary.

4.2 Provisional Staff

4.2-1 Initial Appointment

All initial appointments shall be provisional for one year. Each provisional appointee shall be assigned to a department and shall be observed by the Chief of Service or designee to determine his or her suitability for permanent appointment. At the end of the year, the Chief of Service shall recommend whether to make the appointment permanent, extend the provisional appointment for six (6) months or to terminate.

4.2-2 Qualifications

The provisional Staff shall consist of practitioners serving in a provisional 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 Provisional 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 Service and committees of which he or she is appointed.

4.2-4 Limitations

Provisional Staff appointees shall not be eligible to vote other than (c) above or to hold a medical staff office.

4.2-5 Renewals

Provisional status may not be renewed for more than six months. If the Chief of Service cannot recommend permanent appointment, then the provisional appointment shall terminate automatically. The appointee so affected shall be given special notice of such termination and shall be entitled to the procedural rights afforded in Article VI.

4.3 Attending Staff

4.3-1 Qualifications

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

- a. 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 UMDNJ Board of Trustees.
- b. Meets the basic qualifications set forth in Article III; and
- c. Whose office and/or residence are close enough, as determined by the Board of Trustees, to the Hospital to provide continuous care to his or her patients; and
- d. Regularly admits patients to, or is otherwise regularly involved in the care of Hospital patients.

4.3-2 Prerogatives

The prerogative of an Attending Staff appointee shall be to:

- a. Admit patients in accordance with the Staff Bylaws, Rules and Regulations, and Hospital policies;
- b. Exercise such clinical privileges as are granted to him or her pursuant to Article V;
- c. Actively participate in the quality assessment activities required of the staff, in supervising provisional appointees where appropriate, in emergency services coverage, and in discharging such other Staff functions as may be required from time to time; and
- d. Satisfy the requirements set forth in Article X for attendance at meetings of the Staff and of the department and committees to which he or she is appointed.
- e. Vote on all matters presented at meetings of the service and committees to which appointed; vote on matters presented at regular staff meetings; be eligible for election to office of the Medical Staff.

4.4 Associate Attending Staff

4.4-1 Qualifications

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

- a. 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 UMDNJ Board of Trustees.
- b. Meets the basic qualifications set forth in Article III, Section 4.
- c. Devotes, in general, a minimum of twenty-two (22) working days per year in the Hospital.

4.4-2 Prerogatives

- a. Associate Attending Staff shall admit patients to the Hospital under the same conditions as specified in Section 4.3-2 for Attending Staff appointees;
- b. Exercise such clinical privileges as are granted to him or her pursuant to Article V; and
- c. Vote on all matters presented at meetings of the service and committees to which he or she is appointed.

4.4.3 Limitations

Associate Attending Staff appointees shall not be eligible to hold a medical staff office or to vote other than (c) above.

4.5 Courtesy Staff

4.5-1 Qualifications

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

- a. 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.

4.5-2 Prerogatives

The prerogatives of Courtesy Staff appointees shall be to:

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

- b. Exercise such clinical privileges as are granted to him or her pursuant to Article V.
- c. Attend meetings of the Staff and the Service of which he or she is an appointee and any Staff or Hospital education programs.

4.5-3 Limitations

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

4.5-4 Responsibilities

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

4.6 Consulting Staff

4.6-1 Qualifications

Consulting Staff shall consist of a special category of practitioners each of whom must present documented evidence of his or her qualifications within the specialty.

- a. Each member of the Consulting 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.
- b. This category may include non-clinicians who provide non-clinical consultative services such as in the area of medical ethics. These individuals may not have licensure qualifications for medical practice but must possess or demonstrate all other qualifications for appointment as stated in Section III.

4.6-2 Prerogatives

Prerogatives of a Consulting Staff appointee shall be to consult on patients by special invitation of a Staff appointee.

4.6-3 Limitations

- a. Consulting Staff appointees shall not admit patients to the Hospital nor be the practitioner of primary care to any patient within the Hospital.
- b. Consulting Staff appointees shall not hold office nor be eligible to vote.

4.6-4 Responsibilities

Consulting Staff responsibility shall be limited solely to his or her rendered consultation and ramifications, thereto.

4.7 Adjunct Staff

4.7-1 Qualifications

The Adjunct Staff shall consist of licensed practitioners permitted by law and by the Hospital to provide specific patient care services under the supervision of the Chief of Service. Each member of the Adjunct Staff shall meet the basic qualifications set forth in Article III, Section 4.

- a. Each member of the Adjunct Staff shall be a member of the faculty, or initiate application for faculty appointment 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 unless exempted as provided for elsewhere in these Bylaws.

4.7-2 Application for Appointment to Adjunct Staff

Such Adjunct Staff may include qualified allied health professionals holding a license, certification or legal credential required by state law and who:

- a. Can document qualifications, status, clinical duties, training, demonstrated ability, physical and mental health status with sufficient adequacy to demonstrate that they can provide a needed service within the Hospital.
- b. Are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions and to work cooperatively with others.

4.7-3 Appointments

Appointments as Adjunct Staff members are at the discretion of the Board of Trustees, may be terminated at will by the Trustees, and shall not be covered by the provisions of Article IX of these Bylaws.

4.7-4 Prerogatives

Prerogatives of the Adjunct Staff shall be to:

- a. Provide specified patient care services solely under the supervision and direction of a physician appointee of the Staff (except as otherwise expressly provided by resolution of the service approved by the MEC and the Board of Trustees);

- b. Serve on Staff, Department and Hospital Committees:
- c. Attend meetings of the Staff and service to which he or she is assigned;
- d. Participate, as appropriate, in quality assurance activities required of the staff, and in discharging such other staff functions as may be required from time to time.

4.7-5 Limitations

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

4.8 Honorary Staff (Emeritus)

4.8-1 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 or dentists who have retired from active practice and, by virtue of age, health or other valid reason, 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.

ARTICLE V-DELINEATION OF CLINICAL PRIVILEGES

5.1 Exercise of Privileges

Every practitioner providing clinical services at this Hospital, by virtue of his or her staff appointment or otherwise, shall, in connection with such practice and, except as provided in Article V, 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 Staff must contain a request for the specific clinical privileges desired by the applicant. A request by a Staff appointee for a modification of privileges must be supported by documentation of training and experience supportive of the request.

5.2-2 Basis For Delineation of Privileges

The decision about clinical privileges, granted or modified on initial appointment, reappointment, or otherwise, is based on the practitioner's education, training, performance, demonstrated ability and judgment, written observations about the practitioner's clinical performance and results from the patient care evaluations and quality assessment reviews about the practitioner, as required by these Bylaws. In addition, information from other institutions about the practitioner's clinical performance can be added to the file established for the applicant and used in this determination. An oral and maxillofacial surgeon possessing both a dental and medical degree may be credentialed as both a physician and as a dentist.

5.2-3 Procedure

All request for clinical privileges shall be evaluated and granted, modified or denied pursuant to, and as part of, the procedures outlined in Article III.

5.3 Special Conditions for Privileges for Oral and Maxillofacial Surgeons and General Dentists

Requests for clinical privileges from oral and maxillofacial surgeons and general dentists shall be processed and granted in the manner specified in Article III. Surgical procedures performed by oral and maxillofacial surgeons and general dentists shall be under the supervision of the Chief of Service for the Department of Dental Medicine or his/her designee. All dental patients shall receive the same basic medical evaluation as

patients admitted to other surgical services. A physician or oral and maxillofacial surgeon appointed to the Medical Staff shall be responsible for the history and physical examination of dental patients upon their admission. A physician, or an oral and maxillofacial surgeon possessing both a dental and medical degree, on the Medical Staff should be responsible for the care of active medical problems existing at the time of the dental patient's admission or arising during hospitalization. The physician shall also analyze the medical risks and benefits of the proposed treatment as they relate to the existing medical problem.

5.4 Special Conditions for Privileges for Podiatrists

Requests for clinical privileges from podiatrists shall be processed and granted in the manner specified in Article III. Surgical procedures performed by podiatrists shall be under the supervision of the Chief of Service for Podiatry or his designee. All podiatric patients shall receive the same basic medical evaluation as patients admitted to other surgical services. A physician appointed to the Medical Staff shall be responsible for the history and physical examination of podiatric patients upon their admission. A physician on the Medical Staff shall be responsible for co managing all podiatric patients at all times during their hospitalization. The physician shall also analyze the medical risks and benefits of the proposed treatment as they relate to the existing medical problems. The Chief of Service for Podiatry reports administratively to the UH Medical Director.

5.5 Temporary Privileges

5.5-1 Circumstances

Upon the written concurrence of the Chief of Service where the privileges will be exercised, and of the Chairperson of the MEC, or their designees, the CEO or designee may grant temporary privileges on a case-by-case basis. Temporary privileges can only be granted on a case-by-case basis when there is an important patient care need that mandates an immediate authorization to practice for a limited period of time while the full credentials information is verified and approved.

a. Pendency of Application

After receipt of an application for Staff appointment, including a request for specific temporary privileges, and in accordance with the conditions specified in Article III, an appropriately licensed applicant may be granted temporary privileges, for an initial period of 90 days, with subsequent renewal not to exceed the pendency of the appointment application. In exercising such privileges, the applicant shall act under the supervision of the Chief of the Service to which he or she is assigned or is appointed.

b. Care of Specific Patients

Upon receipt of written request, an appropriately licensed practitioner who is not an applicant for appointment may be granted temporary privileges

for the care of one or more specific patients. This practitioner must provide proof of malpractice coverage, a valid New Jersey license and delineation of clinical privileges. Such privileges shall be restricted to the treatment of not more than ten patients in any one year by any practitioner, after which such practitioner shall be required to apply for appointment on the Staff before being allowed to attend additional patients.

c. **Locum Tenens**

Upon receipt of a written request, an appropriately licensed practitioner who is serving as locum tenens for an appointee of the Staff may, without applying for appointment to the Staff, be granted temporary privileges for an initial period of 30 days. Such privileges may be renewed for one successive period of 30 days. Documentation must include proof of malpractice coverage, a valid New Jersey license and delineation of clinical privileges.

d. **Emergency Consultation (Second Opinion)**

In the event that a second opinion is requested by a patient or family, emergency temporary privileges for consultation may be granted by the CEO, or designee, upon recommendation of the Chief of Service, or designee. Documentation must include proof of malpractice coverage, a valid New Jersey license and delineation of clinical privileges. Practitioner may not order medications or testing, but may provide a consultation

5.5-2 Conditions of Practicing with Temporary Privilege

- a. Temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualification, ability and judgment to exercise the privileges requested by the practitioner.
- b. Special requirements of consultation and reporting may be imposed by the Chief of Service responsible for supervision of a practitioner granted temporary privileges. Before temporary privileges are granted, the practitioner must acknowledge, in writing, that he or she has received and read the Staff Bylaws, Rules and Regulations, and that he or she agrees to be bound by the terms thereof in all matters relating to his or her temporary privileges.

5.5-3 Termination

On the discovery of any information or the occurrence of any event of a professionally questionable nature about a practitioner's qualifications or ability to exercise any or all of the temporary privileges granted, the CEO may, after consultation with the Chief of Service responsible for supervision, the Chairperson of the MEC and the President of the Medical Staff or designees, terminate any or all of such practitioner's temporary

privileges; provided that where the life or well-being of a patient is determined to be endangered by continued treatment by the practitioner, the termination may be effected by any person entitled to impose summary suspensions under Article VI. In the event of any such termination, the practitioner's patients then in the Hospital shall be assigned to another practitioner by the Chief of Service responsible for supervision. The wishes of the patient shall be considered where feasible in choosing a substitute practitioner.

5.5-4 Rights of the Practitioner

A practitioner shall not be entitled to the procedural rights afforded by Article VI because of his inability to obtain privileges or because of any termination due to above reasons or due to inability to obtain faculty appointment except as waived.

5.6 Emergency Privileges ("Good Samaritan")

For the purpose of this section, an "emergency" is defined as a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger. In the case of an emergency, any practitioner, to the degree permitted by his or her license and regardless of service, staff status or clinical privileges; shall be permitted to do, and be assisted by Hospital personnel in doing, everything possible to save the life of a patient or to save the patient from serious harm.

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ARTICLE VI-DISCIPLINARY ACTIONS

6.1 Summary Suspension

6.1-1 Criteria and Initiation

Whenever a practitioner willfully disregards these Bylaws, Rules and Regulations or Hospital policies 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, then the President of the Medical Staff, the CEO, and the Chairman of the MEC, on the recommendation of the Chief of Service, 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 special notice of the suspension to the practitioner, who may request a hearing pursuant to the Hearing Procedures as described in Section 6.6. The terms of the summary suspension shall remain in effect pending such a hearing.

Immediately upon the imposition of a summary suspension, the responsible Chief of Service shall make provisions for alternative medical care for those patients in the hospital of the suspended member of the staff.

6.1-2 Medical Executive Committee Action

As soon as possible after such summary suspension but not to exceed 30 working days, a meeting of the MEC, or sub-committee thereof, shall be convened to review and consider the action taken. The MEC may recommend modification, continuation, or termination of the terms of the summary suspension.

6.2 Automatic Suspension

Practitioners must report any of the circumstances described below to the CEO, through the Chief of Service, 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.

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. The MEC may then recommend such further corrective action as is appropriate to the facts disclosed during subsequent investigation.

6.2-3 Conviction of a Felony

A practitioner who has been convicted of a felony, whether it is related to the practice of medicine or not, he/she should be 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 suspensions in any twelve-month period constitute grounds for termination of all privileges and attending status.

6.2-5 Loss of Privileges in Another Facility

For those 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, then the President of the Medical Staff, the CEO, and the Chairman of the MEC, on the recommendation of the Chief of Service, 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 special notice of the suspension to the practitioner, who may request a hearing pursuant to the Hearing Procedures as described in Section 6.6. The terms of the summary suspension shall remain in effect pending such a hearing.

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 Chair of the Medical Executive Committee, will suspend this member, and a hearing will be held as described in Section 6.6. The Office of Corporate Compliance must be notified immediately. This same process will apply to all reappointments to the medical staff. The Office of Corporate Compliance must report quarterly to the President of the Medical Staff, who then notifies the CEO and MEC simultaneously.

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, MEC, the CEO, the Trustees, 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

6.4-1 The following recommendations or actions shall, if deemed adverse to the practitioner, entitle the practitioner to a hearing:

- a. Denial of initial staff appointment
- b. Denial of reappointment
- c. Suspension of staff membership
- d. Revocation of staff membership
- e. Denial of requested advancement in staff category
- f. Reduction in staff category
- g. Limitation of the right to admit patients
- h. Denial of requested service/section affiliation
- i. Denial of requested clinical privileges
- j. Reduction in clinical privileges
- k. Suspension of clinical privileges
- l. Revocation of clinical privileges
- m. Individual requirement of consultation/supervision

6.4-2 Exceptions

- a. Neither the issuance of warning, 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.
- b. 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

6.5-1 A practitioner who receives an adverse recommendation or action described in Section 4 of this article shall, within 10 days, be given special notice of such action by the CEO. Such notice shall:

- a. 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.

- b. 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.
- c. Specify that within 30 days following the date of the notice of adverse action the practitioner must request a hearing, in writing, to the CEO of University Hospital.
- d. 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.
- e. 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. At least 7 working 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 date shall be not less than 30 days, nor more than 60 days from the date of receipt of the request for hearing, provided, however, that a hearing for a practitioner who is under suspension then in effect shall be held as soon as the arrangements for it may reasonably be made, but never later than 14 days from the date of receipt of the request for 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 Trustees, depending on whose action prompted the request for hearing.

Statement Issues and Events

The notice of hearing shall contain a concise statement of the practitioner's 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

- a. The hearing shall be conducted by a Hearing Committee consisting of the six-at-large members of the MEC who are elected by the Medical Staff at the annual meeting, none of whom shall occupy the rank of Dean or Chairperson/Chief of Service or are in direct economic competition with the physician involved. The Presiding Officer shall be designated by the President of the Medical Staff.

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

6.6-3 Presiding Officer

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.

6.6-4 Representation

- a. 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.
- b. The Practitioner who requested the hearing shall be entitled to be represented by an advisor or legal representative. 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, in advance, if an advisor or attorney is to be present at the hearing.

6.6-5 Rights of Parties

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

- a. 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.
- b. Introduce exhibits and documents relevant to the issues.
- c. Cross-examine any witness on any matter relevant to the issues.
- d. Rebut any evidence.
- e. Have counsel or advisor present as an observer even though either party has elected not to be represented by such at the Hearing. 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 copies of the record for use by the practitioner.

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 hearing shall be declared finally adjourned.

6.6-12 Hearing Committee Report and Further Action

Within 10 days after final adjournment of the hearing, the Hearing Committee shall make a written report of its findings and recommendations in the matter and shall forward the same, together with the hearing record and all other documentation considered by it, to the body whose adverse 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 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 shall transmit the result, together with the hearing record, the report of the Hearing Committee and all other documentation considered, to the Board of Trustees, with a copy to the CEO.

6.6-14 Notice and Effect of Result

- a. 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.
- b. If the result of the MEC is adverse to the practitioner in any of the respects listed in Section 6.4-2, the CEO, by certified mail, return receipt requested, shall inform the practitioner of the right to request an appellate review by the Board of Trustees as provided in Section 6.7 below.

6.7 Appellate Review

6.7-1 Request for Appellate Review

- a. A practitioner shall have 14 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.
- b. 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 Trustees. As soon as practicable, the Board or subcommittee thereof (described below), shall schedule and arrange for an appellate review which shall be not less than 14 days from the date of receipt of the appellate review request, provided however, that an appellate review for a practitioner who is under suspension then in effect shall be held as soon as the arrangements for it may reasonably be made, but not later than 10 days from the date of receipt of the request for review. 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 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 Trustees 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 Chairman by the Chairman of the Board of Trustees.

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. The statement shall be submitted to the appellate review body, through the CEO, with a copy to the MEC at least five (5) 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 days prior to the scheduled date of the appellate review.

b. Presiding Officer:

The Chairperson of the appellate review body shall be the Presiding Officer. The Chairperson 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 declared finally concluded.

g. Action Taken

The appellate review body may recommend that the Board of Trustees, as a whole, affirm, modify or reverse results or action taken by the MEC, or at its discretion, may refer the matter back to the Hearing Committee for further review and recommendation, to be returned within 14 days as in accordance with its instructions. Within 7 days after receipt of such recommendations, after referral, the appellate review body shall make its recommendation to the entire Board.

6.7-5 Final Decision of the Board of Trustees

If the appellate review body is a committee of board members, then within 14 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 body whose adverse professional review recommendation or action occasioned the hearing. The CEO shall report to the Board of Medical Examiners and other authorities, 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 10 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 NPDB 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 Chair 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.

When titles, services, sections, or divisions are established, renamed or deleted by the Board of Trustees, the list of current Services and Sections/Divisions in these Bylaws shall be administratively revised to incorporate these changes.

7.2 Designations

7.2-1 Current Services and Sections/Divisions

- A. Anesthesiology
 - 1. Critical Care Medicine
 - 2. Obstetrical Anesthesiology
 - 3. Pain Management
 - 4. Surgical Anesthesiology
- B. Emergency Services
- C. Family Medicine
- D. Dental Medicine
 - 1. Oral Maxillofacial Surgery
 - 2. Hospital Dentistry/Oral Medicine
 - 3. Pediatric Dentistry/Handicapped Dentistry
- E. Pathology and Laboratory Medicine
 - 1. Anatomical Pathology
 - 2. Autopsy Pathology
 - 3. Blood Banking & Immunohematology
 - 4. Chemical Pathology
 - 5. Clinical Microscopy
 - 6. Clinical Pathology (including bone marrow aspiration procedures)
 - 7. Clinical Pathology (excluding bone marrow aspiration procedures)
 - 8. Dermatopathology
 - 9. Cytopathology
 - 10. Hematopathology (including bone marrow aspiration procedures)
 - 11. Hematopathology (excluding bone marrow aspiration procedures)
 - 12. Immunopathology
 - 13. Microbiology
 - 14. Nephropathology
 - 15. Neuropathology
 - 16. Pediatric Pathology
 - 17. Radioisotopic Pathology
 - 18. Serology & Immunology
 - 19. Surgical Pathology
- F. Medicine
 - 1. Allergy/Immunology/Rheumatology
 - 2. Cardiology
 - 3. Dermatology
 - 4. Emergency Medicine
 - 5. Endocrinology
 - 6. Gastroenterology
 - 7. General Internal Medicine
 - 8. Geriatric Medicine
 - 9. Hematology
 - 10. Hepatology

- 11. Infectious Diseases
- 12. Nephrology
- 13. Oncology
- 14. Pulmonary Diseases
- G. Neurosciences
 - 1. Adult
 - 2. Pediatric
- H. Neurosurgery
- I. Obstetrics & Gynecology
 - 1. Genetics/Infectious Diseases
 - 2. Maternal-Fetal Medicine
 - 3. Oncology
 - 4. Reproductive Endocrinology & Infertility
- J. Ophthalmology
 - 1. Adult
 - 2. Neuroophthalmology
 - 3. Oculoplastic
 - 4. Pediatric
 - 5. Retina-Vitreous
 - 6. Glaucoma
 - 7. Uveitis-Infectious Diseases
 - 8. Cornea-External Diseases
- K. Orthopaedics
 - 1. Pediatric Orthopaedics and Spine
 - 2. Musculoskeletal Oncology
 - 3. Orthopaedic Trauma
 - 4. Sports and Arthroscopy
 - 5. Total Joints
 - 6. Hands and Microvascular
 - 7. Foot and Ankle
 - 8. Adult Spine
- L. Pediatrics
 - 1. Adolescent Medicine
 - 2. Allergy/Immunology/Infectious Diseases
 - 3. Ambulatory Care
 - 4. Cardiology
 - 5. Child Development
 - 6. Critical Care
 - 7. Emergency Services
 - 8. Endocrinology
 - 9. Gastroenterology
 - 10. Genetics
 - 11. Hematology/Oncology
 - 12. Lead Poisoning
 - 13. Neonatology
 - 14. Nephrology

- 15. Pulmonary Diseases
- M. Podiatry
- N. Psychiatry
 - 1. Adult
 - 2. Child
- O. Radiology/Nuclear Medicine/Radiation Oncology
 - 1. Adult
 - 2. Neuroradiology
 - 3. Pediatric
 - 4. Ultrasound
- P. Rehabilitation Medicine
- Q. Surgery
 - 1. Cardiothoracic
 - 2. Critical Care
 - 3. Emergency Services
 - 4. General
 - 5. Oncology
 - 6. Otolaryngology
 - 7. Pediatric
 - 8. Plastic
 - 9. Transplants
 - 10. Trauma
 - 11. Urology
 - 12. Vascular

7.2-2 Service Changes

In consultation with the CEO, the MEC may create, eliminate or subdivide a service or section subject to the approval of the Board of Trustees.

7.3 Assignment to a Service or Section

Each appointee of the Staff shall be assigned to at least one service and, if applicable, may be granted privileges in one or more of the other services. 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:

- a. 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.
- b. 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.

- c. 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.
- d. Monitor, on a continuing and concurrent basis, adherence to:
 - 1. Staff and Hospital policies and procedures;
 - 2. Requirements for adequate coverage and for consultations;
 - 3. Fire and other regulations designed to promote patient safety.
- e. Coordinate the patient care provided by the service members with nursing and other non-physician patient care services and with administrative support services.
- f. Foster an atmosphere of professional decorum.
- g. Meet at least monthly for the purposes indicated in (h) and receive, review, and consider reports on other service and staff functions.
- h. Submit written reports or minutes of service meetings to the MEC and the Quality Assurance and Performance Improvement Committee on a regular basis concerning:
 - 1. Findings, conclusions, recommendations, actions and evaluations of continuous performance improvement activities as defined in the hospital-wide PI Plan.
 - 2. Recommendations for maintaining and improving the service and the Hospital; and
 - 3. Such other matters as may be requested from time to time by the MEC or Quality Assurance and Performance Improvement Committee.
- i. Establish committees within the services, as necessary.
- j. Formulate rules and regulations consistent with the rules and regulations of the Hospital, Bylaws of the Board of Trustees and the Bylaws of Medical Staff.

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 Chairman 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 Chairman 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 Chairs, have the prerogative of inviting guests as may seem indicated and/or appropriate.
- e. Except where provided, appointment and re-appointments 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.

8.2 Standing Committees

8.2-1 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 shall be a member. The CEO, the Assistant VP for Patient Care Services and the Medical Director shall be ex-officio members without vote. 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.
4. Recommend to the Board of Trustees all matters relating to appointments, reappointments, staff categories, service assignments, clinical privileges, specified services and corrective action.
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.

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. Reviewing and approving all criteria to be used in any monitoring activity.
6. Documenting all findings and conclusions and submitting all

reports of committee meetings to the Performance Improvement 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.

8.2-3 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 Chair, 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 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.
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 the call of the Chair.

8.2-5 Clinical Practice Committee

a. Membership

The Clinical Practice Committee shall consist of representatives from Anesthesiology, Family Medicine, Medicine, Neurology, Obstetrics/Gynecology, Ophthalmology, Oral and Maxillary Surgery, Pathology, Pediatrics, Physical Medicine and Rehabilitation, Psychiatry, Radiology, Surgery, Orthopaedics, Administration, Nursing, Chairs of Nutrition, Medical Records, Patient Education, Oncology, Infection Control, Utilization Management, Operating Room, Bioethics, Radiation Safety, and Combined Critical Care Committees and representatives from Nursing, Nutrition and Food, Social Work, Medical Records, Infection Control, UM, QI 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.
4. Deliberating clinical practice issues and reviewing reports of identified Standing Committees to identify issues related to quality of care.
5. Reporting proceedings of committee to the MEC.

c. Meetings

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

8.2-6 Combined Critical Care/Resuscitation Committee

a. Membership

The Combined Critical Care/Resuscitation Committee shall consist of selected representation from Surgical ICU, Medical ICU, Neuro/Neurosurgical ICU, Neonatal Intensive Care, Medical Intermediate Care, Quality Assessment/Performance Improvement, Nursing and Administration.

b. Functions

The duties include:

3. Monitoring and evaluating the quality of care rendered in the critical care units.
4. Standardizing the plan of care and use of equipment in critical care areas wherever possible.
5. Establishing policies and procedures common to all units related to the delivery of critical health care services.
6. Reviewing the delivery of resuscitation activity within the institution.
7. Monitoring and evaluating the delivery of care by support services to critically ill patients.
8. Addressing future plans for the critical care 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 monthly.

8.2-7 Cardiorespiratory Care Sub-Committee of Combined Critical Care Committee

a. Membership

The Cardiorespiratory Care Sub-Committee shall consist of representatives from Medicine, Surgery, Pediatrics, Anesthesiology, Respiratory Therapy, Administration and Nursing.

b. Functions

The duties include:

1. Recommending guidelines and procedures in order to clarify the functions and responsibilities of those involved in respiratory care.
2. Reviewing problems and making recommendations regarding unmet needs.
3. Monitoring the quality and appropriateness of respiratory care, and recommending educational programs where appropriate.
4. Reporting proceedings of sub-committee meetings to the Critical Care/Resuscitation Committee.

c. Meetings

Meetings shall be held bi-monthly.

8.2-8 Continuing Education Committee

a. Membership

The membership and Chairperson of this Committee shall be selected, as deemed appropriate, by the MEC, but shall have no less than seven members.

b. Functions

The duties include:

4. Developing, planning, and participating in programs of continuing education that are designed to keep the Staff informed of significant new developments and new skills in medicine.
5. Evaluating, through the Hospital's quality assurance program and, specifically, the patient care evaluation, the effectiveness of the educational programs developed and implemented.
6. Reviewing the Hospital's and Staff's needs for professional library services.
7. Acting upon continuing education recommendations from the

MEC, the services, or other committees responsible for patient care evaluation and quality assurance.

8. Maintaining a permanent record of education activities, specifically including their relationship to the findings of the patient care evaluation and patient care monitoring functions of the staff.
9. Documentation of the performance of these functions shall be reflected in the appropriate committee minutes on a bi-monthly basis.
1. 7. Uses reports, findings, conclusions, recommendation, actions, and evaluations of actions taken to the Clinical Practice Committee and the MEC, as identified in the hospital-wide PI Plan in developing continuing education.

c. Meetings

Meetings are to be held bi-monthly.

8.2-9 Credentials Committee

a. Membership

The Credentials Committee shall consist of one representative from each clinical service, Nursing and 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 Medical Executive Committee 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.

c. Meetings

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

8.2-10 Sub-Committee of the Credentials 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 Credentials Committee membership 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. Confrontation.
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 Chair.

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.

8.2-11 Ethics Committee

a. Membership

The Ethics Committee shall consist of at minimum the following representatives: (7) from the Medical Staff to include representation from Medicine, Surgery, Neurology, Pediatrics, Psychiatry, Anesthesia and OB/GYN, (3) from Nursing, (1) from Administration, (1) from Social Services, (1) Hospital Attorney, (1) from the Institutional Review Board, (1) from the Board of Trustees, (2) from the Community, and (1) Bioethicist.

b. Functions

The duties include:

6. Creating a forum for discussion of ethical issues and their impact on University Hospital.
7. Documenting conclusions of the Committee's deliberations and recommendations to the MEC.
8. Planning for and implementing educational programs for physicians and Hospital staff regarding ethical matters.

c. Meetings

Meetings shall be held bi-monthly.

8.2-12 Prognosis Sub-Committee of Ethics Committee

a. Membership

The Prognosis Committee shall consist of representatives from among the Ethics Committee and other specialties dependent upon the particulars of the patient's case.

b. Functions

The duties include:

To confirm adverse prognosis in persistently vegetative hospitalized patients who have not executed an advanced directive prior to withdrawing or withholding life sustaining medical treatment.

1. Receiving and acting upon requests to discontinue life support equipment on patients who further treatment would be futile.
2. Documenting findings and recommendations regarding life support issues for inclusion in the medical record.
3. Submitting a summary of activities and final recommendations to

the MEC through the Bioethics Committee.

c. Meetings

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

8.2-13 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:

5. Maintaining surveillance of hospital infection potential
6. Identifying and analyzing the incidence and cause of all nosocomial infections.
7. Developing and implementing a preventive and corrective program designed to minimize infection hazards.
8. Supervising infection control in all phases of the hospital's activities.
9. Acting upon recommendations related to infection control received from the MEC, other Staff and Hospital committees and the Department of Health of New Jersey.
10. Maintaining a permanent record of all activities relating to infection control and submitting periodic reports thereon to the MEC and the Quality Assurance Committee.
11. 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.

8.2-14 Institutional Review Board

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 annually by the Dean after reviewing recommendations made by the Chair 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 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.

8.2-15 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 Quality Assurance/Performance Improvement.

b. Functions

The duties include:

10. 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 the Joint Commission 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.
11. 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.

12. Acting upon recommendations from committees responsible for patient care evaluation and quality improvement activities.
13. Providing liaison with Hospital Administration and the medical records professionals in the employ of the Hospital on matters relating to medical records practice.
14. 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 Chairman, 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, and from Administration, Social Service, Quality Assurance/Performance Improvement and Nursing.

b. Functions

The duties include:

1. Maintain a tumor registry in accordance with the guidelines of the American College of Surgeons.

2. Recommend to the MEC those policies and processes that will provide optimal diagnostic and therapeutic services as well as preventive care. Evaluate overall care for cancer patients.

3. Recommend educational programs where appropriate.

4. 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, who shall be an ex-officio member.

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 each clinical service, 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.

7. Nutrition Services

- f. Review and revise, as necessary, the diet manual of the Hospital.
- g. 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.
- h. Assure that food and nutrients offered to each patient meet the nutritional requirements of that patient.
- i. Evaluate the adequacy of methods used to ensure an adequate food intake, regardless of the mode of feeding, i.e., oral, tube or parenteral.

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

c. Meetings

Meetings shall be held no less than quarterly.

8.2-20 Quality Assurance Committee

a. Membership

The Quality Assurance and Performance Improvement Committee 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 who shall serve as Chairperson.

b. Functions

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

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

This Committee shall meet monthly.

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

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 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 QA/PI 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.

8.2-23 Length of Stay Committee

a. Membership

The Length of Stay Committee shall consist of selected representatives from the clinical services, Social Services, Admitting, and the Utilization Management Department. The Chair of the committee shall be the Medical Director of the Hospital.

b. Functions

The primary function of the Length of Stay 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. Formulating and updating, annually, a written Utilization Management Plan for the Hospital.
3. 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.
4. Conducting its activities in compliance with applicable federal and state regulations and JCAHO requirements.

c. Meetings

Meetings shall be held 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 Quality Assurance/Performance Improvement 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 convene not less than 90 days prior to the annual meeting and shall submit to the Secretary 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

- m. 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.
- n. 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.

9.2 Other Officials of the Staff

9.2-1 Chief of Service

- a. Qualifications, selection, and terms of office shall be pursuant to the Bylaws for the governance of the University of Medicine and Dentistry of New Jersey (UMDNJ), Article II, Title C, Section 4. Unless otherwise specified by the Board of Trustees, the Chairman 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 after consultation with the President and President-elect of the Medical Staff and presented to the MEC for approval.
- b. Duties include:
 1. Account to the MEC for all professional and medical activities within his or her service.
 2. Organize, implement, and supervise the administration of his or her service.
 3. Develop and maintain departmental goals, objectives, policies and procedures and all programs regarding research.
 4. Organize and implement a quality assessment system for patient care that includes, but is not limited to, morbidity and mortality analysis and conferences as part of an overall program of quality assurance.
 5. Ensure that monthly service meetings are held and minutes are maintained which reflect patient care reviews.
 6. As a member of the MEC, give guidance on the overall medical policies of the Hospital and make specific recommendations and suggestions regarding his or her own service.
 7. Maintain continuing review of the professional performance of all practitioners with clinical privileges within the service.
 8. Transmit to the appropriate authority, as required by Articles VI, VII, and VIII, recommendations concerning appointment and classification,

reappointment, delineation of clinical privileges or specified services and corrective action with respect to practitioners in his or her service.

9. Appoint such committees as are necessary to conduct the functions of the service, as specified in Article VII, Section 4 and designate a chairperson and secretary for each.

10. Participate in every phase of medical administration of his or her service through cooperation with the nursing service and other hospital departments.

11. Assist in the preparation of such annual reports pertaining to his or her service, as may be required by the MEC, the CEO or the Board of Trustees.

12. Appoint an appropriate practitioner of the service to act in the chairperson's absence.

13. Perform such other duties commensurate with his or her office as may, from time to time, be reasonably requested of him or her by the President, the MEC or the Board of Trustees.

9.3 Administrative Officers

The Board of Trustees may appoint additional practitioners to administrative positions within the Hospital, e.g., Medical Director, 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:

- b. Reading and acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting.
- c. Reports from the CEO, the President of the Staff, Chiefs of Service, and certain committee chairperson, as deemed appropriate.
- d. The election of officers and at-large representatives of the Staff as required by these Bylaws.
- e. 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 Staff category required to attend meetings under Article IV shall be required to attend:

- a. The annual Staff meeting
- b. At least 50% of all meetings of each service or committee of which he or she is a member.

10.7-2 Absence from Meetings

Any member who is compelled to be absent from any Staff, service or committee meeting shall notify the regular presiding officer thereof, the reason for such absence. Absence without good cause shall be duly recorded by the presiding officer, and repeated absences may be cause for removal.

Failure to attend the required number of Staff meetings without good cause may result in action for removal from Staff membership.

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

The determination of the need for 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.

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

Annual review of the Bylaws is the responsibility of the Bylaws Committee.

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.

Accepted by the Medical Executive Committee on July 24, 2001 and approved by Staff Ballot on July 31, 2001.

SIGNATURE ON FILE _____
President of the Medical Staff Date

SIGNATURE ON FILE _____
Secretary/Treasurer of the Medical Staff Date

SIGNATURE ON FILE _____
Chairperson, Medical Executive Committee Date

SIGNATURE ON FILE _____
Approved by Board of Trustees Representative Date