Hackensack Meridian *Health*
Bayshore Medical Center

BAYSHORE MEDICAL CENTER
Medical Staff Rules and Regulations

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Bayshore Medical Center
Medical Staff Rules and Regulations

The Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within the Bylaws, subject to the approval of the Medical Executive Committee. These shall relate to the proper conduct of Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the Hospital. The Medical Executive Committee shall approve such Rules and Regulations as may be necessary for the proper conduct of the Staff. Such Rules and Regulations may be amended at any regular meeting of the Medical Executive Committee, without previous notice, by a two-thirds (2/3) vote of the total membership of the Medical Executive Committee.

SECTION I: GENERAL RULES AND REGULATIONS

The purposes of the organized Medical and Dental Staff shall be to strive towards assuring that patient care is consistently aligned with the Institute of Medicine's six domains of health care quality: 1) the safety of the patient and that we do no harm to the patient, 2) effective, 3) timely care to our patients, 5) efficient, 6) provide patient care regardless of religion, race, age, gender, and financial and social ranks in society, and the addition of 7) mutual respect and appreciation of the Medical Staff, Administration and Nursing Staff.

PART ONE: ADMISSION OF PATIENTS

1.1 Patients may be treated only by physicians or Allied Health Professional Staff members who have proper credentials and who have been duly appointed to membership on the Staff, except as otherwise provided by these Rules and Regulations.

1.2 Except in cases of extreme emergency, no patient shall be admitted to the Hospital until after a provisional diagnosis has been stated by the attending physician.

1.3 <u>Admission of Pregnant Patients.</u>
Due to the lack of maternal/child unit at BCH, any pregnant patient with an estimated gestational age (EGA) of 20 weeks or more that requires admission/observation will be transferred to a facility that regularly provides OB related services as soon as they are deemed stable for transfer by the treating physician.

Pregnant patients <20 weeks gestation may be admitted to BCH when appropriate, but OB/GYN consultation is required.

PART TWO: ORDERS

2.1 All orders for treatment shall be in writing, dated, timed and authenticated by the responsible practitioner. An order shall be considered to be in writing if dictated to a registered nurse or other licensed professionals. The individual accepting the order must sign his/her name to the dictated order. All telephone orders/verbal orders will be completed within the timeframe of Medical Record Completion (within 30 days as per The Joint Commission and CMS). For all Medicare admissions, the admission order must be countersigned or validated by the admitting physician prior to discharge from the hospital, including telephone admitting orders. Physicians may give telephone orders to the following: registered nurses, respiratory therapists, pharmacists, physical therapists, dieticians and physician assistants. Verbal orders will only be accepted in emergency situations when writing an order would put the patient at risk of death or sever injury. Physicians may call in a DNR order to a nurse with a second nurse verifying the order.

2.2 Orders for narcotics are to be renewed every ninety-six (96) hours. phenobarbital, prescribed for hospitalized patients for control of epileptic disorders, will be exempted from the institution's automatic stop order policy. Thus, the drug intended for such indications should not be discontinued without the prescriber's order.

PART THREE: MEDICAL RECORDS

3.1 The attending physician shall be held responsible for the preparation of a complete medical report for each patient, according to standards established by the Quality Committee. All physicians joining the staff will be required to use CPOE and must maintain at least 75% of orders in CPOE. No medical record shall be filed until it is complete, except on order of the Quality Committee.

3.2 The physician shall be responsible for an appropriate history and physical examination which must be completed and a typed copy of the H&P placed on the chart within twenty-four (24) hours after admission and must be dictated on the same day that it is performed. A handwritten admitting note or EMR note should be entered should be entered on the chart at the time of the physical. If part of the physical examination is deferred, the reason for such deferment shall be noted on the chart. The history and physical can also be done within 30 days before admission and always prior to surgery. Medical Clearance may be used as an H&P provided it contains all of the elements of an H&P and is updated by the

surgeon. When a history and physical is completed within 30 Days **PRIOR TO** inpatient admission or registration of the patient, an update is required within 24 hours **AFTER** the patient physically arrives for admission/registration but starts when the patient physically presents for admission/registration. **NOTE:** The term 'registration' generally applies to patients scheduled for same day or outpatient procedures. A member of the Medical or Dental Staff shall be responsible for the update of the history and physical. If the dictated history and physical is not available to be placed on the chart prior to surgery, the surgeon will leave a handwritten short form H&P with pertinent findings on the chart. Licensed physicians not on staff at the hospital may perform a preoperative history and physical exam but under these circumstances the physician performing the procedure must confirm the document by signature and update if needed within 24 hours by signing off on them. Podiatric patients admitted for care or having a procedure in the Operating Room (O.R.) shall have a comprehensive History and Physical examination performed by a licensed Medical Doctor, licensed Osteopathic Doctor or a licensed Podiatrist who is a member of the Medical and Dental Staff with admitting privileges. The Podiatrist is authorized to perform the history and physical examination only on their podiatric patients and the H&P must conform to the standards outlined in these Medical Staff Rules and Regulations. Minor Podiatry surgery requires only a short form H&P.

3.3 A medical record should contain the following:

a) Identification data including patient's name, address, date of birth, and next of kin.
b) Identifying number.
c) Medical history obtained from patient, whenever possible, or relative.
d) Report of relevant physical examination.
e) Diagnostic and therapeutic orders should be signed and dated by the physician.
f) Clinical observations, including result of therapy.
g) Reports of procedures, tests, and results.
h) Summary at termination of hospitalization or evaluation/treatment. (Discharge Summary) The clinical resume should concisely recapitulate the reason for hospitalization, the significant findings, procedures performed, treatments rendered the condition of the patient on discharge, and any specific instructions given to the patient and/or family as pertinent. Consideration should be given to instructions relating to physical, medication, diet and follow-up care. The condition of the patient on discharge should be stated in terms that permit a specific measurable comparison with the condition on admission, avoiding the use of vague relative terminology such as "improved." The summary must be completed within thirty (30) days.
i) All notations should be signed, timed and dated.
j) Nurses' notes.

k) Evidence of appropriate informed consent.
l) Progress notes and consultations.
m) History and physical examination must be on the patient's chart within 24 hours of admission.

3.4 The content of a History and Physical will contain the following:

- Patient's chief complaint
- Present illness including reason for admission
- Past medical and surgical history
- Medications (may refer to medications list)
- Allergies
- Review of systems
- Relevant past social, family and psychosocial history
- Physical examination
- Conclusions/impressions
- Plans/course of action

The committee will be responsible for monitoring, on an appropriate basis, the adequacy of the H&P.

3.5 All records are the property of the Hospital and shall not be removed except by subpoena, court order, or statute. In cases of readmission of a patient, all previous records shall be made available for the use of the attending physician.

3.6 Short Stay operative procedures may be done with a short form H&P. All other procedures must have a long form H&P. Patients receiving General anesthesia or Moderate Conscious Sedation must have a written Preoperative anesthesia assessment. All procedures requiring general anesthesia or anticipated moderate sedation will require a H&P.

3.7 Operative Procedures:
All charts must contain a preoperative diagnosis written by a surgeon before the operation can be performed. At the completion of the operation/procedure the operating surgeon or proceduralist will enter a post-operative note into the medical record. This will be available on the chart before the surgeon or patient leaves the PACU. Additionally, a full operative report will be dictated by the operation surgeon or proceduralist. This report should be dictated as soon as reasonably possible, but in no event beyond 24 hours after surgery. Medical Staff members with outstanding Operative Report dictations shall be notified via telephone that he/she is required to dictate an Operative Report by 3:00 p.m. the following day to avoid the suspension of invasive procedure privileges. Should a physician fail to dictate the Operative Report within the specified time period, the physician shall be notified by telephone and fax that suspension has been invoked. All tissue removed at operations shall be sent to the Hospital

Pathologist who shall make such examination as he/she may consider necessary to arrive at a diagnosis and he/she should sign his/her report. Exemptions include foreskins from newborn circumcisions, orthopedic hardware removed in the absence of significant complications, all stents, PEG's, implanted venous access devices, pacemakers, IUD's, pessaries, and other foreign bodies removed at endoscopy, and cataracts. All exemptions require that the physician performing the procedure write a note describing the "specimen" removed and indicating that there is no need for examination by a pathologist.

3.8 All Hospital records, including non-inpatient service and procedures, will be completed within a reasonable period of time, not to exceed thirty (30) days; a warning notice will be sent ten (10) days previously. Should the record not be complete within this period, the practitioner shall be subject to suspension through the office of the President of the Hospital. Suspension shall be defined as the temporary loss of ordinary privileges. Physicians who are on suspension should not be permitted to: 1) admit patients, 2) accept transfers, 3) accept consultations, 4) take E. D. call, or 5) carry out procedures. These privileges will not be restored until the Medical Record Administrator has notified the President of the Medical Staff that the record has been completed and this will take place only during the regular hours of the Medical Record Department. Should a suspended practitioner violate these rules, he/she shall be liable to additional penalties as determined by the President of the Hospital and the President of the Medical Staff.

3.9 If a physician is suspended for medical records delinquency and knowingly continues to see patients, perform consults or engage in any activities prohibited while on suspension, the physician will be required to attend the Credentials Committee meeting. Continued disregard for the edicts of suspension will be considered a valid reason for summary suspension.

4.0 Recording errors in the medical record shall be corrected by drawing a single line through the incorrect entry. The date of the correction and legible signature or initials of the person correcting the error shall be included.

PART FOUR: GENERAL RESPONSIBILITY FOR AND CONDUCT OF CARE

4.1 Every patient should be visited as frequently as necessary in accordance with the state of the patient, the diagnosis, and consistent with good medical care but not less than daily. An entry in the progress note should be made for each encounter.

4.1.1 The collaborating/supervising physician may not abdicate his role in providing medical care to the patient and must continue to provide daily visits to all patients of which he is the attending physician of record, or weekly visits to

those patients for whom he is consulted. Consultants need to only visit those patients with active medical problems when that physician was consulted by another physician.

4.2 A doctor who is admitting a patient to another doctor's service must notify the doctor to whose service he/she is admitting and must continue care until the attending takes over the case. If a consultant evaluates and admits a patient to another physician's service, he/she is responsible for notifying that doctor prior to the transfer with the approval of the accepting physician.

4.3 It is the responsibility of each member of the Staff to provide adequate coverage for his/her patients in his/her absence. Coverage must be submitted in writing to the Medical Staff Office. In case of failure to provide such coverage, the President of the Staff or the President of the Hospital shall have the authority to call any member of the Active Staff he/she considers necessary.

4.4 In the event that a physician in unavailable it is the responsibility of that physician to arrange for coverage for their practice. The covering physician is responsible for acting in a manner consistent with that of the physician he is covering. In doing so, he must accept all patients belonging to or referred to the physician being covered. In addition, he is responsible for continuing timely diagnosis, treatment and disposition of the patient as if he were the physician he is covering. This includes responding within the times frames stipulated in the Rules and Regulations and maintaining constant availability for the duration of the coverage.

4.5 Abandonment of a hospitalized patient before an alternate physician with appropriate clinical privileges accepts the patient may be grounds for corrective action.

4.6 When doubt exists as to diagnosis, treatment, or management, appropriate consultations must be sought in dealing with any patients. The consultant must respond to the call within 24 hours. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall, except in emergencies so verified in the record, be recorded prior to the operation. The consultation report shall be written, if possible, at the conclusion of the consultation visit. It is mandatory that patients who are admitted and are on vents and/or C-Paps, including non-invasive ventilation have a pulmonary consult immediately as a STAT consult (physician communication required). Patients that bring their own C-Pap equipment to the hospital do not need a pulmonary consult. The

physician can write an order that the patient may use their own equipment however the physician cannot change the settings.

4.7 Every patient twelve (12) years of age and who is admitted shall receive a pediatric consultation.

4.8 It is required that a psychiatrist and the Social Services Department be consulted within twenty-four (24) hours in all cases where the patient is admitted because of attempted suicide.

4.9 Physicians admitting patients shall be held responsible for giving such information as is known to him/her to assure protection of other patients from those who are a source of danger from any cause whatsoever.

5.0 Physicians are expected to respond to all calls by phone or in person from anywhere in the hospital (excluding the Emergency Department., *See 10.1*) within 30 minutes or being called.

PART FIVE: CRITICAL CARE UNIT

5.1 All medical, surgical and neuro patients admitted to the Critical Care Unit shall have a consultation immediately ordered with an intensivist upon admission to the Critical Care Unit. Patients with a primary diagnosis related to the cardiovascular system may be managed by a cardiologist in lieu of an intensivist. Intensivist privileges will only be approved if the group agreed upon is contracted.

5.2 Patients being admitted to the ICU must be seen by the attending physician or a consultant within a medically appropriate time limit not to exceed eight (8) hours of admission. The consulting intensivist shall co-manage the patient for the duration of their stay in the Critical Care Unit. When the patient no longer meets ICU criteria, the Intensivist co-managing the patient will notify the attending physician to facilitate transfer arrangements. When ICU needs exceed capacity, the intensivist is responsible for triaging.

PART SIX: DISCHARGE OF PATIENTS

6.1 Patients are to be discharged only on written order of the attending physician. At the time of discharge, the physician shall see that the record is complete, state his/her final diagnosis, and sign the record.

PART SEVEN: HOSPITAL DEATHS AND AUTOPSIES

7.1 Every member of the Staff shall be actively interested in securing autopsies. No autopsy shall be performed without written consent of a responsible relative or authorized person.

PART EIGHT: CONSENTS

8.1 With the exception of a documented medical emergency, all medical and surgical treatment shall be performed only with the permission of the patient or his/her legal representative after and informed consent has been given which shall be documented.

PART NINE: AHP SURGICAL REQUIREMENTS

9.1 All RNFA's will be credentialed through the medical staff process and will be reviewed by the department Chair where the RNFA is working.

PART TEN: EMERGENCY DEPARTMENT REQUIREMENTS

10.1 Physicians who do not respond within 20 minutes should be subject to disciplinary action such as loss of E.D. call or ICU privileges. Disciplinary actions should be carried out by the respective Department Chair with referral to the Credentials Committee if deemed necessary.

10.2 If there is a conflict between the E.D. physician and the attending physician regarding assignment of a case or urgency to come and evaluate the patient, the opinion of the E.D. physician will prevail until the patient is seen by the attending. If disagreement still persists, the Chair of the service involved should be called.

10.3 A medical screening examination as defined by EMTALA may be performed by a licensed physician or a PA or Nurse Practitioner working under the supervision of that physician. A medical screening examination and such further treatment as may be necessary to stabilize an emergency medical condition for any individual coming to the ED seeking treatment, regardless of the individual's medical or psychiatric condition, race, religion, age, gender, color, national origin, immigration status, sexual preference, handicap, or ability to pay. (As per Meridian Health policy EMTALA-MHC-ADMIN-02-1002)

10.4 If a particular specialty is not available or the on-call physician cannot respond due to circumstances beyond his/her control, the respective Department Chair will be called. If permission is given to physicians to take simultaneous call,

scheduling elective surgery while on call or other required procedures required by EMTALA and the physician cannot be reached, the Chair of the Department will be called.

PART ELEVEN: REVIEW AND AMENDMENT

11.1 These Rules and Regulations shall be reviewed or revised on an as needed basis.

SECTION II: MEDICAL STAFF ORGANIZATION

PART A: MEDICAL STAFF DEPARTMENTS

A Each department shall establish a set of standard operating procedures for routine situations to be approved by the Medical Executive Committee. A quorum for these meetings is described in the Bylaws, Article XIV, 14.4, stating a count of 50 for Semi-Annual Staff meetings and 15% for all other meetings.

A-1 Each department is encouraged to review its own rules and regulations with regard to admission of patients, use of consultants, responsibilities for coverage and disciplinary actions to be taken when these rules are violated.

A-2 Organization of Clinical Departments and Services

Each department shall be organized as a separate part of the Staff and shall have a Chair who shall be responsible for the overall supervision of the clinical work within his/her department. The departments are as follows:

Department of Medicine
Department of Surgery
Department of Orthopedic Surgery
Department of Pediatrics
Department of Anesthesiology
Department of Pathology and Clinical Laboratories
Department of Emergency and Ambulatory Care Services
Department of Radiology
Department of Urology
Department of Physical Medicine and Rehabilitation

A-3 Organization of Clinical Sections

a. When the need arises, the Medical Executive Committee, with the approval of the Board of Trustees, may create various clinical sections comprised of two (2) or more members in a specified area of practice as a section assigned to one (1) or more of the various clinical departments.

b. A clinical section may be organized by the Medical Executive Committee after receipt of a statement signed by two (2) or more members setting forth their desire to organize such a section. At that time, the Chair of the department who most likely would be involved in the supervision of the section will be assigned to assist the members in preparing a statement to be submitted to the Medical Executive Committee. (This statement will set forth the manner in which the section would be organized and its affairs conducted.) This statement will be submitted, along with proposed rules and regulations for the section. Upon submission to the Medical Executive Committee of such a statement and the proposed rules and regulations for the section, the Medical Executive Committee shall determine whether or not such a clinical section should be organized, and if so, which department will supervise the activities of the section.

c. The initial Section Chief shall be appointed by the Chair of the department for a term of one (1) year. If the section remains established the initial Section Chief will be appointed for an additional two (2) years subject to the approval of the Medical Executive Committee. Subsequent Section Chief's shall be elected in the same fashion as departmental Chairs for a term of two (2) years. All Chiefs of sections must be Attendings and their appointments approved by the Medical Executive Committee. In accordance with the Bylaws, exceptions may be made for an appointment more than 2 years if there no Section member meets the Division's qualifications or the Section has less than six (6) members.

d. The members of a section will be required to attend meetings of the supervising department and shall vote in that department.

e. Members shall be recommended for assignment to sections in the same fashion as they are recommended for assignment to departments by the Credentials Committee. Members may be assigned to more than one department and more than one section at the same time; however, a member may only vote in one department and in his/her respective section(s). Any physician to whom this may pertain must declare at the time of appointment in which department he/she will always vote.

f. At the same time as two-thirds (2/3) of the total membership of the section votes to make application for departmental status, such application shall be made to the Medical Executive Committee, in writing, setting forth the reasons why the section should be accorded departmental status and incorporating the written recommendation of the Chair of the department or departments supervising the section respecting whether or not departmental status should be accorded the section. The application for departmental status

shall include a complete set of proposed rules and regulations for the new department.

g. The Medical Executive Committee shall determine and recommend to the Board of Trustees whether or not departmental status will be accorded the section. The Medical Executive Committee, if it determines that departmental status will not be accorded, will set forth those criteria which the section must achieve in order to be accorded departmental status.

h. In the event that the Medical Executive Committee determines that departmental status will not be accorded the section, the section may, by a two-thirds (2/3) vote of the total membership of the section, initiate a review of the determination by the Medical Executive Committee, pursuant to the hearing procedure set forth in the Bylaws.

i. Each Section shall be organized as a separate part of the Staff and shall have a Section Chief who will be responsible for the overall supervision of the clinical work within his/her Section. The Section Chief will report to the Department Chair. The Clinical Sections are as follows:

- Podiatry Section, Department of Orthopedic Surgery
- Psychiatry Section, Department of Medicine
- Cardiology Section, Department of Medicine
- Pain Medicine Section, Department of Physical Medicine and Rehabilitation

A-4 Family Practice

a. Family practitioners shall have clinical privileges in one or more departments in accordance with their education, training, experience and demonstrated competence. They shall be subject to all of the rules of such departments and to the jurisdiction of each department Chair and/or service Chair involved.

b. Each Family Practitioner shall be assigned to one clinical department for purposes of participating in the required functions of the Staff, for holding office and for fulfilling all of the other obligations which go with Staff membership. This should be the department in which the Family Practitioner is most active and interested and this is the only department where he/she may vote.

PART B: MEDICAL STAFF COMMITTEES

B. Committee Assignments

a. With the exception of those members who serve ex officio and where otherwise designated, all committee Chairpersons and members are appointed

by the President of the Medical Staff with the advice and consent of the Medical Executive Committee. With the advice and consent of the Medical Executive Committee, the President may remove and replace a committee Chairperson. With the advice and consent of the Medical Executive Committee, and upon the recommendation of a committee Chairperson, the President of the Medical Staff may be instructed to remove and replace a committee member. Additional physicians may be appointed to committees, other than the Medical Executive Committee, at the discretion of the President of the Medical Staff, with the advice and consent of the Medical Executive Committee.

b. In order to equitably share Staff responsibilities, it is required that each Active member serve on at least one (1) committee. He/she shall be obliged to attend a minimum of fifty (50) percent of committee meetings over a period of one (1) year.

c. Except where otherwise provided, a quorum shall consist of those present and voting. Each committee shall consist of a minimum of six (6) members of the Medical Staff.

d. The President of the Hospital, or his/her designee, is an ex officio member of all Medical Staff committees without vote. The Chief Medical Officer will be an ex officio member of all Medical Staff committees without vote. The President of the Medical Staff is also an ex officio member of all such committees without vote with the exception of the Medical Executive Committee where he/she is a voting member.

e. Every committee is established for the purpose of providing efficient, safe quality care to the patients at Bayshore Medical Center, properly furnished with modern equipment and trained personnel.

f. The only individuals who can vote on Medical Staff committees are physician members of the committees.

The standing committees provided for in the Bylaws are:

Bioethics Committee
Bylaws Committee
Credentials Committee
Critical Care Committee
Operating Room Committee
Nominating Committee
Pharmacy and Therapeutics Committee
Medical and Dental Staff Quality Committee
Professional Assistance Committee; and
Joint Conference Committee.

In addition to these standing committees provided for in the Bylaws, the following committees are hereby created in these Rules and Regulations:

B-1 Bylaws/Rules and Regulations

a. Composition: The Bylaws/Rules and Regulations Committee shall consist of a chairperson who will be appointed by the Medical Staff President, and at least six (6) members of the Medical Staff appointed by the President. One half (l/2) of the total membership of the Bylaws/Rules and Regulations Committee shall constitute a quorum.

b. Duties: The Bylaws Committee shall be responsible for entertaining and recommending changes in the Bylaws/Rules and Regulations in order to improve patient care and the functioning of the Medical Staff. All such changes must emanate from this Committee although suggestions will be entertained from the Medical Executive Committee and the general Medical Staff.

c. Meetings: The Bylaws/Rules and Regulations Committee shall meet as needed but at least annually to review the Bylaws and shall maintain a written record of its findings, proceedings, and actions and shall make a report to the Medical Executive Committee.

B-2 Cardiology/Cardiac Catheterization P.I. & Peer Review Committee

a. Composition: The Cardiac Catheterization Performance Improvement Committee will be appointed by the President of the Medical Staff. Members will include the Chief of the Cardiology Section and the Director of the Cardiac Cath Lab, the Chair of the Department of Medicine, the Nurse Coordinator for the Cardiac Cath Lab, at least one cardiac surgeon from a hospital to which a major portion of the cases are referred for surgery (as an advisor without vote) and other cardiologists, physicians and nurses as appointed by the President.

b. Duties: The Committee will evaluate the indications for catheterization, the degree to which cases are limited to low risk patients, mortality and morbidity rates, percentage of normal studies, and any additional quality issues that may be indicated.

c. Meetings: The Cardiology/Cardiac Catheterization Peer Review Committee shall meet as needed but at least quarterly to review the Bylaws and shall maintain a written record of its findings, proceedings, and actions and shall make a report to the Medical Executive Committee.

B-3 Credentials Committee

a. Composition: The composition of the Credentials Committee will consist of the Chairs of each medical staff department and any other physicians appointed by the President of the Medical Staff. The Credentials Committee Chair will be appointed by the Medical Staff President.

b. Duties: The Committee will review and evaluate the qualifications and credentials of each applicant and Health Professional Affiliate for initial appointment, reappointment (if requested by the Department Chair), or

modification of appointment or Clinical Privileges (if requested by the Department Chair), and in connection therewith, obtain and consider the recommendations of the appropriate Departments.

Recommend to the Medical Executive Committee criteria for new procedures or expansion of Privileges and resolve issues of overlap of Department Privileges.

c. Meetings: The Credentials Committee shall meet at least ten (10) times a year and shall maintain a written record of its findings, proceedings, and actions and shall report on the status of applications, actions regarding any changes in the status of the medical staff and Allied Health Professionals, and expansion of privileges. The Committee shall resolve any issues of overlap of Department Privileges to the Medical Executive Committee.

B-4 Critical Care Committee

a. Composition: The composition of the Critical Care Committee will consist of the ICU Intensivists, the Chief of Cardiology, and other physicians appointed by the President of the Medical Staff. The Chair will be appointed by the President.

b. Duties: The committee will review and evaluate patients that are admitted and discharged for criteria for ICU and Telemetry. The committee will be responsible to review policies for ICU and review infection control, ventilator days and ventilator utilization, oversee respiratory, nutrition and policies pertaining to the Critical Care Unit. Any changes in policies and clinical decisions will be forwarded to the Medical Executive Committee for approval.

c. Meetings: The Critical Care Committee will meet bimonthly and shall maintain a written record of its findings. The Committee shall report its findings to the Medical Executive Committee.

B-5 Emergency Services/Throughput Committee

a. Composition: The Chair of the Committee will be appointed by the President of the Medical Staff. The Members of the Committee will include the Department Chairmen, Section Chiefs, any ER Physicians that can attend, a Hospitalist representative, and the Manager of Resource Management.

b. Duties: The committee will facilitate the traffic of the patient from admission to the ER to discharge. The committee will look at the assessment of the patient based on risk, and not opinion, to see if the patient should be discharged, admitted as observation, or admitted as an inpatient.

c. Meetings: The Emergency Services/Throughput Committee will meet monthly and shall maintain a written record of its findings. The Committee shall report its findings to the Medical Executive Committee.

B-6 Endoscopy

a. Composition: The Endoscopy Committee shall be multi-disciplinary in nature, its membership consisting of a Chairperson who shall be a recognized endoscopist, physicians and surgeons who do endoscopic procedures and nursing staff who are involved in the care of endoscopy patients.

b. Duties: The purpose of the Endoscopy Committee is to maintain an endoscopy facility that is efficient and safe. The performance of endoscopic procedures will be evaluated periodically to determine quality and appropriateness. The Committee shall be responsible for finding solutions to problems which relate to the efficient use of the Endoscopy Room.

c. Meetings: The Endoscopy Committee shall meet on a quarterly basis, shall maintain a permanent record of its proceedings and activities and shall submit a report thereof to the Medical Executive Committee.

B-7 Hearing and Appellate Review/Investigating Committee

a. Composition: The Investigating Committee shall consist of the members appointed by the President of the Medical Staff) and the MSO. The Chair of the committee shall be appointed by the President of the Medical Staff. If any member of the committee has an economic or other conflict of interest with the LIP being investigated that member may self-recuse or be recused by the President of the Medical Staff. If the President of the Medical Staff is being investigated, the immediate past President of the Medical Staff shall function as the President for the investigation. The Hearing and Appellate Review/ Investigating Committee report shall be reviewed by the full Credentials Committee before being presented to the Medical Executive Committee. Any interviews with a LIP being investigated must be attended by at least 2 members of the committee.

b. Duties: The purpose of this committee is to investigate any conduct issues if required by policy.

c. Meetings: The Investigating Committee shall meet as needed, shall maintain a permanent record of its proceedings and shall submit reports thereof to the Medical Executive Committee.

B-8 Infection Control

a. Composition: The Infection Control Committee is a Medical Staff committee with multidisciplinary participation. The President of the Medical Staff will appoint the physician members of the Committee, including a physician chairperson who is known to have interest and expertise in infectious diseases. The Committee is comprised of a chairperson, the Infection Control Coordinator, the Director of Nursing, and a Hospital administrator or their designees. The Committee also includes as advisory members a pathologist, the Director of

Surgical Services, a surgeon, a medical doctor, a representative from Bacteriology, the Director of Dietary, the Director of Pharmacy, the Director of Environmental Services, the Director of Central Sterile Supply, the Director of Plant Operations, the Director of Respiratory Therapy, the Director of Cardiac Services, the Employee Health Coordinator and the Director of Quality Improvement or designees. These persons may attend when agenda items are relevant.

b. Duties: The Committee will perform the functions outlined in the policies and procedures of the Infection Control Department. The role of physicians on the Committee should be to provide direction and strengthen the clinical aspects of the program. Policies and clinical decisions will be made by the Committee only when an appropriate physician member and Hospital administrator are present. The Infection Control Committee will determine the type of surveillance and reporting mechanisms to be used. The Committee will provide standard criteria for reporting and evaluating all types of infections. The Committee will review medical records for unexpected infections.

c. Meetings: The Committee shall meet every other month or at least six (6) times a year, shall maintain a record of its proceedings and activities, and shall report thereon to the Medical Executive Committee. A copy of the minutes are forwarded to the Chief Operating Officer, the Nursing Administrator and the V.P. of Medical Affairs. The Infection Control Committee will report its findings and recommendations to the Medical Staff through the Medical Executive Committee.

B-9 Information Technology

a. Composition: The Information Technology Committee shall consist of a number of physicians determined by the President of the Medical Staff.

b. Duties: To enforce the privacy, confidentiality, integrity and security of patient/clinical health information through the development of policies and procedures, mediate infractions and issue sanctions, determine and enforce clinical documentation standards to promote continuity of care, encourage proper use information, and to develop a mechanism for patient information and ensure that Information Technology supports the collection and analysis of clinical and administrative data.

c. Meetings: The Information Technology Committee shall meet as needed, shall maintain a permanent record of its proceedings and shall submit reports thereof to the Medical Executive Committee.

B-10 Joint Practice/Private Practice Committee

a. Composition: The Joint Practice/Private Practice Committee shall consist of a number of physicians determined by the President of the Medical Staff. The Chair of the Committee shall be appointed by the President of the

Medical Staff.

b. Duties: To discuss healthcare changes and to exchange ideas about technology, insurance, computer systems, and issues to improve private practice to facilitate interaction with the hospitals and to share technology and ideas.

c. Meetings: The Joint Practice/Private Practice Committee shall meet monthly, shall maintain a permanent record of its proceedings and shall submit reports thereof to the Medical Executive Committee.

B-11 Medical Education/Library

a. Composition: The Medical Education/Library Committee shall be composed of a Chairperson who is appointed by the President of the Medical Staff. Membership shall include members of the Medical Staff, the Hospital Librarian, and a representative from the Nursing Services and Administration.

b. Duties: The primary purpose of the Committee is to establish and maintain a multidisciplinary core library within the Hospital. The Committee will also establish and approve library policies and procedures. It will be responsible for ongoing medical education for the Medical Staff and shall post a yearly curriculum of ongoing medical education within the Hospital. At least annually, the Committee will evaluate the books and journals in the Library and establish priorities on ordering new texts, journals and other library materials. Annually, the Committee will evaluate the usage and effectiveness of the Library in meeting the informational and educational needs of its users.

c. Meetings: The Medical Education/Library Committee shall meet at least quarterly, shall maintain a permanent record of its proceedings and finances, and shall make a written report to the Medical Executive Committee.

B-12 Multi-Disciplinary Peer Review Committee

a. Composition: The Multi-Disciplinary Peer Review Committee shall be composed of Chair/Section Chief of each of the disciplines as well as any others appointed by the President of the Medical Staff. The Chairman of the Committee will be the Chair of the Department of Medicine.

b. Duties: The purpose of this committee will be to provide a fair, unbiased, reproductive system of review with respect to all practitioners. A wide variety of cases will be referred for review. Cases will include mortality; untoward outcome; complications; hospital readmissions; etc. Depending on the surgical discipline to be reviewed, the PI nurse will, in consultation with the Department/Section Chief, assign a reviewer from the discipline to review the case.

1. the reviewer may not be a member of the Multi-Disciplinary Case Review Committee
2. an individual may not review his/her own case or that of a partner
3. the reviewer will complete the appropriate portion of the case

review sheet and make recommendations to the committee
4. the individual reviewer shall not discuss the case with the Practitioner under review

The committee will convene, review and create a disposition on all cases.

1. Either the committee or the physician reviewer may choose to have the physician reviewer present their findings before the committee
2. The committee may choose to have the practitioner whose case is under review, appear before the committee
3. The committee will review not only cases but will also help determine rule and rate indicators for services

c. Meetings: The Multi-Disciplinary Performance Improvement Committee shall meet on a monthly basis with the time designated by the Chair, shall maintain a permanent record of its proceedings and finances, and shall make a written report to the Medical Executive Committee.

B-13 Nominating Committee

a. Composition: This Committee shall be composed of elected member(s) from each Department as provided for in the Rules and Regulations of the Division. The Committee shall elect its own Chair annually. Members of the Committee shall be ineligible for nomination by the Committee.

b. Duties: The Committee shall consult with Members of the organized Medical and Dental Staff concerning the qualifications and acceptability of the Prospective nominees. The committee will nominate and submit one or more Qualified candidates for each elective office.

c. Meetings: The Nominating Committee shall meet as needed, shall maintain a permanent record of its proceedings, and shall make a written report to the Medical Executive Committee.

B-14 Operating Committee

a. Composition: This committee shall be composed of the Chairs of the Departments of Surgery, Anesthesiology, Urology, Orthopedics, and Section Chiefs that utilize the Operating Room, and such other representatives who are deemed appropriate by the President of the Medical and Dental Staff or Medical Executive Committee. The Chair of Surgery shall be the Chair of the O.R. Committee.

b. Duties: The Committee shall review, make recommendations on, and assure the implementation of policies and procedures governing surgical facilities and functions, including but not limited to:

1. scheduling, reserving, prioritizing, and otherwise accessing facilities, including emergencies:

2. prompt and efficient utilization of facilities;

3. pre-operative requirements, including patient identification, preoperative medical evaluation and documentation, consent forms, and otherwise ensuring quality of care standards are satisfied; care and transport of patients; outpatient operations; infection, conductivity, and other environmental control; radiation safety; monitoring the maintenance and purchasing surgical instruments, including lasers; innovation and new technology; and review of financial impact of O.R. management and efficiency.

c. Meetings: The Operating Room Committee shall meet on a monthly basis with the time designated by the Chair, shall maintain a permanent record of its proceedings and finances, and shall make a written report to the Medical Executive Committee.

B-15 Pharmacy & Therapeutics Committee

a. Composition: The Pharmacy and Therapeutics Committee shall be composed of a Chair as well as any others appointed by the President of the Medical Staff.

b. Duties: The purpose of this committee is to review, make recommendations as to, and oversee implementation of policies and procedures addressing;

1. administration of drugs.
2. use of patients' previously acquired drugs, including requirements for physician orders and pharmacy identification of the drugs before use,
3. Storage and distribution of drugs,
4. Stop orders and discontinue orders
5. Identification, reporting, reviewing and monitoring of adverse Drug reactions and medication errors,
6. identification of food/drug interactions and coordination of the responsibilities of the pharmacy, nursing and food services
7. Make recommendations concerning drugs to be stocked on the nursing unit floor and by other services.
8. Submit periodic reports and recommendations to the Medical Medical Executive Committee concerning drug utilization p policies and practices in the hospital.

c. Meetings: The Pharmacy and Therapeutics Committee shall meet at least Semi-Annually with the time designated by the Chair, shall maintain a permanent record of its proceedings and finances, and shall make a written report to the Medical Executive Committee.

B-16 Transfusion/Tissue Review Subcommittee

a. There shall be a Transfusion/Tissue Review Subcommittee consisting of a Chairperson and at least four other physicians including a surgeon, a pathologist, and a hematologist/oncologist; the Perioperative Director and the Quality Improvement Coordinator. The major function of the group is to improve patient care by conducting the following quality assessments: 1) Transfusion review will be conducted quarterly with a review of the appropriateness of all blood and blood products transfused, the evaluation of all confirmed transfusion reactions, the adequacy of transfusion services, the development and approval of policies and procedures related to transfusion services, and blood and blood products ordering practices. This review will include data from the Hospital Blood Bank, intraoperative cell salvage, and therapeutic pheresis. There will be an annual review of the screening criteria for all components transfused and all services performed. 2) Surgical case review will be conducted on all cases which did not involve a tissue specimen and on an adequate sampling of cases which did not involve tissue removal to assure that surgery performed is justified and of appropriate quality. In addition, review is to be conducted on all cases where major discrepancies exist between the preoperative and postoperative diagnosis. 3) Surgical indications monitoring will review the appropriateness of surgical procedures as measured against pre-established criteria. Identified concerns will be reported to the Chair of the department involved for further investigation and then reported back to the Chairperson of the Transfusion/Tissue Review Subcommittee. To achieve its purposes, the Transfusion/Tissue Review Subcommittee shall have access to all necessary medical and ancillary records of patients.

The Transfusion/Tissue Review Subcommittee shall meet at least quarterly and at any additional times called by the Chairperson. The Subcommittee must provide a written report of its findings to the overall Performance Improvement Committee. This report must include committee conclusions, recommendations for improvements and actions taken, with documentation of compliance.

B-17 Medical and Dental Staff Quality Committee

a. Composition: Except as otherwise provided, the Medical Staff President, with the concurrence of the Medical Executive Committee, shall determine the composition of each committee, shall appoint and remove its Chair and other members, and shall fill any vacancies. The appointment, removal, and filling of vacancies on committees with employees of the Division who are not members of the Medical Staff shall be jointly made with the President. Committee Chairs shall be and shall have been Attendings in good standing for at least two (2) years. The Medical Staff President or his designee shall serve as a member of all committees, without a vote. Ex-officio members

of committees shall serve for the terms of their respective offices, and other members shall serve for one-year terms and until a successor is appointed.

b. Meetings and Minutes: The Committee shall meet monthly to perform its functions. Minutes shall be kept of each committee meeting and shall be promptly submitted by the committee Chair (or designee) to the Medical Executive Committee.

c. Composition: This Committee shall be composed of at least one Medical Staff member from each Department, The Vice-President for Clinical Effectiveness/Medical Affairs (or his equivalent) or his designee (without vote), and an appointee from the nursing service appointed by the Division (without vote).

d. Duties: The Committee shall:

1. Subject to the approval and authority of the Medical Executive Committee, Division Administration and the Board of Trustees, be responsible for directing the Division's quality in improvement and outcomes program, as implemented through a written quality improvement and outcomes plan which meets all legal, accreditation and institutional requirements, which integrates and coordinates the quality improvement and outcomes activities of the Department and of other Staff and /or Division services, and which provides for continuing review of the program's effectiveness.

2. Adopt, subject to final approval, specific programs and procedures for reviewing, evaluating, and maintaining the quality and efficiency of patient care within the Division, including at least mechanisms for: establishing clinical protocols; objective criteria: measuring actual practice and outcomes against the criteria by peers; taking appropriate action to correct identified problems; following up on actions taken; and reporting the findings and results of such activity to the Medical Executive Committee and the Board of Trustees.

3. Be actively involved in the following: (i) medical assessment and treatment of patients, (ii) use of information about adverse privileging decisions for any Member of the Medical of the Medical Staff, (iii) use of medications: (iv) us of blood and blood components; (v) operative and other procedures: (vi) appropriateness of clinical practice patterns; (vii) significant departures from established patterns of clinical practice; and (viii) the use of developed criteria for autopsies. Information used as part of performance improvement mechanisms, measurement or assessment shall include sentinel event date and patient safety data.

4. Review and act upon, on a regular basis, factors affecting the quality and efficiency of care provided in the Division.

5. Coordinate its activities with those of other committees affecting the quality of care.

6. Submit regular reports to the Medical Executive Committee on the overall quality and efficiency of care provided in the Division and its quality maintenance and monitoring activities.

7. Develop a resource management plan which is appropriate to the Division and which meets legal and regulatory requirements. Such a plan must include provision for at least: (a) review of admissions and of continued Division stay: (b) discharge planning; and (c) data collection and reporting.

8. Require that the resource management plan be in effect, known to the Staff members, and functioning at all times.

9. Conduct such studies, take such actions, submit such reports and make such recommendations as are required by the resource management plan.

10. Submit regular reports to the Medical Executive Committee on resource management activities.

B-18 Miscellaneous Committees

1. The Professional Assistance Committee shall be established on an as needed basis for the purpose of improving internal quality control, reducing morbidity or mortality and improving patient care in accordance with the Bylaws.

2. The Joint Conference Committee is the forum in which the Medical and Dental Staff and Board of Trustees resolve any disputes between the Medical and Dental Staff and Hospitals Corp. or Division administration and may accept requests to resolve differences between or among other Medical and Dental Staff and/or Hospitals Corp. or Division leaders. This committee will also meet on an as-needed basis.

3. The Semi-Annual Staff Meeting will meet on the third (3rd) Wednesday of the Month in June and in December. In order to accommodate Medical Staff members, the June meeting will be held in the evening at 6:00 p.m. and the December meeting will be held in the morning at 11:30 a.m.

SECTION III: MEDICAL STAFF POLICIES AND PROCEDURES

I. All physicians must designate their Primary Division. All other Divisions will be considered secondary.

II. A Staff member who is disabled by virtue of physical or mental illness shall have restrictions to his/her privileges delineated by the Credentials Committee in accordance with the rules set forth by the New Jersey State Board of Medical Examiners. It is required that the physician certify that he/she is mentally and physically able to practice medicine.

III. Physicians must certify that they have earned fifty (50) CME credits in a calendar year or one hundred fifty (150) CME credits over a three (3)-year period of which sixty (60) will be Category 1 as defined by the American Medical Association. If a physician is granted a medical leave of absence during the two-year reappointment period, he/she will be granted an extension of time equal to the leave in which to obtain the necessary credits. Educational activities must relate, at least in part, to the privileges granted.

IV. All physicians must comply with the New Jersey State Department of Health and Senior Services Regulation 8:43 G-20-2 requiring all physicians to have Quantiferon Test upon initial appointment done within the last 12 months. If the facility is declared by the State to be "Low Risk", only ID Physicians, Pulmonologists, Hospitalists, and ER Physicians will be required to have a yearly Quantiferon test. If a physician has a positive result, he/she must submit documentation of having received and completed appropriate medical treatment.

V. All physicians must have an email address and it must be submitted to the Medical Staff Office.

VI. Peer Review and Quality Monitoring - Medical Staff has a leadership role in organizational improvement activities designed to ensure that the findings of the assessment process are relevant to an individual's performance. The medical staff is responsible for determining the use of information in the ongoing and focused professional practice evaluation process of an individual granted clinical privileges. The Multi-Disciplinary Performance Improvement Committee will monitor the overall quality process.

VII. Focused Professional Practice Evaluation (FPPE) – A FPPE will be conducted in the following situations.

1. For all new applicants to the Medical Staff. The FPPE occurs during the period when the new practitioner is on supervision. The conduct and criteria for the FPPE is department specific and should be relevant to the type of privileges requested.
2. When a practitioner requests a new privilege.
3. When any other below triggers are met. This list is not meant to be all-inclusive and criteria not meeting the list stipulated below can be used to trigger an FPPE.
4. A concern about the quality of medical care rendered is raised by medical staff leadership based on:
    - any member of the hospital staff
    - the patient or family
    - any deviation from usual practice
    - deviation from an expected range of values resulting from PI data

collection. This may include items such as resource utilization, length of stay, returns for re-treatment within a period, expected or unexpected complications or adverse events and any and all other indicators of deviant practice.

- The results of patient satisfaction surveys, incidents reports, or confidential compliance data.
- Adverse or negative performance trend over six consecutive months of OPPE.

Repeated failure to follow hospital or medical staff policy, (late to surgery, failure to respond to pages, refusing to allow read back, etc.). Notice from regulatory or peer review agency.

5. When conducting a review any or all of the following aspects may be considered:
   - Through patient care, medical/clinical knowledge.
   - Practice based learning and improvement.
   - Interpersonal communication skills.
   - Professionalism
   - Systems based practice.
   - Patient safety.
   - Medical management
   - Medication use.
   - Patient outcomes data.
6. Resources to utilize:

   Data may be gathered from:
   - chart review
   - chart review
   - direct observations
   - statistical reviews
   - proctoring
   - peer references
   - interviews

Reviews will be sent to Medical Staff leadership and conducted in-house unless it is determined that for reasons of conflict or insufficient expertise that an outside reviewer is required. This decision may be made by the departmental chair or the chairperson of the Multi-Disciplinary PI committee.

VIII. Ongoing Professional Practice Evaluation (OPPE) - Medical Staff will conduct periodic performance reviews of all current medical and affiliated staff. This also will include physician assistants and nurse practitioners. OPPE data will be collected and placed in the physician's file for review by the departmental chair or his designee. Available data will be reviewed every eight months and may come from various sources and reports. Not all reports will be required to be reviewed simultaneously.

The following data may be reviewed.

- Information acquired through periodic chart review.
- Direct observation.
- Monitoring of diagnostic or treatment techniques.
- Discussion with other individuals involved in the care of the patient including consulting physicians, nursing and administrative personnel.
- Reports compiled by medical records, obtained by extraction from the EMR or data collection agency, or other hospital departments.
- Other sources as deemed appropriate.

Aspects of OPPE to be considered may include, but should not be limited to, any of the items below.

1. Medical assessment and treatment of patient.
2. Adverse privileging decision.
3. Use of medications.
4. Use of blood and blood components.
5. Appropriateness and outcome of operative and other procedures.
6. Appropriateness and clinical practice patterns including length of stay, denials, avoidable days.
7. Significant departures from established patterns of clinical practice, department specific indicators, meeting criteria for autopsies.
8. Sentinel event data, patient safety data including Do Not Use abbreviations. Accurate timely and legible completion of medical records including time and quality of H&P's and operative notes. Number of unsigned telephone orders. Patient complaints, patient compliments, coordination of care treatment and services with other practitioners and hospital personnel.
9. Morbidity and Mortality data.
10. Use of consultants.
11. Other relevant criteria as determined by the medical staff, returns to the O.R., returns to the E.R., returns of infections including surgical site infections, central line infections, ventilator required pneumonia.
12. Hand washing.
13. Critical events.
14. Core measures compliance. Information derived from OPPE may be used to determine whether:
    - To Continue
    - To limit
    - To revoke any existing privileges
    - To initiate a problem specific focused professional practice review (FPPE).

Actions may be taken when deficiencies in OPPE become apparent and need not wait until the bi-annual reappointment process. Data from each 8-month evaluation should be considered in aggregate when reviewing data for reappointment. All practitioners are subject to review.

SECTION IV: MEDICAL STAFF MEMBERSHIP

QUALIFICATIONS

1. Qualifications for Membership:

   Effective April 11, 1996, all new applicants seeking Active Medical Staff Membership must practice medicine full time and have a bona fide office within New Jersey and within thirty (30) minutes' travel time of the Hospital in order to insure prompt and appropriate response to E. D. call. Exceptions may be made according to hospital need. For example, in extenuating circumstances where the area lacks certain services, privileges may be granted to physicians and other health care providers practicing and residing outside of the area in order to make available proper and adequate care to patients served by this Hospital. Tele-medicine physicians do not need to maintain an office within the geographical area. Members admitted to the Organized Medical Staff prior to the effective date of November 25, 2014 shall be subject to the terms and conditions relating to office address that were in effect at the time of their admission to the staff. All applicants to the Medical Staff must meet the membership requirements stated in the HMH Medical Staff Bylaws Article III, 3.2 and 3.3. All Medical Staff members shall pay $250.00 dues annually with the exception of AHP's and Telemedicine physicians. They shall pay $100.00 medical staff dues annually.

2. When a doctor changes his/her office address or telephone number, he/she should notify the Medical Staff Manager immediately. In addition, all physicians must supply their cell phone number. If there is any change in his/her home address or telephone number, he/she must notify the Medical Staff Manager within thirty (30) days of such change. Failure to do so will require an explanation to the Credentials Committee and Medical Executive Committee of the Medical Staff.

3. All applicants to the Medical Staff will be required to pay a non-refundable application fee in the amount of $1,000.00 plus $300.00 processing fee. The Meridian Application Fee Schedule will be followed for all applicants.

4. Individuals in administrative positions who desire medical staff membership or clinical privileges are subject to the same procedures as all other applicants for membership or privileges.

5. Surgical Assistants will be reappointed to the staff every two (2) years in the same way as other staff members. Surgical Assistants do no need to have an office address. The reappointment form and Delineation of Privileges form will be designated for Surgical Assistants.

6. Each Medical Staff member agrees to abide by the HIPAA regulations and the Bayshore Medical Center "notice of privacy practices".

7. The Senior Medical Staff. Staff members can be eligible for Senior Attending status after age 55 (fifty-five) and 20 years of Active Status. Senior Attending members shall be eligible to vote, hold office, and serve on committees. They shall pay the annual Staff dues until the age of sixty-five (65) at which time they will be relieved of this obligation.

GENERAL RULES OF MEMBERSHIP

1. Previous Seniority Status

   When a physician who had previously been on the Medical Staff is approved again for Medical Staff membership, the previous time of his/her membership shall count towards his seniority status.

2. The Active Medical Staff

   The Active Staff (excluding Regional) shall consist of practitioners who meets the basic and specific qualifications set forth in the Meridian Bylaws in Section 3.2 and Section 3.3, as well as further qualifications set forth as follows: Practitioners who admit at least six (6) patients a year to the Hospital or who provide services to at least twenty-five (25) hospital-based patients. Description of services would include a history and physical examination, recommendations for treatment or actual provision for treatment in the form of consultation, performance of a procedure, or hands-on examination and treatment in the Emergency Department. Descriptions of such services must be a matter of hospital medical record. Each member of a group must admit at least six (6) patients a year or provide services to at least twenty-five (25) hospital-based patients in order to remain on the Active Staff. The physician must practice medicine full time and maintain a bona fide office within thirty (30) minutes' travel time or within the recognized service area of the Hospital in order to assure prompt and appropriate response to E. D. call.

3. Change in Status

When a physician who is currently an Affiliate Staff member with no clinical privileges decides to change status to Active Staff, that physician must then be put on Provisional Status for one year and placed on FPPE.

4. Promotions

When a practitioner is due for a promotion, his/her status and activity will be reviewed on his/her anniversary date to see if the practitioner is eligible for promotion. The Chair of the respective department must take into account the following:

a) Degree of activity of the candidate for promotion which is consistent with his/her specialty and practice. Activity at the Hospital including admissions and patient contacts of sufficient number so that the doctor's work can be evaluated.

b) Participation in Medical Staff activities to include department meetings, committee meetings, and Semi-Annual Staff meetings.

c) Eligibility to vote in the year that the candidate is suggested for promotion. The previous years' records should also be reviewed.

d) No pattern of being on suspension for incomplete medical records. The Quality reports on the practitioner's work should be reviewed by the Chair of service.

e) Before a doctor can be promoted from Assistant Attending to Attending, he/she must have attained Board Certification.

5. Tele-Radiology Staff

a) The tele-radiology staff shall consist of medical staff appointees who are granted specific privileges to provide medical services via a tele-radiology link from a remote location for the specific purpose of providing consultation in the diagnosis and treatment of patients.

b) Appointment to the Tele-Radiology Staff does not entitle the appointee to admit patients, to vote or to hold staff offices. Tele-radiology staff may attend meetings but are not required to. They are not required to participate on any on-call schedule and they shall be required to pay Medical Staff dues of $100.00. They must comply with the Medical Staff Bylaws and Rules and Regulations policy on Appointment.

c) To be eligible for tele-radiology staff, the applicant must satisfy the specific departmental or division requirements for tele-radiology privileges in accordance with individual department/division policy/procedure.

d) All applicants are required to produce two forms of photo identification, one of which must be of governmental issue.

e) The division or department of the Medical Staff will be required to determine which services and modalities commonly provided by via tele-radiology in the form of policy and procedure which must be approved by the Medical Executive Committee and determine what specific criteria for clinical privileges are relevant to those services in a form of policy and procedure. They must be imported into the departmental QA process and review each application to determine the appropriateness and security of the tele-radiology equipment to be used by the applicant requesting tele-radiology privileges.

6. The Tele-Neurology Staff

a. The Tele-Neurology staff shall consist of medical staff appointees who are granted specific privileges to provide medical services via a tele-neurology link from a remote location for the specific purpose of providing consultation in the diagnosis and treatment of patients.

b. Appointment to the Tele-Neurology Staff under Telemedicine Staff does not entitle the appointee to admit patients, to vote or to hold office. Tele-medicine staff may attend meetings but are not required to. They must comply with the Medical Staff Bylaws and Rules and Regulations policy on Appointment.

c. To be eligible for Tele-Neurology Staff, the applicant must satisfy the Specific departmental or division requirements for Tele-Neurology privileges in accordance with individual department/division policy/procedure.

d. All applicants are required to produce two forms of photo Identification, one of which must of governmental issue.

e. The division or department of the Medical Staff will be required to determine which services will be provided via tele-neurology through the granting of clinical privileges in tele-neurology. Tele-neurology activity must be included in the department QI process.

7. Special Staff Meetings

a. The President of the Medical Staff or a two-thirds (2/3) majority of the Medical Executive Committee may call a special meeting of the Staff at any time. The President of the Medical Staff shall call a special meeting within thirty (30) days after receipt by him/her of a written request for same, signed by not less than one-fourth (1/4) of the Active Staff stating the purpose for such meeting. The Medical Executive Committee shall designate the time and place of any special meeting.

b. Written or printed notice stating the place, day and hour of any special meeting of the Staff shall be delivered, either personally or by mail, to each member of the Active Staff not less than five (5) nor more than twenty (20) days before the date of such meeting by, or at the direction of, the President of the Medical Staff. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each

Active Staff member at his/her address as it appears on the records of the Hospital. Notice may also be sent to members of other Staff groups who have so requested. The attendance of a member of the Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

8. Sentinel Event Focus Review Process

a. In the case of a sentinel event and if a focus review process is necessary, the Medical Staff will participate in a Sentinel Event Ad Hoc Committee.

9. Special Physician Meeting

a. Whenever the medical staff suspects that a physician is not complying with medical staff or hospital policies or has deviated from standard clinical or professional practice, the practitioner may be required to confer with the president of the medical staff or the applicable department or committee chair, or with a standing or ad hoc committee that is considering the matter. The practitioner will be given special notice of this mandatory meeting at least 10 days prior notice. This notice will include the date, time, place a statement of the issue involved, and a statement requiring the practitioner's attendance. Should the physician fail to appear at such meeting after two notices, unless excused the MEC for an adequate reason, the physician's membership and privilege will be automatically terminated. Such termination would not give rise to a fair hearing, but would be automatically rescinded if, and when the practitioner participates in a subsequent meeting.

10. Allied Health Professionals

At no time shall the AHP assume the responsibilities of the physician member. All Allied Health Professionals will be assigned to a clinical department. An AHP is not eligible to provide sole consultation and may only perform a preliminary review of the patient. The collaborating/supervising physician may not abdicate his role in providing medical care to the patient and must continue to provide daily visits to all patients of which he is the attending physician of record, or weekly visits to those patients for whom he is consulted. AHP's will be required to pay $100.00 medical staff dues annually. AHP's are not allowed to vote or to hold office.

IMPAIRED PHYSICIANS

1. Impaired Physicians:

a) For the purpose of these Bylaws, an impaired physician is defined as a "physician whose professional performance has been impaired as a consequence of alcohol abuse, the abuse of drugs other than alcohol, mental or emotional illness, dementia, or a physical disability severe enough to impact on professional performance."

b) The President of the Medical Staff, on January 1, shall appoint for a term of one (1) year (this term may be renewed), two respected members of the Medical Staff to serve as a Physicians' Health Team. The composition of this team is to be reported in confidence, and in writing, to the President of the Hospital. The team will act as a liaison with the Physicians' Health Program of the Medical Society of New Jersey. (The State Society Program should be recognized as an extension of Hospital resources and not as an outside agency to deal only with serious problems).

c) All questions, complaints or inquiries that arise concerning the professional performance of any Staff member where the issue of "impairment" is a consideration shall be referred to this team.

d) It is their responsibility to review the issues and the allegations and to document the facts in the individual case.

e) If there is sufficient reason to believe that impairment may be an issue, the Physicians' Health Team should seek consultation with the Physicians' Health Program Staff of the Medical Society of New Jersey. After a review of the issues, allegations, and the factual documentation, the MSNJ Physicians' Health Program will interview the physician and render an opinion as to the existence of impairment.

f) Referral for treatment after evaluation shall be the responsibility of the Physicians' Health Program. If the physician refuses referral, or refuses to continue or complete a recommended treatment plan, and a determination is made that his/her activities, competence or professional conduct are below the standards established by the Medical Staff for proper patient care, the President of the Medical Staff, the President of the Hospital, and the Chair of the respective department shall be notified immediately and shall have the authority to summarily suspend all or any portion of the clinical privileges of the physician, such suspension to become effective immediately upon imposition. A physician upon whom summary suspension has been imposed, may request a hearing by the Medical Executive Committee within a reasonable time in accordance with the procedures provided in Articles VII and VIII of the Medical Staff Bylaws.

g) The monitoring of treatment shall be the responsibility of the Physicians' Health Program with assistance from the Medical Staff members, as requested. Reports of such monitoring shall be submitted on a regular basis to the President of the Medical Staff and shall be discussed, on a need to know basis, with the President of the Hospital and the involved practitioner's Department Chair. Any cost for treatment or laboratory testing required for monitoring shall be the responsibility of the involved practitioner.

h) Following appropriate treatment, a recommendation concerning clinical privileges shall be made by the Physicians' Health Program and the Physicians' Health Team to the President of the Medical Staff and transmitted to the Department Chair. Any such requested change in privileges shall follow the normal course prescribed in Article VI, Section 1.e. of the Bylaws of the Medical Staff.

i) The Hospital shall abide by the reporting provisions of the New Jersey professional Conduct Reform Act of 1989 and subsequent regulations. When appropriate, the involved physician may be enrolled in the "***Alternative Resolution Program"*** described in N.J.A.C.13:35-11.

j) Subject to paragraphs (f) and (i) of this Rule and other law, ethical obligation or patient safety, information relating to a physician who has sought referral or has been referred for assistance shall be maintained by the Physicians' Health Team on a confidential basis.

k) An education program will be made available to the Medical Staff and all hospital staff annually, that will address illness and impairment recognition issues specific to all health care providers and administration.

DISRUPTIVE PHYSICIANS

1. Disruptive Physician Behavior:

(a) Expected Conduct of Medical Staff Members

Members of the Medical Staff shall conduct themselves in accordance with the ethical principles of their professions, and with courtesy and respect towards patients, colleagues, visitors, and employees of Bayshore Medical Center.

(b) Definitions

i. "Harassment" is defined as any verbal or physical conduct that denigrates or shows hostility or aversion toward an individual because of that person's race, skin color and other characteristics, religion, gender, national origin, age, sexual orientation or disability, or that person's relatives, friends or associates and that 1) has the purpose or effect of creating an intimidating, hostile or offensive work environment; 2) has the purpose or effect of unreasonably interfering with the individual's work performance; or 3) otherwise adversely affects the individual's employment opportunities.

ii. "Sexual harassment" is defined as any unwelcome verbal or physical conduct of a sexual nature when submission of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, promotion or other aspects of employment; or this conduct substantially interferes with an individual's employment or creates an intimidating, hostile or offensive work environment. Sexual harassment also includes conduct which indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities. Examples of sexual harassment include, but are not limited to,

unwanted sexual advances; demands for sexual favors in exchange for favorable treatment or continued employment; repeated sexual jokes, flirtations, advances or propositions; verbal abuse of a sexual nature; graphic verbal commentary about an individual's body, sexual prowess or sexual deficiencies; leering, whistling, touching, pinching, assaulting, coercing sexual acts or suggestive insulting, obscene comments or gestures; and displays in the workplace of sexually suggestive objects or pictures.

iii. "Disruptive Behavior" is defined as conduct engaged in by a member of the Medical Staff which constitutes verbal or physical abuse or harassment, or whose actions interfere with the orderly operation of the Medical Staff or the Hospital. Examples of disruptive behavior include, but are not limited to the following:

(A) Willful disregard for the standards, rules and procedures established by the Hospital or Medical Staff.
(B) Failure to work in a harmonious or cooperative manner with others.
(C) Threatening, intimidating or coercing any member of the Medical Staff, employee of the Hospital, patient, or other individual on Hospital premises, whether verbally or physically.
(D) Use of abusive language and/or shouting.
(E) Throwing objects at or in the direction of another individual.
(F) Making inappropriate comments or illustrations in patients' medical records or other official documents.
(G) Use of non-constructive criticism toward other staff members which is intimidating or belittling.
(H) Offensive or discriminatory verbal, non-verbal or physical conduct regarding an employee's race, color, religion, age, sex, sexual orientation or national origin.
(I) Any type of harassment, sexual or otherwise, as such terms are defined in Sections (b)(1) and (b)(2) of this Section.

(c) Investigation of Disruptive Behavior

i. It is the duty and function of the Medical Staff President to safeguard the Medical Staff's interest by initiating the appropriate investigations of any known Disruptive Behavior by any of its members. The Medical Staff is committed to the prompt investigation of every reported incident.

ii. Any allegation of a member's Disruptive Behavior shall be communicated to the Medical Staff President in writing, unless such allegation is brought against the President, in which case it shall be communicated to the Medical Staff Vice President. Such allegation must be supported by reference to the specific activities or conduct which constitutes Disruptive Behavior. Allegations may be brought by any employee of the Hospital or by any member of the Board of Trustees.

(d) Upon receipt of an allegation of Disruptive Behavior, the Medical Staff President (or Vice President, as the case may be) shall assemble an Ad Hoc

Committee consisting of three members of the Medical Staff, who shall conduct an informal investigation. The Medical Staff President shall also notify the alleged disruptive member of the allegations brought against him or her, and the member shall be afforded an opportunity to refute or explain such allegations in an informal meeting with the Ad Hoc Committee. Such meeting shall be preliminary in nature, shall not be considered a hearing as defined in Article VIII of the Medical Staff By-Laws, and shall not confer upon the alleged disruptive member any of the rights enumerated thereunder. Upon consideration of the allegation and the member's response, the Ad Hoc Committee shall present to the Medical Staff President its findings and a recommendation.

iv. The Medical Staff President shall determine, based upon the recommendation of the Ad Hoc Committee and his or her own investigation of the facts, whether further action should be taken in accordance with Article VII of the By-Laws ("Formal Corrective Action For Disruptive Behavior").

A. First Incident If the allegation is the first alleged incident of Disruptive Behavior by the member, then the Medical Staff President shall convey his findings to the member in an informal meeting and advise him whether further action will be pursued under Article VII of the By-Laws. If deemed appropriate, the Medical Staff President shall send a letter to the member advising the member of the findings that were made and the recommendations regarding the member's future conduct, if any.

B. Second or Subsequent Incident. If a second or subsequent incident of Disruptive Behavior is alleged, or if the Medical Staff President has reason to believe that a pattern of Disruptive Behavior has developed, the member shall be so informed. In such case, a letter shall be sent to the member, advising him or her that continued failure to conform with the standards of conduct set forth herein shall result in the institution of proceedings under Article VII of the By-Laws.

d) Egregious Disruptive Behavior.

Notwithstanding the procedure described above, if at any time the Medical Staff President or a majority of the Ad Hoc Committee determines that egregiously disruptive conduct has occurred which is likely to be repeated or is sufficiently serious to require formal corrective action, the matter may be referred to the Credentials Committee for the purpose of initiating formal corrective action proceedings under Article VII of the By-Laws, at which time the investigation under this regulation shall be terminated.

e) Referral for Corrective Action.

If, after an investigation conducted pursuant to Section 32 of the Rules and Regulations, a member is found to have engaged in Disruptive Behavior that is serious enough to warrant formal corrective action, the matter shall be referred

to the Medical Executive Committee in accordance with Article VII, Section 1, of the Medical Staff Bylaws.

BOARD CERTIFICATION

1. Board Certification

All new members of the Medical Staff entering and asking for privileges after January 11, 1997 will be required to sit for Board Certification by a Board recognized by the American Board of Medical Specialties or the American Osteopathic Association in the specialty in which they practice within five (5) years of completion of residency and fellowship (if fellowship training is applicable) in their primary area of training, and as otherwise required in the Medical Staff or Department rules and regulations. Any physician that does not achieve Board Certification within five (5) years of completion of residency and fellowship (if fellowship training is applicable) in their primary area of training, and as otherwise required in the Medical Staff or Departmental rules and regulations will be considered to be voluntarily resigned. Any applicant removed from the staff will not be entitled to a Fair Hearing. The foregoing five (5) year time period shall be extended by the amount of time that an applicant is in the active military service or temporarily disabled and as a result unable to meet the requirement to become Board Certified. Any applicant who was terminated at another hospital after not achieving board certification within five (5) years shall not be permitted to reapply until board certification is obtained.

All Current physicians on our Medical Staff, with time-limited privileges either his/her specialty, must achieve Board Certification in accordance with the Meridian Medical Staff Bylaws 3.3.1., f.

APPLICATION PROCESS

1. Pre-application

A pre-application will not be given. The Medical Staff Office will review the candidates for qualifications before sending an application. The qualifications are listed in HMH Bylaws, Article III, and Basic Qualifications for Membership. 3.2 and 3.3, as well as having a bona fide office address within thirty (30) minutes driving time (according to Mapquest or Google Maps) of the hospital where the candidate is applying.

2. Criminal Background Checks

All applicants to the Medical Staff shall agree to a criminal background check, Rubella and Rubeola Titers, Quantiferon, and Drug Screen as a condition for eligibility for membership on the Medical Staff. Physicians that have joined the staff at any of the other Hackensack Meridian Health Division within the last 2 years do not need to have an additional drug screen. Any and all relevant information obtained as a result of the criminal background check and/or drug screen shall be considered by the applicable department, the Credentials Committee, the Medical Executive Committee and the Board of Trustees in making any recommendations or determination regarding any application for membership on the Medical Staff. All applicants will agree to appear before the Credentials Committee if necessary.

3. Application for Appointment

The application fee will be submitted with the application. If the application is submitted electronically, the fee will be forwarded with the required supporting documentation. Until such time that the fee is received no work will commence on the application. At the request of the department Chair or president of the medical staff, however, this requirement may be waived.

a. A complete (clean) application is one which all questions have been answered, materials and required information has been received, and has been reviewed by the Department Chair and an interview has been conducted with the applicant.

4. Reappointment Process

a. Each recommendation concerning the reappointment of a Staff member and the clinical privileges to be granted upon reappointment shall be based upon evidence of the following: such member's (1) basic medical knowledge, (2) professional judgment, (3) sense of responsibility, (4) ethical conduct, (5) competence and skill, including quality improvement reports, (6) cooperativeness, ability to work with others, (7) use of hospital facilities, (8) appearance, (9) history and physical exam taking, (10) record keeping, (11) case presentations, (12) patient management, (13) physician-patient relationship, (14) ability to understand/speak English, (15) participation in Medical Staff affairs, (16) physical and mental capabilities, (17) continuous professional education, and (18) attendance at meetings.

b. The Staff member will submit a copy of his/her current license and copies of current Controlled Substances Registrations, both from the Drug Enforcement Administration and the New Jersey Department of Health. Tele-medicine physicians do not need a CDS or a DEA as those privileges are not relevant to the service provided by them. He/she must also submit a copy of the current binding agreement for malpractice insurance from his/her insurance company indicating policy number, limits of coverage, and expiration date. All members of the Medical Staff and Dental Staff are required to carry a minimum

of $1 Million per single occurrence and $3 Million per aggregate in liability insurance.

ELECTIONS

1. Nominations

a. Nominations for Officers and Members-at-Large:

The Nominating Committee shall be responsible for the nomination of officers of the Staff and members-at-large of the Medical Executive Committee. The Nominating Committee may nominate the President, Vice President, Secretary and Treasurer of the Medical Staff for a term of one additional year providing that an Officer who has served for two years is eligible to be re-elected. The Medical Staff President, Vice President, Secretary and Treasurer shall not be eligible to serve more than three consecutive years as a slate. If an officer cannot fulfill the additional year for any reason, the MEC can approve someone to finish out the year that is eligible and accepting of the position to serve out the additional year.

b. Nominations for Department Chairs:

A Nominating Committee for each departmental election shall be appointed by the respective department Chair and shall be comprised of three (3) members of the Active Staff, all of whom must be members of the department and eligible voters. They may not be nominated for office. Those departments which, because of their nature and size, do not wish to have a formal Nominations and Elections Committee may dispense with that procedure by a two-thirds (2/3) vote of the members of the department.

2. Eligible Voters

Eligibility for voting privileges will also be based on attendance to at least one (1) Semi-Annual Staff meetings and five (5) committee, section, or attendance at one 1) Semi-Annual Staff Meetings combined with Active Staff status (excluding Regional) for the year prior to elections. Active Staff shall consist of physicians who attend at least one (1) Semi-Annual Staff meetings and who admit at least six (6) patients a year to the Hospital or who provide services to at least twenty-five (25) hospital-based patients. Description of services would include a history and physical examination, recommendations for treatment or actual provision for treatment in the form of consultation, performance of a procedure, or hands-on examination and treatment in the Emergency Department. Descriptions of such services must be a matter of hospital medical record. Each member of a group must admit at least six (6) patients a year or provide services to at least twenty-five (25) hospital-based patients in order to remain on the Active Staff. The physician must practice medicine full time and maintain a bona fide office

within thirty (30) minutes' travel time and within New Jersey in order to assure prompt and appropriate response to E. D. call.

Active Staff Status includes attendance to at least one (1) Semi-Annual Staff meetings during the one-year period beginning January 1 to December 31 of the year preceding the election. Eligible voters will also include oral surgeons, dentists and podiatrists providing they meet the requirements. At the discretion of the Medical Executive Committee, those new members of the Staff who have been Staff members for twelve (12) months immediately preceding any election in which they would otherwise be eligible to vote but for their lack of inclusion on the then current eligibility list may be added to the list by the Medical Medical Executive Committee by written request to this Committee setting forth their compliance with all requirements during the preceding twelve (12) months.

The list of eligible voters shall be posted by the Medical Staff Manager by August 1. This list shall be applicable to all elections conducted by the Medical Staff and departments until the new list of eligible voters is posted on the following August 1.

3. Eligible Candidates

a. Only eligible voters may be nominated for office. The candidates who are nominated must have interest, either expressed beforehand or determined after presentation of their names. All candidates interested in running for office must submit their request in writing to the Medical Staff Office and attest that they are eligible to run for office thirty (30) days prior to the posting of the proposed slate. All candidates for officers, members-at-large, and Chairs of departments must be Active members of the Medical Staff. Candidates for officers must have Attending status; candidates for members-at-large may be Attending for at least two (2) years Attending or Senior Attending members; candidates for Chair of a department must be Attendings for at least three (3) years and will be eligible in accordance with the Rules and Regulations of that department. The physicians who are nominated may not be on suspension either at the time of nomination or at the time of election. In addition, the number of times a physician has been on suspension from the Medical Staff because of inadequate records should also be taken into consideration. It is expected that all nominees will be those physicians who use Bayshore Medical Center as their primary hospital facility. Any physician who has been on suspension for 30 days or more cumulative for one year prior to the November 1st nominations will be ineligible to run for office.

4. Posting of Slate

a. For Officers and Members-at-Large:
The slate for officers and members-at-large of the Executive Committee must be posted by November 1 in a conspicuous place.

b. For Chairs of Departments:
The slate for Chairs of departments must be posted in September or one month prior to the elections.

5. Nomination by Petition

a. For Officers and Members-at-Large:
Nominations by petition for officers and members-at-large will be accepted within ten (10) days after posting of the slate. Such petitions must contain signatures of at least one-third (1/3) of the eligible voters.

6. For Officers and Members-at-Large:

The Nominating Committee will become the Election Committee and will be responsible for conducting the election for officers and members-at-large of the Medical Executive Committee. All candidates for Officers must have Bayshore Medical Center as their Primary Division and must be an Attending for at least seven (7) years. There will be a maximum of eight (8) seats and a minimum of six (6) seats for members-at-large, the number to be determined by the Medical Executive Committee prior to the election. All candidates for Members-at-Large must be an Attending for at least two (2) years and must have Bayshore Medical Center as their Primary Division. Elections for Members-at-Large will be conducted yearly at the December Semi-Annual Staff Meeting. Members-at-Large may not serve more than three (3) years consecutively. For the election of the designated number of seats the physicians receiving the highest number of votes will serve as members-at-large. The printed ballot of the candidates chosen by the Nominating Committee, as well as any nominations by petition, shall be presented at the Semi-Annual Staff Meeting in December. The election shall be conducted by secret ballot. Absentee and proxy ballots will not be accepted. The balloting will cease at the time the meeting is adjourned and votes will be tallied and the results announced as soon as possible following the completion of the balloting. All elections for officers shall be decided by majority vote of the persons voting. In the event that no candidate for officer receives a clear majority (greater than 50%), a runoff election between the two candidates with the highest vote totals shall be conducted as soon as possible after the completion of the tallying of the ballots. In the event of a special election or of a tie for the last seat for members-at-large, a run-off election between the candidates who are tied will be conducted. The election shall be determined by a majority of the votes cast in the run-off election. In the event of a tie, the run-off election would be conducted in private in the medical staff office with only one ballot per eligible voter to only those eligible voters who were present at the Semi-Annual Staff meeting. In the event of a special election, the election will be held in private in the medical staff office with only one ballot per eligible voter.

7. For Chairs of Departments:

If a Nominating Committee has been appointed by the Chair of a department, this Committee will be responsible for conducting the election for Chair of that department. Candidates for Department Chair must have Bayshore Medical Center as their Primary Division and must be an Attending for at least three (3) years. The printed ballot of the candidates chosen by the Nominating Committee, as well as any nominations by petition, shall be presented at the September meeting of the respective departments. The election shall be conducted by secret ballot. Absentee and proxy ballots will not be accepted. The results of the election will be announced at the close of the meeting. All elections shall be decided by majority vote of the persons voting. In the event that no candidate receives a clear majority, a runoff election between the two candidates with the highest vote totals shall be conducted as soon as possible after the completion of the tallying of the ballots. The election shall be determined by a majority of the votes cast in the runoff election.

8. Election Disputes

a. Disputes - Voting Eligibility:

Should any practitioner dispute his/her loss of voting privileges as signified by exclusion from the list of eligible voters, the practitioner must notify the Nominating Committee within seven (7) days of the posting of the list, in writing, of his/her request for a reconsideration of eligibility to vote. This dispute shall be reviewed by the Nominating Committee in an informal manner. At this informal review, the aggrieved practitioner may be present if he/she so desires and a review of the attendance records maintained respecting Staff, departmental and committee meetings will be undertaken. The Nominating Committee will then confer outside of the presence of the aggrieved practitioner and make a determination as to eligibility. Notice of this determination will be forwarded to the aggrieved practitioner, either in person or by mail, within seven (7) days. If the aggrieved practitioner is not added to the list of eligible voters, he/she may then appeal the decision to the Medical Executive Committee.

b. Disputes - Nominations or Elections:

In case of a dispute as to either nominations or an election, the aggrieved practitioner(s) shall give written notice of the dispute to the Nominating Committee within seven (7) days of the posting of the nominations or of the final tallying of the ballots respectively, as the case may be. The Nominating Committee shall review the dispute with the aggrieved practitioner(s) at a special meeting to be convened within seven (7) days of its receipt of the written notice of dispute. This shall be an informal meeting with the aggrieved

practitioner(s) and any other practitioners who may wish to be heard. The Nominating Committee shall then confer outside of the presence of the aggrieved practitioner(s) and any other interested practitioners and shall determine how the dispute shall be resolved. The Committee may order a new slate of nominations to be prepared, a new election with the same or a different slate of candidates, or may determine that the dispute is invalid and let the result of the election stand. In the event that the aggrieved practitioner(s) or some other practitioner(s) is dissatisfied with this resolution of the dispute by the Committee, then written notice of this dispute shall be served upon the Medical Executive Committee as soon as is practicable and not later than seven (7) days from the announcement of the Nominating Committee's decision. No further action shall be taken by the Nominating Committee respecting the election after such notice is filed until so ordered by the Medical Executive Committee.

Upon receipt of notice of a dispute with the determination by the Nominating Committee, the Medical Executive Committee shall, at its next meeting, consider the dispute and rule on the matter. Any member of the Medical Executive Committee named in the dispute shall abstain from voting. The decision of the Medical Executive Committee shall be final. In the event that new elections are ordered, they shall be held within thirty (30) days of the directive from the Medical Executive Committee.

DISCLOSURE

1. Any candidate that is running for Medical Staff Office must disclose any indictments or convictions to the Nominating Committee. If still nominated, all candidates must disclose this information by letter to all of the eligible voters for that election. The letter will contain a confidentiality statement. Failure to disclose this information in advance will be grounds for removal from office.

2. If a physician is a member of the Board of Trustees at this hospital and he/she is running for an Officer of the Medical Staff, he/she must disclose this information to the eligible voters.

PRIVILEGES

1. Temporary Privileges

Circumstances. The President or his/her designee may grant temporary Privileges ("Temporary Privileges") in accordance with Section 8.3.1 in the following circumstances:

Pending application. The President or his/her designee may grant Temporary Privileges in accordance with this Section when an applicant has satisfied the criteria and has a "clean" application set forth in Section 8.3.1(iii) and the

applicant's complete application has been recommended for approval by the Division Medical and Dental Staff President and Credentials Committee and is awaiting review and approval of the Medical Executive Committee and/or the Board, or to fulfill an important patient care, treatment and service need, upon the written concurrences of the President and of the Medical and Dental Staff President. Temporary privileges may be granted for no more than a period of forty-five (45) days.

Locum Tenens. A Physician engaged as a Locum Tenens may be granted Temporary Privileges if requirements are met in accordance with Articles 3.2, 3.3., 7.2 (if applicable), and 7.3 and 7.4 of the Medical Staff Bylaws. Temporary Privileges may be granted by the Board.

2. Disaster/Emergency Privileges

a) In the case of disaster or emergency, any duly licensed physician, to the degree permitted by his/her license and regardless of service or Staff status or lack of it, shall be permitted and assisted to do everything possible to prevent serious harm to a patient and/or save the life of a patient, using every facility of the Hospital. When a disaster or emergency situation no longer exists, such practitioner must request the temporary privileges necessary to continue to treat the patient. In the event such privileges are denied or the member does not desire to request such privileges, the patient shall be assigned to an appropriate member of the Staff. For the purpose of this Section, a "disaster or emergency" is defined as a condition in which serious 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.

b) Disaster or Emergency privileges may be granted when the Emergency Management Plan has been activated, and the organization is unable to handle the immediate patient needs. During disaster(s) in which the Emergency Management Plan has been activated, the chief executive officer or medical staff president, or his or her designee(s) has the option to grant emergency privileges to volunteer physicians upon receipt of at least one of the five identification (ID) documents listed below:

1. Current hospital photo ID card.
2. Current medical license and a valid picture ID issued by a state, federal, or regulatory agency (when presented with an out-of-state license, defer to your state law on whether he or she may practice without an in-state license).
3. ID that certifies that the individual is a member of a disaster medical assistance team (DMAT).
4. ID that certifies a state, federal, or municipal entity has granted the individual the authority to administer patient care under emergency circumstances.

5. Presentation by a current hospital or medical staff member who can vouch for the practitioner's identity (It is recommended that hospitals be less willing to rely on this particular option).

c) When the Emergency Management Plan has been activated, primary source verification of licensure begins as soon as the immediate situation is under control and is completed within 72 hours from the time the volunteer practitioner presents to the organization. In extraordinary circumstances when the primary source cannot be completed within 72 hours, it is expected that it will be done as soon as possible and documented.

d) The emergency privileges granted under this Section shall not in any way be deemed to confer upon the physician membership of any sort on the Medical Staff of this Hospital. He/she will act in accordance with the Bylaws and the Rules and Regulations of the Hospital with respect to the treatment of such patients.

3. Expedited Privileges

a. To expedite the approval process for the appointment, reappointment, or modification of clinical privileges. The Hackensack Meridian Health Corporation Board of Trustees has delegated the authority to approve initial appointment, reappointment, and renewal of modification of clinical privilege decisions to the Credentialing Subcommittee of the Medical Council. This procedure is to be made available only in exceptional cases at the request of the department chair. Expedited credentialing would only be exceptional when the time period between a recommendation to approve an application at the Medical Executive Committee and the anticipated approval at the next Board of Trustees meeting would constitute an undue burden for the division or for the physician/group.

b. In those cases when expedited credentialing is requested, a positive recommendation from the Medical Executive Committee on an application is forwarded to the Credentialing Subcommittee. The Subcommittee shall review and evaluate the qualifications and competence of the practitioner applying for appointment, reappointment, or modification of clinical privileges and render its decision.

c. Membership of the Subcommittee shall consist of the following members:

I. The Chair of the Medical Council
II. The President of Hackensack Meridian Health Corporation
III. The Division President
IV. The Chief Medical Officer
V. The President of the Medical Staff

At least two members of the Board of Trustees must be present to approve an application.

Action by the State Board of Medical Examiners revoking or suspending a practitioner's license shall automatically suspend all of his/her division privileges. It shall be the duty of the President of the Medical Staff to cooperate with the President of the Hospital in enforcing all automatic removal of privileges.

4. Automatic Suspension of Privileges

a. Action by State Board

Action by the State Board of Medical Examiners revoking or suspending a practitioner's license shall automatically suspend all of his/her hospital privileges.
It shall be the duty of the President of the Medical Staff to cooperate with the President of the Hospital in enforcing all automatic removal of privileges.

5. Automatic Temporary Suspension

b. Failure to Complete Medical Records

A temporary suspension in the form of withdrawal of a practitioner's admitting privileges, effective until medical records, including but not limited to operative reports, discharge summaries, H & P's, cardiology reports, etc., are completed, shall be imposed automatically after warning of delinquency for failure to complete medical records within thirty (30) days of a patient's discharge. All physicians who repeatedly do not comply with chart completion and whose non-compliance is documented by the Medical Record Department will be presented by the Chairperson of the Performance Improvement Committee to the Credentials Committee for review and recommendation.

If a physician is on suspension for incomplete medical records for three (3) consecutive times within a 12-month period, that physician would be suspended from all new hospital activities including consultations until all records are completed.

c. Failure to Maintain Adequate Up-to-Date Malpractice Insurance

Any physician who is non-compliant in maintaining up-to-date malpractice insurance for all of the procedures for which he/she is fully credentialed will be automatically suspended by the President of the Medical Staff for that period during which he/she is not insured. It remains the responsibility of the physician to request a diminution in his privileges prior to altering his/her malpractice coverage.

d. Failure to Pay Dues

Annual dues shall be assessed members of the Staff on January 1. Failure to pay dues within ninety (90) days shall result in automatic suspension on March 31. A warning notice will be sent fifteen (15) days previously. Should the dues not be paid within this period, the practitioner shall be suspended through the office of the President of the Medical Staff. Suspension shall be defined as the loss of ordinary privileges. These privileges will not be restored until the dues are paid. Should a practitioner violate these rules, he/she shall be liable to additional penalties as determined by the President of the Medical Staff. Monthly extensions for just cause may be granted by the President at his/her discretion.

Failure to Follow Medical Staff Rules and Regulations

Any member who does not follow the Medical Staff Rules and Regulations regarding compliance with policies and procedures and complying with the New Jersey State Department of Health and Senior Services Regulation 8:43 G-20-2 requiring all physicians to have a yearly Quantiferon test. If the facility is declared by the State to be "Low Risk", only ID Physicians, Pulmonologists, Hospitalists, and ER Physicians will be required to have a yearly Quantiferon test.

LEADERSHIP

1. Qualifications of Officers

Each officer elected must have Bayshore Medical Center as his/her primary division. Organized Medical and Dental Staff Officers must be Attendings or Senior Attendings in good standing, have been Members of the Staff for at least seven (7) consecutive years, have served at least one term as Chair of a Committee or Department, or served at least one term as a Vice Chair of a Department or Section Chief, and at least one term on the Medical Executive Committee.

2. Duties of Officers

a. **President**: The President shall serve as the chief administrative officer of the Staff to:
(1) act in coordination and cooperation with the President of the Hospital in all matters of mutual concern within the Hospital;
(2) call, preside at, and be responsible for the agenda of all general meetings of the Staff;
(3) serve as Chairperson of the Medical Executive Committee, with the Right to vote;

(4) serve as ex officio member of all other Staff committees without vote;

(5) be responsible for the strict enforcement of Staff Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

(6) appoint committee members to all standing, special, and multi-disciplinary Staff committees except the Medical Executive Committee. At the first Medical Executive Committee meeting of the year the President will submit his/her recommendation of appointments of committee members to all standing and multidisciplinary Staff committees except the Medical Executive Committee. Special committee assignments will be excluded.

(7) represent the views, policies, needs, and grievances of the Staff to the Board of Trustees and to the President of the Hospital;

(8) receive and interpret the policies of the governing body to the Medical Staff and report to the Board of Trustees on the performance and maintenance of quality with respect to the Staff's delegated responsibility to provide medical care;

(9) be the only spokesman for the Staff in its external professional and public relations; and

(10) serve as an ex officio member of the Board of Trustees.

b. **Vice President:** In the absence of the President, he/she shall assume all of the duties and have the authority of the President. He/she shall be a member of the Medical Executive Committee and the Bylaws/Rules and Regulations Committee. He/she shall automatically succeed the President when the latter fails to serve for any reason. He/she shall serve as the Chairperson of the Medical and Dental Staff Quality Committee (beginning January 1, 2015). He/she should also have a full vote as a member of these committees.

c. **Immediate Past President**: The immediate Past President serves in an advisory nature. He/she is a member of the Medical Executive Committee with full vote. He/she will serve for a period equal to the term of the succeeding President.

d. **Secretary**: He/she shall be a member of the Medical Executive Committee, and shall function as a parliamentarian in the interpretation of Bylaws/Rules and Regulations and in the application of Roberts' Rules of Order at Medical Executive Committee meetings. All committee chairpersons will present to the Secretary any changes needing Medical Executive Committee approval. The Secretary will act as their advocate in clarifying the individual committee requests and will act as direct liaison to the Medical Executive Committee for each individual committee. The Secretary will have the responsibility of reviewing all committee reports and can be called upon to give a general committee report at the Medical Executive Committee session. In the absence of the Vice President, the Secretary shall assume his/her duties.

e. **Treasurer**: He/she shall be accountable for all funds entrusted to him/her and shall be responsible for collection of dues. He/she shall prepare a budget for the year and suggest to the Medical Executive Committee the amount of dues to be assessed. He/she shall pay bills authorized by the Medical Executive Committee. He/she shall advise the President of the Medical Staff on or before March 1 of the names of those Staff members who have not paid their annual dues. In the absence of the Secretary, the Treasurer shall assume his/her duties.

f. Any officer vacancies which remain after any officer successions which may occur pursuant to Section 5 b, d, or e of this Article IX shall be filled by a special election to be held within 45 days after the vacancy occurs, all in accordance with the procedures set forth in Section 7 of Article XIV for the election of officers and members-at-large of the Medical Executive Committee. Election will be conducted by mail ballot and ballots will have a deadline return time of one (1) week from mailing.

g. All officers and members-at-large are responsible to attend at least a one-day medical staff leadership seminar within the first three months of taking office. The leadership seminar will be provided by the hospital. If an elected officer or member-at-large misses the seminar, they would be responsible to take another course deemed acceptable by the president of the medical staff.

h. The President will appoint the Chairman of the Credentials Committee and Chairman of the Bylaws/Rules and Regulations Committee with the approval of the Medical Executive Committee. He/she should also have a full vote as a member Medical Executive Committee and will be a member of Medical Cabinet.

3. Qualifications, Selection and Tenure of Department Chairs

a. Each Chair elected shall be an Attending or Senior Attending member of the Active Staff in good standing in that department of his/her Primary Division, shall be Board Certified in his/her respective specialty, have the majority of his/her practice at Bayshore Medical Center and be best qualified by training, experience, and demonstrated ability for the position as a qualified practitioner in his/her specialty. The Department Chair shall have been an Attending therein for at least three (3) years.

b. Each Chair shall be elected for a two (2) year term, at a departmental meeting held in September every other year. The appointment is subject to approval by the Medical Executive Committee of the Medical Staff and by the Board of Trustees. The term of office shall commence on January 1. The Chair shall serve no longer than two (2) terms and then must be out of office for a period of one term. After a two (2) year term and if there is no one qualified to be Department Chair, the Department Chair may continue with approval of the Medical Executive Committee.

c. The foregoing provision b. does not apply to the Departments of Pathology, Emergency and Ambulatory Care Services, Radiology, and

Anesthesiology which will be governed by the terms of their own departmental rules and regulations.

d. Removal of a Chair during his/her term of office may be initiated by the President of the Medical Staff for due cause. No such removal shall be effective unless and until it has been ratified by a three-quarters (3/4) vote of the full Medical Executive Committee and by the Board of Trustees. Appointment of an acting Chair for that department may be made by the President of the Medical Staff with ratification by a majority vote of the Medical Executive Committee for a period not to exceed ninety (90) days. At the end of that time, a general election will be held within the department.

e. A Vice Chair will be appointed by the Chair of a department, subject to the approval of the President of the Medical Staff and the Medical Executive Committee. The Vice Chair of any department in this institution must have the necessary qualifications to serve as Chair.

f. Upon the resignation of the Chair of a department, an interim Chair will be appointed by the President of the Medical Staff with ratification by a majority vote of the Medical Executive Committee for a period not to exceed ninety (90) days. Within that time, a general election for a new Department Chair will be held by the department.

g. If there is no member of the department who is eligible to become the Chair and/or if there is no member who is willing to fulfill the responsibilities as Chair and State regulations require the department to exist, another department member of the same department will assume the duties as Acting Chair until another Chair can be elected. If the previous Chair has already served two (2) 2-year terms and no other member is willing to become Chair, that Chair may continue for an additional term of two (2) years with the consent of the Department and the approval of the Medical Executive Committee.

Each Chair shall:

a. be accountable for all professional and administrative activities within his/her department;

b. be a member of the Medical Executive Committee, giving guidance on the overall policies of the Hospital and making specific recommendations and suggestions regarding the department in order to assure quality patient care. Chairs or their designee must attend Medical Executive Committee meetings.

c. maintain continuing review of the professional performance of all practitioners with clinical privileges in the department and report regularly thereon to the Medical Executive Committee;

d. be responsible for assuring the implementation of a planned and systematic process for monitoring and evaluating the quality and appropriateness of the care and treatment of patients served by that department.

e. be responsible for enforcement of the Hospital Bylaws and of the

Medical Staff Bylaws, Rules and Regulations within the department;
f. be responsible for implementation within the department of actions taken by the Medical Executive Committee;
g. transmit to the Medical Executive Committee the department's recommendations concerning the Staff classifications, the reappointment, and the delineation and criteria of clinical privileges for all practitioners in the department;
h. be responsible for the teaching, education and research program in the department;
i. participate in every phase of administration of the department through cooperation with the nursing service and the Hospital Administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques;
j. assist in the preparation of such annual reports, including budgetary planning, pertaining to the department as may be required by the Medical Executive Committee and the President of the Hospital;
k. supervise the activities of any sections assigned to his/her department;
l. be responsible to prepare on an annual basis a review of the work of the section in conjunction with the section Chief and be able to make recommendations to the Medical Executive Committee as to whether the section should be accorded departmental status;
m. In the event that a department member cannot complete a patient's chart, the department Chair may complete and sign the same, indicating on the chart the reasons why it was not completed and signed by the attending physician.

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